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The Self-Stigma of Mental Illness and Active Help-Seeking in College Students

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Abstract

College students are most likely to have a mental disorder and least likely to think the mentally ill live normal lives post-treatment (Auerbach et al., 2017). This misconception is due to stigma and leads to foregoing treatment. Specifically, research on self-stigma and active help-seeking is lacking. This study examined the relationship between public stigma, self-stigma, and active help-seeking among college students with anxiety and depression. 100 undergraduates completed measures of their mental health services utilization, public stigma, self-stigma, anxiety, and depression. Results indicate self-stigma is positively influenced by public stigma and negatively influences active help-seeking, and those with mental illness indicate increased perceived public stigma. These findings are discussed in terms of changing the community's

perception of mental illness, hopefully decreasing the negative consequences of perceived public stigma on self-stigma, thus, active help-seeking.

Keywords: stigma, public stigma, self-stigma, anxiety, depression, college students, active help-seeking.

The Self-Stigma of Mental Illness and Active Help-Seeking in College Students

College students (i.e., people aged 18-25) are the most likely group to have mental illness around the world, and some of the least likely to seek help (Auerbach et al., 2017; Gulliver et al., 2010). The main reason for not seeking help is stigma (Rabinowitz, Gross, Feldman, 1999; Gulliver et al., 2010). Stigma is defined as a negative label regarding a group of people, causing the group to be avoided by others and deemed undesirable by mainstream society (Mojtabai, 2010). The two types of public stigma—perceived public stigma (i.e., the stigma an individual thinks the public has towards the mentally ill) and personal stigma (i.e., an individual's own attitudes against a group)—are especially influential on the decision to seek help or not (Mojtabai, 2010; Schnyder et al., 2017). Self-stigma (i.e., the attitude an individual has towards oneself as a member of the mentally ill) is also thought to influence help-seeking behaviors; however, research on this topic is slim to none regarding active help-seeking, which includes the process of searching for and receiving help (Schnyder, Panczak, Groth, & Schultze-Lutter, 2017). The purpose of this research project is to explore the relationship between active help-seeking and self-stigma. Since self-stigma is influenced by public stigma, it is reasonable to think self-stigma will also have a large influence on active help-seeking in those with mental illness.

Literature Review

Stigma about the mentally ill is still present in Western societies (CDC, 2010; Schnyder et al., 2017). Common stigmas towards the mentally ill include negative character traits and misconceptions about recovery. The mentally ill are often thought to be dangerous and unpredictable, weak, and/or responsible for their illness in some way (Mojtabai, 2010; Yap, Wright, & Jorm, 2011). These stigmas not only influence how people treat the mentally ill, but also how the mentally ill view themselves. For example, when asked in a survey, 50% of adults without mental health symptoms believed the mentally ill were treated with compassion and care by others. Of adults with mental health symptoms, only 24.6% believed they were shown compassion and care by others (CDC, 2010). These statistics are indicative of the presence of stigma towards the mentally ill. A 2010 study done by the CDC found 88.6% of adults across the United States believed the mentally ill could live normal lives if given the proper treatment. Those less confident in that statement included young adults. Those young people, aged 16-24, are the very population in need of the most help since they have the highest rate of mental illness (Auerbach et al., 2017; Gulliver et al., 2010). If they are not confident in the treatment offered to the mentally ill, it is reasonable that they would be less likely to seek help. This is a dangerous mindset because the risks of homelessness, low income, lack of friends, low self-esteem, and loneliness that come with having a mental illness could be the highest for young people as well (Hansson, Stjernswärd, & Svensson, 2016).

The focus of this project, self-stigma, arises from public stigma, which consists of perceived public stigma and personal stigma. Public stigma is the most influential type of stigma on active help-seeking for college students (Mojtabai, 2010; Schnyder et al., 2017). Perceived

