# Mental health stigma and barriers to seeking help: A survey of the university undergraduate student population

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# Mental Health Stigma and Barriers to Seeking Help: A Survey of the University Undergraduate Student Population

**A Senior Honors Thesis submitted to the Honors Program of the College of Arts and Sciences and Connell School of Nursing**

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## Abstract

The issue of mental health awareness has been a familiar topic of concern in recent years, due to increasing incidence of suicide, PTSD, anxiety disorders, and other behavioral illnesses. Patient populations impacted by mental illness are diverse and research has focused on the recognition of symptoms and the treatment. Less research has investigated the barriers that hinder access to mental health services and the early identification of individuals who need mental health assistance. The specific aim of this study is to evaluate how the stigma of mental illness, both perceived and personal, may affect the willingness of college students to obtain behavioral health care. Based upon the findings, recommendations for improving access to mental health services on a college campus will be proposed.


**Keywords:** mental health; stigma; college students; help-seeking; mental health treatment; university counseling services

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# CHAPTER ONE - OVERVIEW OF STUDY

## Introduction

College is a transitional period in our lives, often unearthing new stressors at a time when young adults are fragile and still developing in maturity. This is especially significant with regards to student mental health, which directly contributes to their academic performance and success. College students are amidst a journey to expand and establish their identity, and thus the thoughts and stigma provided by their peers and role models play a great role in their self-development. This is especially detrimental to the way that they identify with mental health.

## Statement of the Problem

The issue of mental health awareness is growing on college campuses across the United States, due to increasing incidence of suicide, PTSD, anxiety disorders, and other behavioral illnesses. College students impacted by mental illness and their need for university counseling services is growing exponentially. Less research has investigated the barriers that hinder access to mental health services and the early identification of individuals who need mental health assistance. Additionally, more research needs to be done to support existing literature on stigma surrounding mental health and mental health treatment in college cultures.

## Significance and Rationale for the Study

By improving data available on the stigma of mental illness and the barriers to seeking treatment, decisions can be made in an informed manner to improve resources for college students in need of mental health care. A review of the literature found numerous studies examining how the stigma of mental illness adversely impacts help-seeking behaviors. Oftentimes, universities acknowledge an imbalance between the supply and demand of their mental health services but are fiscally unable to resolve it. Counseling centers on college

campuses are facing both a marked increase in the need for their programs and also an increase in the severity of mental illness among students seeking counselors.

**Purpose and Specific Aims of the Study**

Our study will examine the amount of stigma associated with mental health within the undergraduate student population and how the perception of that stigma impacts the willingness of students to seek mental health counseling services on campus. The specific aim of this study is to evaluate how the stigma of mental illness, both perceived and personal, may affect the willingness of college students to obtain behavioral health care. Another aim of the study is to discuss how the university is meeting the needs of students in need of mental health services or ways in which outreach may be improved. Based upon the findings, recommendations for improving access to mental health services on a college campus will be proposed.

# CHAPTER TWO - REVIEW OF LITERATURE

## Introduction

In recent years, mental health has become a common topic of conversation, especially on college campuses where increased competition, workloads, and stress can exacerbate issues with mental wellbeing. College, being a time of transition and change, often provokes new stressors at a time when young adults are arguably more vulnerable than they will be throughout the rest of their lifetime. Young adults entering college "...encounter many developmental changes and challenges, such as separating from parents, forming personal relationships, living independently, and discovering their self-identity. Seventy-five percent of mental illnesses are diagnosed by the age of 24" (D'Amico, Mechling, Kemppainen, Ahern, & Lee, 2016, p. 303). "The prevalence of serious suicide consideration was higher among adults aged 18-29 years than it was for the overall U.S. population" (Crosby, Han, Ortega, Parks, & Gfoerer, 2011). Mass casualty events such as the mass shooting at Virginia Tech, as well as a spike in campus suicides, have brought the college mental health crisis into the public's awareness.

In 2012 there were 5,178 deaths attributed to suicide within the age group 10-24 years old in the United States. This number is suicides alone, but when the number of young adults with suicidal ideation and suicide attempts are included the number rises. In addition to these tragic events, the number continues to rise when other mental illnesses are taken into account, including but not limited to depression, anxiety, and bipolar disorder. There are thousands more college students in the United States battling mental illness daily. In one study, more than 1 in every 10 college students reported that mental health problems considerably affected their academic performance and success (Sontag-Padilla et. al., 2016). Young adults is one of the

populations at highest risk for mental illness and its consequences on their present and future prosperity.

Unfortunately, large proportions of these young adults that exhibit help-seeking behaviors are living at college and are unable to utilize the university counseling services. Almost half of 18-24 year olds in the United States attend a college or university, and about 17% of those student experience serious psychological distress in some form (Sontag-Padilla, et al., 2016). However, data suggests, "only about one-third of college students with mental health problems receive treatment" (Sontag-Padilla et al., 2016, p. 890).

Research is limited analyzing the reasons students in need of mental health services have not sought help. The rates of serious mental illnesses in college students are increasing and studies suggest the majority of seriously suicidal students do seek some form of treatment (Arria, et al., 2011). Although there is extensive research on the rate of mental illness on college campuses, there is a still gap our understanding of the factors that contribute to the rise of mental illness among college age students and help-seeking behaviors. Recent research across the country "...indicates that mental illness in college students is both increasing and becoming more chronic" (Bohon, Cotter, Kravitz, Cello, & Garcia, 2016, p. 594). What are the factors contributing to the rising rates of suicide, and mental illness in general, on college campuses? Does the stigma surrounding mental health play a role in the culture on many campuses deterring students from seeking mental health services?

**Stigma**

Stigma of mental illness is defined as the stereotyping, discrimination, distancing, and status loss faced by the person who is recognized for suffering from a mental illness (Lannin, Vogel, Brenner, & Tucker, 2015). Stigma may be a factor negatively affecting students'

willingness to seek mental health help. “Fear of this stigma prevents students from disclosing their mental health diagnosis, according to the NAMI survey” (Van Pelt, 2013). Not only does stigma deter students from sharing their mental health problems with their peers, but it may keep them from sharing this with the professionals that can help them as well. The Suicide Prevention Resource Center cites stigma as one of the greatest influences on why students are hesitant to seek help.

Stigma can be further differentiated into two subcategories, public stigma and personal stigma, both of which influence thoughts about mental illness and a person’s willingness to reach out for help. Public stigma is defined as, “the prejudice and discrimination endorsed by the general population that affects a person” (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012, p. 963). For example, the public may assume that people with psychiatric conditions are violent and dangerous” (*Definitions of Stigma and Discrimination*, 2017). However, it is possible to be aware of prejudices and stigma without concurring with them or internalizing them, which is the reason that public stigma and personal stigma both need to be addressed (Pattyn, Verhaeghe, Sercu, & Bracke, 2014). Personal stigma consists of negative self-judgments that occur when people acknowledge prejudices and public stigma about mental illness and apply it to themselves (Lannin, Vogel, Abraham, & Heath, 2015). Individuals tend to apply negative public perceptions to their individualized situations, and this can be detrimental to their own mental health.