public stigma negatively influences help-seeking behavior, especially in people ages 18-25, the usual age range of college students. They are mostly influenced by the belief that there is a large amount of perceived public stigma, even from mental health professionals (Gulliver et al., 2010). Personal stigma is also associated with less active help-seeking. Possible reasons for this relationship are the desire to socially avoid the mentally ill as well as the belief that the mentally ill are weak, not sick (Schnyder et al., 2017; Yap et al., 2011). Although public stigma is generally associated with less active help-seeking, it has been found that different beliefs of public stigma influence the desire for help-seeking in different ways. For example, if someone suspects their community believes that the mentally ill are dangerous or unpredictable, they are more likely to seek help from a mental health professional (Mojtabai, 2010; Yap et al., 2011). Likewise, if someone suspects their community believes recovery from mental illness is not likely to occur, they are also more likely to seek help from a mental health professional (Mojtabai, 2010). These findings are surprising because people tend not to bother with things that might not work; however, fear of what could happen if help is not tried may drive people to seek it. Conversely, if someone suspects their community believes the mentally ill are weak and are responsible in some way for their illness, they are less likely to seek help from a mental health professional. Further, if someone prefers to be socially distant from the mentally ill, they are also less likely to seek help from a mental health professional (Mojtabai, 2010; Yap et al., 2011). Specifically, these relationships are found in young people (Yap et al., 2011). From the data on public stigma, it is reasonable to say a large amount of self-stigma could negatively influence active help-seeking since it is influenced by public stigma. Self-stigma does not have

many appearances in active help-seeking research, and it is recommended that further research be performed with self-stigma as the focus (Schnyder et al., 2017; Yap et al., 2011).

Of the research regarding self-stigma and mental illness, it has been proposed that self-stigma results from actual experienced discrimination because of one's mental illness. Participants with mental illness have often felt embarrassed about their illness and taken measures to avoid feeling that way. These steps include withholding information about their mental health from others, not getting too involved with personal relationships, not applying for job opportunities, and not applying for educational opportunities. Of the steps, slightly more than half of participants with mental illness reported withholding information and staying distant in personal relationships. These behaviors most likely resulted from internalized public stigma, which was found to slightly increase as the number of mental health hospitalizations increased (Hansson et al., 2016). This research is important to young adults because they report feeling more self-stigma. Since self-stigma is influenced by public stigma, it is reasonable to suspect that, like public stigma, self-stigma both positively and negatively influences active help-seeking behavior in college students.

This study will examine the relationship between the two types of public stigma, self-stigma, and active help-seeking regarding mental illness. For this study, mental illness will be defined as high levels of anxiety and/or depression. This is because the most frequently appearing groups of disorders among college students around the world are anxiety disorders, specifically phobias, and mood disorders, specifically major depressive disorder (Auerbach et al., 2017). Both depression and anxiety will be measured using Beck's Depression Inventory II (BDI-II) and the State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA),

respectively. It is hypothesized that there is a negative relationship between public stigma and active help-seeking (i.e., as public stigma increases, active help-seeking will decrease); there is a positive relationship between public stigma and self-stigma (i.e., as public stigma increases, self-stigma will also increase); there is a negative relationship between self-stigma and active help-seeking (i.e., as self-stigma increases, active help-seeking will decrease); there is a positive relationship between anxiety and depression and perceived public stigma (i.e., as anxiety and depression increase, perceived public stigma will also increase); there is a negative relationship between personal stigma and active help-seeking (i.e., as personal stigma increases, active help-seeking will decrease).

Method

Participants

This study used a sample of 100 students at Christian Brothers University (CBU), a small private university in the South. The sample included 37 males and 63 females. The majority were African American (31%) and Caucasian (29%), followed by Hispanic (18%), Asian (7%), Middle Eastern (4%), Latinx (3%), Hispanic/Latinx (3%), multiracial (1%), and other (4%). All participants were undergraduates, with freshmen as the majority (47%), followed by sophomores (24%), seniors (14%), juniors (13%), and 5th years (2%). It was suspected at least 20% of participants would have an indication of anxiety or depression (Auerbach et al., 2017). Of the 100 participants, 48% most likely have clinical anxiety, 48% most likely have clinical depression, and 39% have both.

Materials

Surveys were used to measure the variables of active help-seeking, public stigma,

personal stigma, self-stigma, and mental illness. Demographics were taken to describe the sample.

Active Help-Seeking. Active help-seeking was measured with the Mental Health Services Utilization Form created by the researchers (see Appendix A). Participants were asked to indicate whether they have used a specific mental health service for their mental health at any point in their lifetime by marking yes or no. Yes, responses were scored as 1, while no responses were scored as 0. With 15 items, possible scores could range from 0 to 15, with higher scores indicating more active help-seeking. An example statement was "I stayed in a psychiatric hospital for overnight/short-term care."

Perceived Public Stigma. Perceived public stigma was measured using the 18-item Public Stigma Scale (PSS-18) developed by Pryor (2012). The PSS-18 (see Appendix B) had a Cronbach's alpha of .84, showing good reliability for measuring public stigma. Participants responded to 18 statements on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores could range from 18 to 90, with higher scores indicating more public stigma towards the mentally ill. An example statement was "most people would regard a severe mental illness as rare or unusual" (Van der Sanden, Bos, Stutterheim, Pryor, & Kok, 2013).

Personal Stigma. Personal stigma was measured using the Personal Stigma Scale (PSS) developed by Griffiths (2004; see Appendix C). The Cronbach's alpha is .83, indicating good reliability for measuring personal stigma. Participants responded to 7 statements on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores could range from 7 to 35 points, with higher scores indicating more personal stigma towards the mentally ill. An example statement was "mental health issues are not real medical illnesses" (Livingston, Tugwell, Korf-Uzan,

Cianfrone, & Coniglio, 2012).

Self-Stigma. Self-stigma was measured using two modified versions of the 10-item Internalized Stigma of Mental Illness Scale (ISMI-10). The ISMI-10 was a shortened version of the actual ISMI, which had 29 items. Between the two measures, the Cronbach's alpha is .94, indicating excellent reliability for measuring self-stigma. The short form was used to lower possible test fatigue in participants (Boyd, Otilingam, & DeForge, 2014). On the short form, modifications were made to relate to the specific mental illnesses of anxiety and depression. To do this, 'mentally ill' and 'a mental illness' were replaced with 'anxious' and 'anxiety' (see Appendix D), and in another version with 'depressed' and 'depression' (see Appendix E). Participants marked answers to ten statements on a scale from 1 (*strongly disagree*) to 4 (*strongly agree*). Using the 4-category method of interpreting scores, participants who scored closer to 4.00 had more internalized stigma. An example statement was, "people with anxiety make important contributions to society" (Boyd et al., 2014).

Mental Illness. Whether a participant qualified as mentally ill was determined by measuring both the anxiety and depression levels. If the participant scored above a certain threshold in one or both surveys, they were considered mentally ill for the purposes of this study.

Anxiety was measured with the STICSA (see Appendix F) developed by Ree, Macleod, French, and Locke (2000) in response to inadequacies of Spielberger's State-Trait Anxiety Inventory (STAI). The STICSA was found to be a superior measure compared to the STAI because it more strongly correlated with other anxiety measures than with depression measures, so it is more accurate in measuring anxiety-specific symptoms. The STICSA had 21 statements the participants answered on a scale of 1 (*not at all*) to 4 (*very much so*). There were two

different versions: the state survey and the trait survey. The state survey measured the participants moods at the time of the survey while the trait survey measured the frequency of symptoms. This study used the trait version of the STICSA, which had a Cronbach's alpha of .88 indicating good reliability for measuring anxiety-related symptoms. An example statement was 'I feel agonized over my problems' (Gros, Antony, Simms, & McCabe, 2007). Scores could range from 21 to 84, with scores 40 and above indicating a likelihood of having anxiety disorders (Van Dam, Gros, Earleywine, & Antony, 2013). The cutoff score of 40 was used to determine the presence of clinical anxiety in participants of this study.

Depression was measured using the BDI-II (see Appendix G) created by Beck (1996). The BDI-II was used instead of the BDI and the BDI-IA because it includes more depressive symptoms, aligning with symptoms in the DSM-IV. The Cronbach's alpha ranges from .89 to .94 depending on the population, with a test-retest reliability of .93 over one week (Groth-Marnat, 2003). It is safe to say this is a highly reliable measure of depression. The BDI-II had a total of 21 categories with four statements indicating the strength of the category (Groth-Marnat, 2003). For example, the category 'irritability' had statements ranging from "I am no more irritable than usual" to "I am irritable all the time" (Beck, 1996). Scores ranged from 0 to 63, with a recommended cutoff score of 18 because it was found to successfully diagnose 92% of people with major depressive disorder. Scores extremely close to 63 were warned to be possible exaggerations or characteristics of histrionic or borderline personality disorders. Scores below 4 indicate possible denial of depression because even the normal general population has higher scores than this (Groth-Marnat, 2003). The cutoff score of 18 was used to determine the presence of clinical depression in participants of this study.