Research on the efficacy of mental health treatments has acknowledged the need to address and reduce public stigma (Townsend, 2012). The sources of this stigma vary, with several studies identifying media as the primary source of stigma for people with mental health diagnoses (Pingani, Luca, et al., 2016). Stigma exists across all demographics, but certain factors can be indicative of whether a person will exhibit more or less personal stigma (Corrigan, 2004).

Stigma “is not just a feature of a particular disease or disability but is inevitably situated in a web of social interactions that reflect the influence of cultural meanings” (Raguram, Raghu, Vounatsou, & Weiss, 2004, p. 736). These combinations of a variety of cultural factors create a stigma that often prevents individuals from reaching out to get help when they are in need.

**Epidemiology of Suicide on College Campuses**

Although public attention about mental illness has grown, some populations remain underserved. There has been an increase in the action taken surrounding college suicides, following many high profile suicides at colleges such as MIT, Harvard, Columbia, and other Ivy League schools (Mowbray et al., 2006). Despite all of this outcry and concern, there has still been a rate of around 7 students per 100,000 enrolled who successfully complete suicide attempts each year ("Suicide Among College and University Students in the United States", 2014). While this rate has not increased much in the past two decades, it has not decreased nearly as much as the rate of suicide in the general population. From 1980 to 2009, the rate of college students committing suicide fell by only 0.5 per 100,000 whereas the rate of suicide in the general population saw a decline from 15 to 12.1 people per 100,000 according to the Suicide Prevention Resource Center. The CDC cites the suicide rate among individuals attending college as 12.6 per 100,000 as of its most recent data in 2015. CDC reports that 8.0% of college-aged individuals (18-22 years of age) have seriously considered suicide.

One study of college students with a lifetime history of suicidal ideation found, “44% of individuals who experienced suicide ideation since the start of college did not seek treatment for the problem at that time” (Arria et. al., 2011, p. 1510). Despite the acuity of suicidal episodes, an alarming number of students did not seek the help that they needed at the time. In light of this information, it is even more concerning that in sample of more than 46,000 students across 76

universities, there were approximately 10.1% of the population who endorsed suicidal thoughts and a further 1.4% reported having attempted suicide in the past year (Farabaugh et al., 2012). Another study from the American College Health Association found that 10% of students report seriously considering suicide and nearly half of them report extremely significant depression as well (Farabaugh et al., 2012). Students are not underreporting their depression and suicidal thoughts because they are not happening, but rather due to other barriers to help-seeking.

Studies have found that suicidal ideation, suicide attempts, and distress related to psychological issues are more common among college students, but the rates vary based upon other "sociocultural" factors (Eskin, Sun, Abuidhail, Yoshimasu, Kujan, et. Al., 2016). Demographics such as race, gender, ethnicity, sexual orientation, and socioeconomic status play an important role in determining the risk factors for suicide among college students. Even within the vulnerable population of college students, there are often unique risk factors to this population which warrant special consideration.

**Help-Seeking Behavior**

Darcy Gruttadaro, director of the National Alliance on Mental Illness (NAMI) Child & Adolescent Action Center, reported after a 2012 NAMI survey of college students countrywide "that stigma remains the No.1 barrier to students accessing mental health services and supports" (Van Pelt, 2013). This result is widely supported, but research into the stigma experienced by college students often yielded a variety of different results. The gap in the literature does not offer sufficient insight into the effect of stigma on help-seeking behavior or the rising incidence of suicide.

Across the spectrum, research indicated that of the large population of individuals with mental illnesses, only a small percentage of them will actively seek help (Ferrari, 2016). The

primary barrier to seeking help rose from the identification of stigma, either internalized or if it was perceived to exist in the public (Van Brakel, 2006). Similarly, Sontag-Padilla et. al. found, "Students who perceived their campus climate as supportive of mental health issues were more likely to report using combined mental health services and were substantially more likely to report use of campus mental health services" (2016, p. 894). If lack of support and positive reinforcement of seeking help are the biggest barriers to the use of mental health services, then it is important for universities to initiate efforts to eliminate the negative mental illness perceptions on their campuses.

Unfortunately, college students' concern about judgment from peers and their own negative perceptions of mental health help are significant enough to prevent many students with serious mental health issues from reaching out. A study of 180 young adults using the Health Belief Model found that people's perceived severity or susceptibility of their mental illness does not significantly affect their intention to seek help (O'Connor, Martin, Weeks, & Ong, 2014). Thus, young adults who understand or believe they are suffering from severe mental illnesses still may not be seeking help.

The same study also showed that individuals with high-perceived benefits and low-perceived barriers towards seeking help for mental health problems had higher intentions to seek mental health care (O'Connor, Martin, Weeks, & Ong, 2014). Young adolescents at risk for mental illness or who wish to seek help are doing so for a variety of reasons. Encouragement and social support from peers, advertised mental health resources, and a minimal stigma to use of mental health resources are the factors that increase the likelihood that young adults will seek counseling services. However, the role of stigma in many college campuses may still negatively affect help-seeking behavior even when there is peer support, outreach, and availability of

university counseling. “Further exploration of factors associated with students’ use of mental health services could facilitate the development and deployment of programs to increase treatment rates” (Sontag-Padilla et al., 2016, p. 890).

As with all health-seeking behavior, willingness to seek mental health care varies across all demographics. Societal stereotypes and cultural “norms” play a large role in willingness and ability of individuals to seek treatment for mental illnesses. College men in particular is a demographic group that is at a very high risk for not seeking help for mental health issues because of the perceived stigma of emotional responses (Gotlib, 2015). Whether it is fear of being viewed differently or unwillingness to admit that they need help, male college students are at the highest risk for withdrawing from help for mental illness. This stigma is related to the masculine stoicism that is pervasive in college culture, making the reporting of mental illness lower than it is in other populations.

In addition to not perceiving themselves as those who should seek help, male students are more likely to believe that women experience more mental health crises and therefore that women are more likely to seek help for those same mental health issues (Boehm et. al, 1993). Many studies show that not only do women seek mental health help more often than men, but they have a more positive outlook on the efficacy of professional help and tend to have a higher “depression” literacy as well (D’Amico, Mechling, Kemppainen, Ahern, & Lee, 2016, p. 303).

In addition to male students, racial-ethnic minority groups, younger students, and heterosexual students also have lower mental health treatment rates in college; women, graduate students, and LGBTQ students were more likely to use mental health services (Sontag-Padilla et al., 2016). While demographics seems to be an important determining factor in terms of seeking mental health care, it does not alone explain the variation in services. “Student characteristics,

students' mental health-related beliefs, the number of campus mental health providers, and campus size explained only a small portion of the two- to threefold variation in service use across campuses" (Sontag-Padilla et al., 2016, p. 890).

It is also important to account for cultural values and views of mental health when looking into help-seeking behaviors. Historically, certain cultures or ethnicities, especially those of Asian descent, may view depression and suicidal ideations as humiliating and disgraceful to the family. In some cultures, it may be perceived as shameful to seek professional help in order to recover from mental disorders (D'Amico, Mechling, Kemppainen, Ahern, & Lee, 2016). In the context of such cultural values and beliefs, there is a possibility of discrimination or marginalization from one's social support (i.e. family and friends) which can act as a deterrent to seeking mental healthcare.