Demographics. The demographics survey, created by the researchers, collected the demographic information of the participants (see Appendix H). Along with the usual age, sex, and race/ethnicity questions, the survey asked the participants to specify their class status (e.g., freshman).

Procedure

Participants were treated in accordance with the APA's "Ethical Principles of Psychologists and Code of Conduct" (2016). Participants volunteered for the study by signing up on Sona Systems. Participants were run in small groups and given a consent form to sign. The surveys themselves were given in a partially consistent order; 23% of participants were given Order 1, 25% were given Order 2, 31% were given Order 3, and 21% were given Order 4. The first survey given was always the Mental Health Utilization Form, so the participant was not influenced by stigmatizing statements on the following surveys. The second and third surveys, presented in counterbalanced order, were either the STICSA or the BDI-II. Other than demographics, the order of the remaining four surveys—the PSS-18, the PSS, and the two ISMI-10s—were counterbalanced to control for any fatigue and practice effects in the participants. The last survey given was always the demographics. Participants were allotted 30 minutes to complete the surveys, not including the time it took researchers to distribute and collect the surveys. After completion of all surveys, the participants were debriefed, which included contact information for the on-campus counselor for any participant upset by the stigmatizing statements or attention to negative emotions.

Results

Relationship Between Public Stigma and Active Help-Seeking

It was hypothesized that there would be a negative relationship between public stigma and active help-seeking. Because public stigma was measured with two different measures (i.e., the PSS-18 and the PSS), two separate bivariate correlations were performed. A nonsignificant positive relationship was found between the PSS and active help-seeking (i.e., as personal stigma increased, active help-seeking increased), $r(98) = .109$, $p = .141$. A weak negative relationship was found between the PSS-18 and active help-seeking (i.e., as perceived public stigma increased, active help-seeking decreased), $r(98) = -.140$, $p = .083$.

Relationship Between Public Stigma and Self-Stigma

It was hypothesized that there would be a positive relationship between public stigma and self-stigma. As with hypothesis 1, multiple bivariate correlations were performed; however, four were performed instead of two because both public stigma and self-stigma have two measures (i.e., the PSS-18, PSS, and two ISMI-10s respectively). A significant, weak positive relationship was found between the PSS-18 and self-stigma concerning anxiety (i.e., as perceived public stigma increased, self-stigma concerning anxiety also increased), $r(98) = .175$, $p = .041$. A significant, weak positive relationship was found between the PSS-18 and self-stigma concerning depression (i.e., as perceived public stigma increased, self-stigma concerning depression also increased), $r(98) = .205$, $p = .021$. A nonsignificant negative relationship was found between PSS and self-stigma concerning anxiety (i.e., as personal stigma increased, self-stigma concerning anxiety decreased), $r(98) = -.059$, $p = .280$. A nonsignificant negative relationship was found between the PSS and self-stigma concerning depression (i.e., as personal stigma increased, self-stigma concerning depression decreased), $r(98) = -.088$, $p = .280$.

Relationship Between Self-Stigma and Active Help-Seeking

It was hypothesized that a negative relationship between self-stigma and active help-seeking would be found. Because there were two measures for self-stigma, two bivariate correlations were performed. In fact, a significant moderate negative relationship was found between self-stigma regarding depression and active help-seeking (i.e., as self-stigma regarding depression increases, active help-seeking decreases), $r(98) = -.325$, $p < .001$. Also, a marginally significant negative relationship was found between self-stigma regarding anxiety and active help-seeking (i.e., as self-stigma concerning anxiety increased, active help-seeking decreased), $r(98) = -.159$, $p = .057$.

Relationship Between Anxiety and Depression and Perceived Public Stigma

It was hypothesized that there would be a positive relationship between anxiety and depression and perceived public stigma. Because anxiety and depression were measured with different scales (i.e., the STICSA and the BDI-II respectively), two bivariate correlations were performed. A significant positive relationship was found between anxiety and perceived public stigma (i.e., as anxiety increases, perceived public stigma increases), $r(98) = .204$, $p = .021$. Also, a marginally significant positive relationship was found between depression and perceived public stigma (i.e., as depression increases, perceived public stigma increases), $r(98) = .164$, $p = .052$.