**Strategies at Universities**

Even if the stigma around mental illness and help-seeking behaviors on college campuses was eliminated, there would still be an issue of a major lack of resources and appropriate services. "The prevalence of mental health problems such as depression and anxiety disorders has been increasing in the past couple of decades among college students in the United States, according to available evidence" (Eisenberg, Hunt, Speer, & Zivin, 2011, p. 301). Daphne Watkins, an assistant professor of social work at the University of Michigan, reports that "...institutions are now faced with increasing numbers of students with severe emotional problems...and budgetary cutbacks that make growth in mental health staffing difficult" (Van Pelt, 2013). Without expansion of services and resources, many college campuses are seeing waitlists for initial assessments and overworked mental health counselors.

For instance, the Provost Committee at the University of Minnesota reported "the waitlist was in existence during approximately 80% of both semesters" in the 2015-2016 academic year (2016, p. 10). For this campus, on average students were on the waitlist for at least 15 days between the student's first request and the actual appointment with a therapist. Some students were on the waitlist for a month or longer. As a result, the Provost's Committee on Student Mental Health proposed increased mental health services at the University of Minnesota in 2016.

Unfortunately, the problem of high demand and low supply of mental health services is common in US universities, but some universities, such as the University of Minnesota, have provided a model for university health counseling services. Another example of a successful program to lower mental health stigma and improve help-seeking behavior on college campuses is at Stony Brook University in New York.

The assistant director of Counseling and Psychological Services (CAPS) at Stony Brook University, Judy Esposito, helped institute a triage-style style walk-in service that does not necessitate any prescreening or initial assessment appointments -- a requirement at most mental health service centers. Esposito describes some of the operational changes that were successfully implemented to meet the growing mental health needs of students. She implores, "If a student can muster up the courage to walk in to CAPS, because we respect that courage, we want to be able to provide them with an opportunity, at that moment, to speak to why they are here, conduct a risk assessment to ensure that they and others are safe, and determine what the next step should be" (Van Pelt, 2013). It seems as though this would be a reasonable standard for the foundation of all college mental health services, yet the reality is that the CAPS model at Stony Brook University to provide all students who request services with an immediate evaluation is uncommon.

Additionally, many students struggle to find value in counseling centers that do not understand or match their diversity. As student populations are becoming more racially, internationally, and religiously diverse, colleges and their counseling centers need to also increase the diversity in their staff. Even with increased resources at some counseling centers across the country, a survey of 529 college counseling centers in the US reported that current clinical staff is 70.9% white (Tate, 2017). Certain colleges are moving in a positive direction in an attempt to correct this. "At Ohio State, for example, the counseling center now offers clinical services in nine different languages to meet the needs of their international students, who make up about 12 percent of the student body" (Tate, 2017). This could be an effective use of potential resources given to campus counseling centers around the country.

**Federal Government Strategies and Involvement**

Oftentimes, universities do recognize the dilemma of unequal supply and demand of mental health services but are fiscally handicapped in their ability to resolve it. Counseling centers on college campuses are facing both a marked increase in the need for their programs and a substantial decrease in the funds available for counselors; in fact, counselors experience increased pressure to complete additional tasks, which reduces time available for each student to receive their counseling. Arria et. al. (2011) found that almost half of the college students experiencing suicidal ideation experienced an unmet need for services at that time. In order to more effectively address the rise in demand for mental health services, the federal government has instituted several programs through the Substance Abuse and Mental Health Services Administration (SAMHSA).

SAMHSA is responsible for planning, developing, and funding grant programs which address the unmet needs of the mental health care of Americans. One such grant, the Garrett Lee

Smith Campus Suicide Prevention Program, allocates funding to universities to help identify at risk students, increase protective factors for students, and reduce both risk factors for suicide and suicide attempts in the college student population ("SAMHSA's Efforts in Schools and on College Campuses", 2016). The federal government is also attempting to reduce the incidence of suicide and the harm caused by untreated mental health issues through the provisions in the Affordable Care Act (ACA). The Affordable Care Act expanded the availability of health insurance to 1.3 million Americans with serious mental illness (Reed Seeks to Enhance Mental Health & Substance Abuse Treatment & Prevention Programs, 2017). Access to health insurance can connect patients to professional resources in the community, which they would otherwise be unable to afford.

# CHAPTER THREE - METHODS

## Measurement Instruments

Questions in the survey were drawn from two previously approved survey tools from peer-reviewed literature. The tool used by Downs and Eisenberg had two scales, each assessing a different stigma. Reliability measured by Cronbach's α was .828 for the scale measuring perceived stigma and .727 for the scale measuring personal stigma (Downs & Eisenberg, 2011). This tool utilized fifteen items to ask about a variety of stigma related beliefs surrounding mental health treatment. It assessed the participant's beliefs about both personal stigma and perceived public stigma. The tool used by Pedersen and Paves (2015) reported an internal reliability of .89, which they regarded to be adequate. This tool utilizes six items regarding an individual's beliefs concerning how others would view them if they sought mental health treatment, which were followed by six more items slightly reworded to ask about their perceptions of others in the same scenario. The approval for the use of the two questionnaires was provided by the first authors of the articles that used the tools prior to review by the institutional review board (Appendix 3.1 and Appendix 3.2). Both investigators were NIH certified at the time of the survey (Appendix 3.3). The survey used to conduct this research can be found in its entirety in Appendix 3.4.

The 34 questions in the survey are multiple choice, utilizing a Likert rating scale to provide for the variety of opinions (Appendix 3.4). The Likert rating scale for the first 15 questions is anchored from 0-5 (0 = strongly agree, 1 = agree, 2 = somewhat agree, 3 = somewhat disagree, 4 = disagree, 5 = strongly disagree). The Likert rating scale for the following 12 questions is anchored from 1-6 (1= I completely disagree, 2 = I disagree, 3 = I somewhat disagree, 4 = I somewhat agree, 5 = I agree, 6 = I completely agree). The remaining questions ask about demographics and any experiences that the participants have had with mental health

services. The survey also includes an open response question to provide information on specific experiences with mental health services, but the participant will only be directed to this question if they respond indicating that they have used the university's mental health services. Otherwise, the participant is asked if they have used mental health services outside of the university.

## Procedures

Participants digitally signed the informed consent form approved by the university Institutional Review Board through the use of radio buttons (Agree/Disagree). The statement of consent was included as the first page of the online survey tool when accessed electronically (Appendix 3.5). Those who do not indicate agreement with the statement of consent were redirected to the "thank you" page at the end of the survey, and no data was collected. The survey was administered online through using Qualtrics©. There was no time limit on the survey, but pilot participants took approximately 6 minutes to complete the survey. Participants could close and return to complete the survey at a later time. Participants could leave questions blank and complete the survey.

## Respondent Information

### Sample and Setting

The sample is a convenience sample of undergraduate students at a private religious-affiliated university in the northeast. All participants are voluntarily involved in the study. All participants clicked a button on the online form to indicate their informed consent before beginning the survey. Participants were assured that there would be no risks or rewards related to their completion of the survey. No personal identifying information was collected. The study was approved by the university IRB on April 4, 2017. Results will be summarized. Individual responses were recorded without any identifying information.

**Risks to Participants**

It is unlikely that participants experienced any emotional distress related to the survey questions and the topic. Subjects were provided with the contact information for the principle investigators and supervisor in the case that they experienced any distress or had any questions or concerns related to the study. The primary potential burden to the participants was the time-demand for survey completion, which was estimated to take participants about 6 minutes to complete. Given that participants were accessed from their email addresses, they were be able to select a convenient time to complete the survey.

# CHAPTER FOUR - RESULTS

## Characteristics of Sample

The survey sample is moderately representative of the university's target population of undergraduate students in most demographic aspects. The sample size itself represents about 2% of the total undergraduate population size, which is currently at a total of 9,192 students (Appendix 4, Table 4.1). Of this sample, school, year of graduation, and sexual orientation are generalizable to the overall undergraduate student population. However, birth sex/gender were extremely skewed. Only 20.20% of participants identified as male, and no participants identified as transgender. Currently 47% of the undergraduate population is of male gender. While the exact transgender population is unknown, it can be assumed that it is more than zero. The survey sample approximates the racial distribution of the total student population.

## Findings

The responses by the participants to the questions on stigma supported previous findings reported in the literature. When asked about specifically personal stigma, answers reflected a much more widespread acceptance of individuals with mental illness. When asked if they would think less of others who seek help, an overwhelming 99.0% of participants stated that they would disagree to some degree with the statement. When asked if they themselves would treat the person differently, 98.09% stated they disagreed. 97.1% of respondents stated to some degree that they would not think less of a person who receives mental health care, with 57.49% answering that they strongly disagree with that statement. When asked if another person should not seek help because they should be embarrassed, 97.09% of participants disagreed to some degree. When asked if they believed people with mental illness were just as trustworthy as the average person, 96.13% of respondents agreed.  Every respondent agreed to some degree that

they would willingly accept someone who has a mental illness as a close friend. A large portion (61.35%) strongly agreed with that statement. Full findings can be found in Appendix 4.

Throughout all of these responses, it was easy to differentiate between questions regarding personal stigma and those regarding perceived public stigma due to the wide variation in responses. Despite a clear absence of personal stigma, there was a strong perception of public stigma. While 82.60% of participants stated agreement with the idea that people would be reluctant to date someone with a prior hospitalization due to mental illness, 63.77% of respondents agreed with the idea that most people would treat a person with mental illness no differently than an average person. Well over half (63.29%) of participants stated that they believed others would think less of a person who receives mental health treatment. When asked if they thought people believed receiving mental health treatment was a sign of personal failure, greater than half (55.29%) of respondents agreed at least somewhat, with 32.21% of respondents agreeing or strongly agreeing. However, when asked if they were hesitant to seek help because their peers would treat them differently, 46.57% of respondents agreed. When asked about if they thought most people believe that a person with a mental illness is just as trustworthy as the average person, over a quarter (27.88%) of respondents disagreed to some degree. Full findings can be found in Appendix 4.

Of the entire survey sample, 91 students (43.54%) responded that they have used university mental health services. Of these 91 students, 66 (72.53%) completed the open response question, “Please tell us, without personal details, about your experience and any recommendations that you may have for (university name) Mental Health Services”. From these open-ended responses, common themes and recommendations were identified and recorded. Twenty-four respondents (36.36%) answered that they have had a positive overall experience

with university mental health services, as opposed to six respondents (9.09%) who reported that have had a negative overall experience with the same services.

"Positive" themes included praise of therapists, feeling as though their specific stressor was dealt with individually, and helpful guidance and referral to psychiatric services off-campus. The most overwhelming "negative" theme included lack of accessibility and resources. Specifically, respondents noted long wait times for appointments, inadequate frequency of appointments, and a stressful process of scheduling appointments. Four students expressed feeling that their problems were not being taken seriously enough by staff. For example, one student wrote, *"I had to prove that I had a "real problem" before I could get regular help. They did help me a lot. However, Mental Health Services should be totally accessible to all students, regardless of whether or not they have an outstanding personal issue to deal with".*

Regardless of whether the student reported an overall positive or negative experience with university mental health services, nineteen respondents recommended that more staffing is needed in order to solve many of the problems surrounding access to the services. One student, who regarded his/her experience as generally positive, added, *"However, there is an enormous demand for counseling and there are not nearly enough [counselors] to meet that demand. This means that I am only able to receive counseling once or twice a month because I cannot afford alternatives outside of Counseling Services."* The literature suggests that this is a common theme and request in campuses around the country.

## CHAPTER FIVE - DISCUSSION

In this study, we examined the perceived public stigma and the personal stigma toward mental illness and mental health treatment among a fairly representative sample of the undergraduate students in one private religiously affiliated university. We found discrepancies between the two types of stigma, suggesting a dichotomy between how students perceive they would be viewed, and how their peers report they would view them if they sought mental health treatment. The low levels of personal stigma and high levels of perceived public stigma reported in the sample identify an important fallacy that pervades the mental health culture at this college. While many students feel that their peers would judge them, blame them, and treat them differently for seeking mental health treatment, the reality is that the majority of students reported that they would personally feel and demonstrate minimal levels of judgment on others. Thus, the student population seems to be caught in a paradox.

Although much of the data provided by the survey was eye opening, the open ended responses provided the most informative look at the actual experiences of students in regards to mental health and help seeking. It is important to note that stigma surrounding mental illness and treatment is still a significant barrier to students seeking help, even though the stigma is not actually real. Perceived stigma is enough to keep many students from seeking mental health care on campus, despite their own acknowledgments of minimal personal stigma. One survey respondent demonstrated inhibiting amounts of perceived public stigma in a response about an experience using the campus mental health resources: *"I was definitely afraid people would see me walk in there and be curious why or what was wrong with me, like something bad had to have happened in my life in order to go to counseling".* This same respondent exhibited virtually no personal stigma, strongly disagreeing that he/she would think less of another person who

received treatment for mental health. However, the respondent felt high anxiety related to perceived public stigma, answering that others would view him/her as less intelligent, less trustworthy, and a personal failure if others knew that the respondent sought mental health treatment. These statements exemplify the dilemma impeding a better mental health culture on this campus and likely many other campuses around the country. Another survey respondent also recognized the difficulty in going to mental health services for the first time, saying *"Just get kids in there the first time. Once they get over the hump of trying it, it's much easier to get treatment."*

Outside of stigma, many themes emerged surrounding the participants' use of the campus mental health services. The great majority of respondents reported an overall positive experience with mental health services, although many suggestions or frustrations were also discussed. The most commonly discussed theme was the availability of mental health services.

While there was some variety of opinions regarding the availability of mental health services, the overwhelming message was that there was a lack of available counseling. Almost half of those who responded mentioned frustration within this theme. This included vexation about a long wait time (often 2-3 weeks) between scheduling and the actual appointment, a lack of available appointment options and times, and too much time between ongoing appointments. It also included frustration with the emphasis on availability for more short-term counseling, as many students felt that they would benefit from ongoing appointments throughout their college career but that they mental health services on campus did not have enough resources to support that demand.

Themes and responses surrounding interactions between students and counselors were varied, but it did not indicate that there was a need to alter the counseling methods. Most

students spoke about experiences with counselors in a positive manner. Among students who were referred off campus there was a mix of appreciation and frustration. A repeated complaint was that off campus resources did not work with the insurance plans of some students or that it was too difficult to create new appointments after going through such a long process for an appointment on campus. Some students expressed a wish for psychiatric prescribers on campus because they felt that it took too long for them to see a psychiatrist since they had to first see counselors on campus for a referral to a prescribing psychiatrist.

Overall, the greatest theme and request focused on a need for more counseling and resources at mental health services on the university's campus. Suggestions from survey participants believe that this would be solved with more counselors, the hiring of psychiatric prescribers, creating more focus groups, and/or better advertisement all of the different mental health service options and resources available to the undergraduate students.

**Recommendations and Policy Implications**

As stigma continues to be one of the biggest impediments in college students seeking mental health treatment, it is important to investigate potential ways to decrease this perceived stigma. Promoting publication and distribution of data and facts surrounding the utilization of mental health services on campus could help student recognize that it is indeed normative. Our study shows that 43.54% of participants have used University Mental Health Services before, and of those who had not, 25.42% have used mental health services outside of the university. This signifies that 57.89% of participants have used mental health services of some type, whether on campus or otherwise. If students were told that seeking mental health help and treatment actually put them in the majority group and that it was a normative behavior amongst their peers,

it could help dissipate some of the stigma and help students feel like they are not outliers when they do so.

With the increasing number of students who require mental health services, it is important to consider the increased needs for counseling funding. Availability and accessibility rather than quality were the most common barriers to seeking care for students. Stigma played a huge role in preventing students from reaching out for help in the first place, but the lack of access to mental health resources for chronic problems was a serious barrier for students seeking long term counseling.

Improving the services that students have available is not a matter of finding better counselors or better methods to treat students seeking mental health care. Increasing the number of counselors or assisting students in transportation to and from counseling at off campus sites are two ways to improve mental health services. Additional improvements to enhance access to care should be made with student consultation and evaluation to validate program efficacy. The most obvious solution to the lack of resources would be to hire more counselors. However, without more financial help from the institution this is not possible. Thus, an actual potential option would be to look for more resources from within the university community.

The university has graduate schools in social work, counseling psychology, and psychiatric nursing. Trainees and their faculty supervisors who are expert clinicians could be a cost-effective solution to increasing professional resources in counseling services. Nurse Practitioners (NPs) are authorized to prescribe medication and students in the Family Psychiatric NP program have required didactic and clinical experiences to prepare them to assume responsibilities of prescriptive authority. Allowing the Family Psychiatric NP faculty and their students to screen and prescribe psychiatric medications in university counseling services, which

is currently the practice in health services with university NP faculty and graduate NP students, could mitigate the need to refer some students off campus in need of psychiatric medication. Social work, counseling psychology, and nurse practitioner students could lead student psychotherapy groups and provide individual psychotherapy. Nurse practitioner, counseling psychology, and social work students are already familiar with and practice under HIPAA regulations, so confidentiality would not be an issue more so than with any existing mental health services staff member.

Another option to boost resources from within the university is to train existing leaders in the community in mental health. For example, resident directors and resident assistants already undergo extensive mental health guidance and training so that they are best equipped as resources for their residents. If this were done for academic advisors, professors, teacher assistants, and other models in the community, the university would have many more available resources for students seeking some form of help or guidance. Informal mental health help, such as talking to peers, advisors, or role models when stressed, is often more readily used and accepted by young adults in the first place, and this would decrease the number of students turning to mental health services as their only perceived resource and outlet.

The survey's implications for men are closely entwined with the need to simply begin the conversation about mental illness and help seeking. The JED foundation has done significant work to begin the process of talking about mental health on college campuses around America. It has become increasingly noticeable how hesitant male populations are to even discussing the implications of having a mental illness or of receiving help for their personal mental health. Issues of stigmatization and public perception of masculinity are repeated themes which prevent men from seeking much needed help for their problems. The JED foundation has formed

programs like JED Campus which are designed to empower schools with guidelines and support to assist with managing student mental health and substance abuse and to promote suicide prevention efforts. Although this program has been implemented on a national scale, it can still benefit from assistance at the local level. The university could easily establish a strong partnership with the JED Foundation to promote education, de-stigmatization, and conversations around suicide.

The most important consideration for planning future efforts in mental health resource improvements is forming programs that last for an extended period of time. Implementation of programs is often ineffective due to a lack of longevity and follow-up evaluations to determine effectiveness. Interventions should be planned with specific goals in mind, such as reducing 5, 10, and 20 years incidences of student suicide or other distinctively measurable goals. The length with which outcomes are monitored will encourage the institutionalization of many of these programs, and will ensure that changes at the university level will become normal practice even after students, faculty, and staff have left. The implementation of long term solutions is essential to promoting lasting change because it provides continuity to allow for changes as new data is presented. Rather than needing to implement a new intervention with each new study presented, prior interventions can be adjusted to meet the evolving needs of the student population.

Additionally, peer-to-peer programs are a possible alteration to the practices that exist in current mental health services on university campuses. Group therapy is already a common practice on college campuses, but there is often a significant concern for violations of privacy and HIPPA related issues. However, the use of peer to peer counseling can help to destigmatize cultures on college campuses and can even help to reduce the sense of isolation that many students who struggle with mental illness encounter. The groups which university health services

run are extremely effective, but they would further benefit from seeing more widespread use on university campuses. As colleges and their students struggle to break down the issues surrounding perceived public stigmas, the use of peer counseling can be a valuable tool to facilitate conversations that are difficult to introduce to the student population.

**Limitations**

Various areas of the demographics of our survey sample may contribute to the limitations of our study. The sample size itself represents only about 2% of the total undergraduate population size, which is currently at a total of 9,192 students. While this is an encouraging response rate for a survey sample of convenience, it did limit our ability to accurately represent all areas of the undergraduate student community.

Gender demographics in the survey were heavily skewed due to a low number of responses from male respondents. The reduced number of male participants in the study limited how much information can be taken from the responses as it is not a complete representation of the undergraduate male population. In reviewing the causes of reduced male response, it is important to consider that the population of university is 53.3% female and 46.7% male. This split, although significant in larger numbers, does not explain the drastic difference in the number of male respondents (n=40) and female respondents (n=158). Additionally, as the literature has noted in prior research, men are less likely to report issues with mental illness and to seek help. Although participation in the survey is not considered “help-seeking behavior” or a diagnosis of a mental health problem, it is possible that male respondents viewed it as such and therefore elected to not respond.

Racial demographics were closely represented the university’s undergraduate population, although some races were still underrepresented in the survey. Asian and Black races were both

underrepresented by about 2% each when comparing the overall undergraduate student population. Whites were overrepresented by about 30%, although this could be attributed to the fact that this survey did not differentiate between White (Hispanic/Latino) and White (non-Hispanic/Latino). If Hispanic/Latino and White demographics are combined from the university's population, the discrepancy between the undergraduate population and the survey sample population would decrease to a 15% overrepresentation of students identifying as White.

**Summary**

In conclusion, findings from this study in addition to the existing literature suggest that the personal stigma in college students associated with mental health care is minimal. Most college studies would not treat a peer differently for seeking mental health treatment. However, the findings have implications for interventions focused on continuing to reduce the perceived public stigma and on improving access to mental health care on university campuses. Additionally, more research needs to be done surrounding the correlations and implications of demographics on stigma. Lastly, recommendations and opportunities for improvement of university counseling services can often be found within the university itself.

# Appendices

## APPENDIX 3 - METHODS

### Appendix 3.1 Eisenberg Letter of Consent for Use

UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH
HEALTH MANAGEMENT AND POLICY

1420 WASHINGTON HEIGHTS
ANN ARBOR, MI 48109-2029
FAX: 734 764-4338
www.sph.umich.edu/hmp

Josh Sogolow

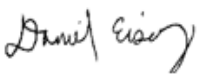
140 Commonwealth Ave, Boston, MA, 02467

Rubenstein Hall C62

Dear Mr. Sogolow:

You have my permission to use the survey measures from our Healthy Minds Study for your research on student mental health. Good luck with your project

Sincerely,



Daniel Eisenberg
Professor of Health Management and Policy
Director, Doctoral Program in Health Services Organization and Policy
School of Public Health, University of Michigan
734-615-7764, daneis@umich.edu

## Appendix 3.2 Pederson Letter of Consent for Use

ERIC R. PEDERSEN
BEHAVIORAL SCIENTIST

1776 MAIN STREET
P.O. BOX 2138
SANTA MONICA, CA
90407-2138

TEL 310.393.0411 X6078
FAX 310.393.4818
eric_pedersen@rand.org

November 7, 2016

Joshua Sogolow and Emily McClure
Boston College
140 Commonwealth Ave
Rubenstein Hall C62
Boston, MA, 02467,

Dear Josh and Emily

Thank you both for the interest in using the survey instrument that Andy Paves and I adapted in our 2014 article "Comparing perceived public stigma and personal stigma of mental health treatment seeking in a young adult sample" published in *Psychiatry Research*. Both Andy and I give consent for you to use the survey in your theses work. Please feel free to adapt the measure to fit your specific parameters and goals for research. You have agreed to properly cite our article as a source in your research.

Good luck with your studies.

Sincerely,

Eric R. Pedersen, corresponding author
1776 Main Street
PO Box 2138
Santa Monica, CA 90407
Email: eric_pedersen@rand.org
Phone: (310) 3930411 x 6078; FAX: 310.393.4818

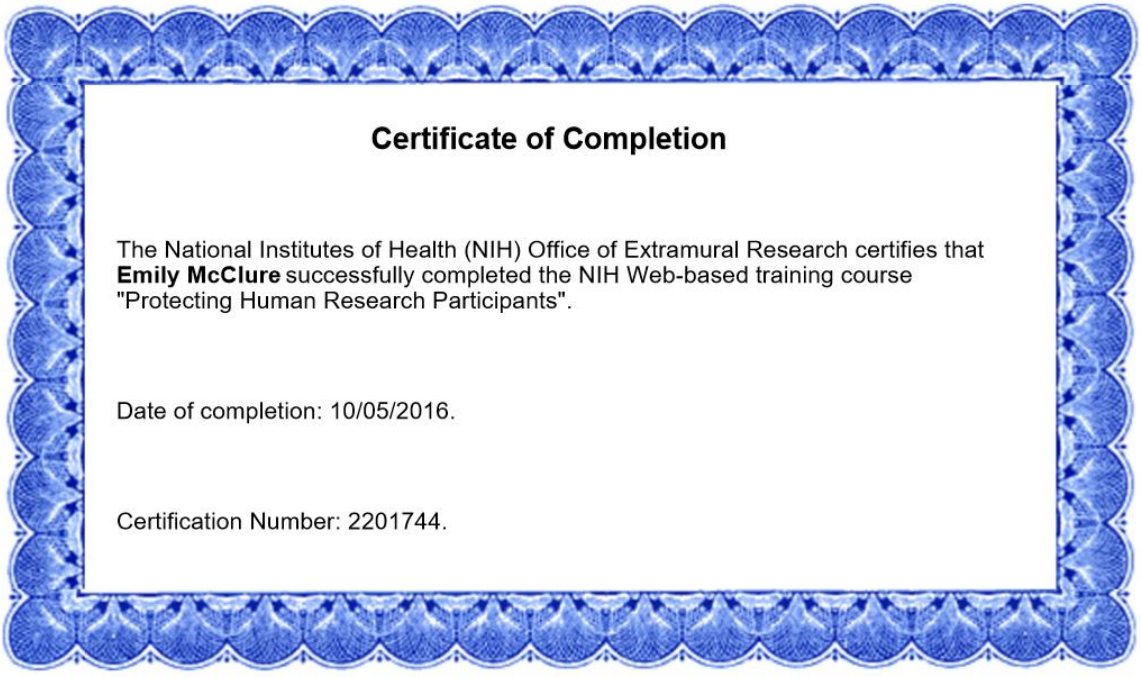
## Appendix 3.3 NIH Certifications of Principal Investigators

**Certificate of Completion**

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Joshua Sogolow** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/05/2016.

Certification Number: 2201723.



**Certificate of Completion**

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Emily McClure** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/05/2016.

Certification Number: 2201744.

**Appendix 3.4 Survey**

Presented below is the survey as it presented below is the survey as it was provided to participants.

**Eisenberg Tool (Downs & Eisenberg, 2012)**

Participants are asked to indicate whether they agree or disagree with the following statements (0= strongly agree, 1 = agree, 2 = somewhat agree, 3 = somewhat disagree, 4 = disagree, 5= strongly disagree). Items with a '*' are reverse-scored—i.e., "Strongly agree" corresponds to 5 points instead of 0 points, and so on.

1. Most people would willingly accept someone who has received mental health treatment as a close friend.
2. Most people believe that a person who has received mental health treatment is just as intelligent as the average person.
3. Most people believe that someone who has received mental health treatment is just as trustworthy as the average person.
4. Most people would accept someone who has fully recovered from a mental illness as a teacher of young children in a public school.
5. Most people feel that receiving mental health treatment is a sign of personal failure.*
6. 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.*
7. Most people think less of a person who has received mental health treatment.*
8. Most employers will hire someone who has received mental health treatment if he or she is qualified for the job.

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

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

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

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

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

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

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

**Pederson Tool (Pederson & Paves, 2014)**

Participants are then asked to rate each pair of statements from 1-6 with 1 being "I completely disagree" and 6 being "I completely agree." The average score for each answer was then provided along with the number of responses it received.

(Public Stigma 1-3) "I would not seek help because…"

(Public Stigma 4-6) "If I did seek help then…"

1. It would be too embarrassing
2. It would harm my reputation
3. My peers might treat me differently
4. My peers would blame me for the problem
5. I would be seen as weak

6. People important to me would think less of me

(Perceived Self Stigma 1-3) “They should not seek help because…”

(Perceived Self Stigma 4-6) “If they did seek help then…”

1. They should feel embarrassed
2. They should worry about their reputation
3. I might treat them differently
4. I would blame them for the problem
5. I would view them as weak
6. I would think less of them

**Open Responses Regarding Personal Experience with Mental Health**

Have you used mental health services (ie Psychiatrist, Therapist, Counseling Groups, etc.) at (University name deleted)?

Please tell us, without personal details, about your experience and any recommendations that you may have for (University name deleted) Mental Health Services.

Have you ever used mental health services (ie Psychiatrist, Therapist, Counseling groups, etc.) at an off-campus (Non-(University name deleted) affiliated) site?

**Demographics**

Race (Select All That Apply): White, Black, Asian, Pacific Islander, Native American/Alaskan Native, Other (Not Listed Above)

Birth Sex: Male, Female

Gender: Male, Female, Transgender (Male to Female), Transgender (Female to Male), Agender, Pangender, Other (Not Listed Above)

Sexual Orientation: Heterosexual, Homosexual, Bisexual, Pansexual, Asexual, Other (Not Listed

Above)

Year of Graduation: 2017, 2018, 2019, 2020

School: MCAS, CSOM, CSON, Lynch, Woods

**Appendix 3.5 Informed Consent Form**

This informed consent form is intended for (University name deleted) Undergraduate Students who we are inviting to participate in this survey.

Name of Principal Investigators: Joshua Sogolow and Emily McClure

Name of Organization: Connell School of Nursing

Name of Sponsor: Not applicable

Name of Project: Mental Health Stigma and Help-Seeking Behaviors in the (University name deleted) Community

**Part I: Information Sheet**

**Introduction**

We are Joshua Sogolow and Emily McClure, two seniors in the Connell School of Nursing at Boston College and the Morrissey College of Arts and Sciences Honors Program. We have both dedicated a large amount of time to researching the issues involving mental illness on college campuses and how it is affecting an alarming number of students in recent years. Our hope is to obtain information from you and many of your classmates to help inform (University name deleted) administrators for improving mental health support systems and education at (University name deleted). Please note, people under 18 years of age are ineligible to participate in this survey.

**Purpose of the research**

Mental Illness is a well-researched topic, but there is very little literature on the effects of stigma towards mental illness on the attitudes towards seeking help. In the (University name deleted) community especially there is a lack of awareness that should be rectified with informed and

relevant information. The intention of this research is to find clear statistical data that will inform changes in the education on mental illness at the university.

**Type of Research Intervention**

This research will involve your participation in a brief survey. It is further explained below.

**Participant Selection**

You are being invited to take part in this research because you are a member of the (University name deleted) Undergraduate population.

**Voluntary Participation**

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate nothing will change at (University name deleted) or any job you hold. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

**Procedure**

We are asking you to help us learn more about stigma surrounding mental illness and the effect of stigma on help-seeking behavior in the (University name deleted) Undergraduate Student community. We are inviting you to take part in this research project. If you accept, you will be asked to complete a survey which will be provided following the completion of this form. If you do not wish to answer any of the questions included in the survey, you may skip them and move on to the next question. The information recorded is confidential, your name is not being included on the forms, and only a number will identify you.

**Duration**

The research takes place exclusively during the time it takes you to complete the survey. There are no follow-ups or second surveys which will be required.

**Risks**

We are asking you to share with us some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or section of the survey if you don't wish to do so, and that is fine. You do not have to give us any reason for not responding to any question. You do not have to answer any question or take part in the survey if you feel the question(s) is/are too personal. There are no risks involving confidentiality, bodily harm, or repercussions from any organization, the school, or administrators for any information provided in the survey.

**Benefits**

There will be no direct benefit to you, but your participation is likely to help us find out more about how to identify the stigmas surrounding mental health in the (University name deleted) community. Additionally, your responses will be valuable in providing administrators with information for improving the mental health services available at (University name deleted).

**Reimbursements**

You will not be provided any incentive to take part in the research.

**Confidentiality**

We will not be sharing information about you to anyone and all responses will be completely confidential. The information that we collect from this research project will be used for statistical analysis, but individual responses will not be written about. Any information about you will have a number on it instead of your name. It will not be shared with or given to anyone. The only individual responses will be open response answers, but those will be recorded anonymously and

will not include information on your demographics or anything that could be traced back to you. Any identifying information in a response will be redacted to protect confidentiality. Demographic information will only be used for statistical analysis, not for identifying individual answers.

**Sharing the Results**

Nothing you share with us will be attributed to you by name or any other identifying information. The knowledge that we get from this research will be shared with the (University name deleted) community and all administrators will have access to the final thesis, not the specific research and data. The thesis itself will be available for all students to read through the Connell School of Nursing upon request. The Boston College IRB will have access to the de-identified data.

**Right to Refuse or Withdraw**

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your grades, enrollment in the school, job or job-related evaluations in any way. You may stop participating in the survey at any time that you wish without the aforementioned aspects being affected. You may return to your past answers at any time, but after you submit the survey you will be unable to amend your survey to protect the integrity of the study.

**Who to Contact**

If you have any questions, you may contact any of the following:

Joshua Sogolow, sogolow@bc.edu

Emily McClure, mcclureb@bc.edu

Judy Shindul-Rothschild, shindulr@bc.edu

This proposal has been reviewed and approved by the Boston College IRB, which is a committee whose task it is to make sure that research participants are protected from harm. The BC IRB may be contacted at (617) 552-4778 or irb@bc.edu.

## Part II: Certificate of Consent

I have read the foregoing information and any questions I have can be directed towards the previously mentioned administrators of the study. I consent voluntarily to be a participant in this study. I certify that I am not less than 18 years of age.

Please select "Agree" below if you consent to the terms of the survey as listed above.

I have read and agree to the above Informed Consent agreement:

Agree

Decline (This will exit the survey)

## APPENDIX 4 - FINDINGS

**Table 4.1 Demographic Results**

| **Characteristics** | **Percentage** | ***n*** **(*N* = 208)** | ***N – n*** **(Missing Responses)** |
|---|---|---|---|
| BIRTH SEX | | 198 | 10 |
| Female | 79.90% | | |
| Male | 20.20% | | |
| GENDER IDENTITY | | 198 | 10 |
| Female | 79.90% | | |
| Male | 20.20% | | |
| Transgender (Male to Female) | 0.00% | | |
| Transgender (Female to Male) | 0.00% | | |
| Agender | 0.00% | | |
| Pangender | 0.00% | | |
| Other (Not Listed Above) | 0.00% | | |

**Table 4.1 Continued**

| **Characteristics** | **Percentage** | ***n*** **(*N* = 208)** | ***N* – *n*** **(Missing Responses)** |
|---|---|---|---|
| RACE | | 199 | 9 |
| White | 92.96% | | |
| Black | 2.01% | | |
| Asian | 8.04% | | |
| Pacific Islander | 0.00% | | |
| Native American/Alaskan Native | 0.50% | | |
| Other (Not Listed Above) | 3.02% | | |
| SEXUAL ORIENTATION | | 195 | 13 |
| Heterosexual | 93.33% | | |
| Homosexual | 2.56% | | |
| Bisexual | 4.10%) | | |
| Pansexual | 0.00% | | |
| Asexual | 0.00% | | |
| Other (Not Listed Above) | 0.00% | | |

**Table 4.1 Continued**

| **Characteristics** | **Percentage** | ***n*** **(*N* = 208)** | ***N – n*** **(Missing Responses)** |
|---|---|---|---|
| GRADUATION YEAR | | 198 | 10 |
| 2017 | 32.32% | | |
| 2018 | 18.69% | | |
| 2019 | 25.25% | | |
| 2020 | 23.74% | | |
| SCHOOL | | 198 | 10 |
| Arts and Science | 52.02% | | |
| Nursing | 19.19% | | |
| Education | 9.60% | | |
| Management | 18.18% | | |
| Advancing Studies | 1.01% | | |

**Table 4.2 Eisenberg Tool Results**

| ***N* = 208** | **Strongly Agree** | **Agree** | **Somewhat Agree** | **Somewhat Disagree** | **Disagree** | **Strongly Disagree** | ***n*** | ***N* - *n*** |
|---|---|---|---|---|---|---|---|---|
| **Most people would willingly accept someone who has received mental health treatment as a close friend.** | 18.75% | 38.94% | 31.25% | 9.62% | 1.44% | 0.00% | 208 | 0 |
| **Most people believe that a person who has received mental health treatment is just as intelligent as the average person.** | 14.42% | 31.73% | 29.81% | 22.12% | 1.92% | 0.00% | 208 | 0 |
| **Most people believe that someone who has received mental health treatment is just as trustworthy as the average person.** | 10.58% | 27.40% | 34.13% | 21.63% | 5.77% | 0.48% | 208 | 0 |
| **Most people would accept someone who has fully recovered from a mental illness as a teacher of young children in a public school.** | 5.29% | 17.31% | 26.44% | 30.77% | 18.75% | 0.96% | 207 | 1 |
| **Most people feel that receiving mental health treatment is a sign of personal failure.** | 8.17% | 24.04% | 23.08% | 16.35% | 24.04% | 4.33% | 208 | 0 |

**Table 4.2 Continued**

| ***N* = 208** | **Strongly Agree** | **Agree** | **Somewhat Agree** | **Somewhat Disagree** | **Disagree** | **Strongly Disagree** | ***n*** | ***N - n*** |
|---|---|---|---|---|---|---|---|---|
| **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.** | 8.17% | 27.88% | 32.69% | 20.19% | 10.10% | 0.96% | 208 | 0 |
| **Most people think less of a person who has received mental health treatment.** | 2.88% | 25.96% | 34.13% | 15.87% | 14.90% | 5.77% | 207 | 1 |
| **Most employers will hire someone who has received mental health treatment if he or she is qualified for the job.** | 7.21% | 37.50% | 30.29% | 20.19% | 3.85% | 0.48% | 207 | 1 |
| **Most employers will pass over the application of someone who has received mental health treatment in favor of another applicant.** | 1.92% | 30.77% | 32.21% | 20.67% | 11.06% | 2.88% | 207 | 1 |
| **Most people in my community would treat someone who has received mental health treatment just as they would treat anyone.** | 11.54% | 24.52% | 27.40% | 25.00% | 10.58% | 0.48% | 207 | 1 |

**Table 4.2 Continued**

| ***N* = 208** | **Strongly Agree** | **Agree** | **Somewhat Agree** | **Somewhat Disagree** | **Disagree** | **Strongly Disagree** | ***n*** | ***N - n*** |
|---|---|---|---|---|---|---|---|---|
| **Most young adults would be reluctant to date someone who has been hospitalized for a serious mental disorder.** | 20.67% | 36.54% | 25.00% | 10.10% | 5.29% | 1.92% | 207 | 1 |
| **Once they know a person has received mental health treatment, most people will take that person's opinions less seriously.** | 1.44% | 6.25% | 25.00% | 29.33% | 30.77% | 6.73% | 207 | 1 |
| **I would willingly accept someone who has received mental health treatment as a close friend.** | 61.06% | 34.62% | 3.85% | 0.00% | 0.00% | 0.00% | 207 | 1 |
| **I would think less of a person who has received mental health treatment.** | 0.00% | 0.00% | 2.88% | 7.21% | 32.21% | 57.21% | 207 | 1 |
| **I believe that someone who has received mental health treatment is just as trustworthy as the average person.** | 42.31% | 42.31% | 11.06% | 2.88% | 0.48% | 0.48% | 207 | 1 |

**Table 4.3 Pederson Tool Results**

| ***N* = 208** | **"I completely agree"** | **"I agree"** | **"I somewhat agree"** | **"I somewhat disagree"** | **"I disagree"** | **"I completely disagree"** | ***n*** | ***N* - *n*** |
|---|---|---|---|---|---|---|---|---|
| **"I would not seek help because it would be too embarrassing"** | 1.01% | 11.06% | 24.12% | 17.09% | 29.15% | 20.10% | 204 | 4 |
| **"I would not seek help because it would harm my reputation"** | 3.02% | 12.06% | 24.12% | 12.06% | 29.15% | 22.11% | 204 | 4 |
| **"I would not seek help because my peers might treat me differently"** | 3.02% | 20.10% | 24.62% | 18.09% | 21.11% | 15.58% | 204 | 4 |
| **"If I did seek help then my peers would blame me for the problem"** | 2.01% | 5.53% | 15.58% | 22.11% | 34.67% | 22.61% | 204 | 4 |
| **"If I did seek help then I would be seen as weak"** | 8.04% | 19.10% | 25.13% | 12.56% | 21.61% | 16.08% | 204 | 4 |
| **"If I did seek help then people important to me would think less of me"** | 2.51% | 19.10% | 25.13% | 14.57% | 25.13% | 22.11% | 204 | 4 |
| **"They should not seek help because they should feel embarrassed"** | 0.50% | 1.01% | 0.50% | 0.50% | 19.10% | 78.39% | 199 | 9 |
| **"They should not seek help because they should worry about their reputation"** | 0.50% | 1.01% | 1.01% | 3.52% | 17.59% | 76.38% | 199 | 9 |

**Table 4.3 Continued**

| ***N* = 208** | **"I completely agree"** | **"I agree"** | **"I somewhat agree"** | **"I somewhat disagree"** | **"I disagree"** | **"I completely disagree"** | ***n*** | ***N* - *n*** |
|---|---|---|---|---|---|---|---|---|
| **"They should not seek help because I might treat them differently"** | 0.00% | 1.01% | 0.00% | 2.51% | 14.57% | 81.91% | 199 | 9 |
| **"If they did seek help then I would blame them for the problem"** | 0.00% | 0.50% | 0.50% | 2.01% | 14.57% | 81.91% | 198 | 10 |
| **"If they did seek help then I would view them as weak"** | 0.00% | 0.50% | 2.01% | 3.52% | 11.06% | 82.91% | 199 | 9 |
| **"If they did seek help then I would think less of them"** | 0.00% | 0.50% | 0.50% | 3.02% | 13.07% | 82.91% | 199 | 9 |

## References

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