Relationship Between Personal Stigma and Active Help-Seeking

It was hypothesized that there would be a negative relationship between personal stigma and active help-seeking. Contrary to the hypothesis, a positive relationship was found (i.e., as personal stigma increased, active help-seeking also increased), $r(98) = .109$, $p = .141$.

Post Hoc Analyses

Post hoc analyses were conducted on various demographics using independent sample t-tests. Statistically significant patterns were found between sex and mental illness tendencies, sex and perceived public stigma, and race and depression.

Females had significantly higher scores than males in both depression (Figure 1) and anxiety (see figure 2), $t(98) = -2.263$, $p = .013$ and $t(92.166) = -2.544$, $p = .0065$ respectively. Females had a greater mean and standard deviation than males concerning depression scores ($M = 20.33$, $SD = 12.833$; $M = 14.68$, $SD = 10.63$, respectively). Females also had a greater mean and standard deviation than males concerning anxiety ($M = 44.75$, $SD = 15.294$; $M = 37.89$, $SD = 11.457$, respectively).

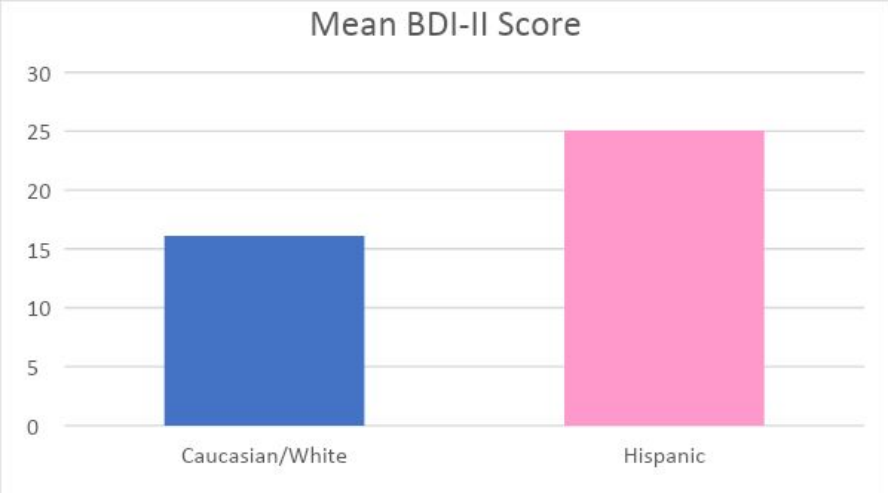

Figure 1

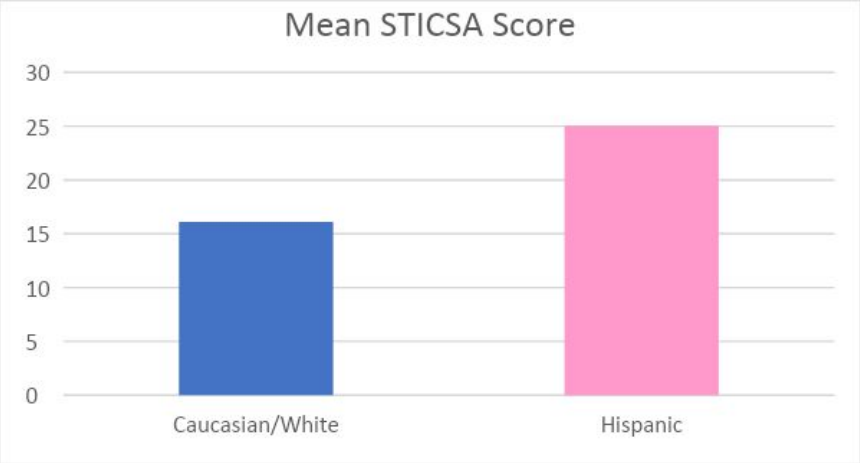

Figure 2

Also, females had significantly higher perceived public stigma scores than males (see Figure 3), $t(81.059) = -2.838$, $p = .003$. Females have a higher mean and standard deviation than males ($M = 55.05$, $SD = 3.871$; $M = 52.89$, $SD = 3.542$, respectively).

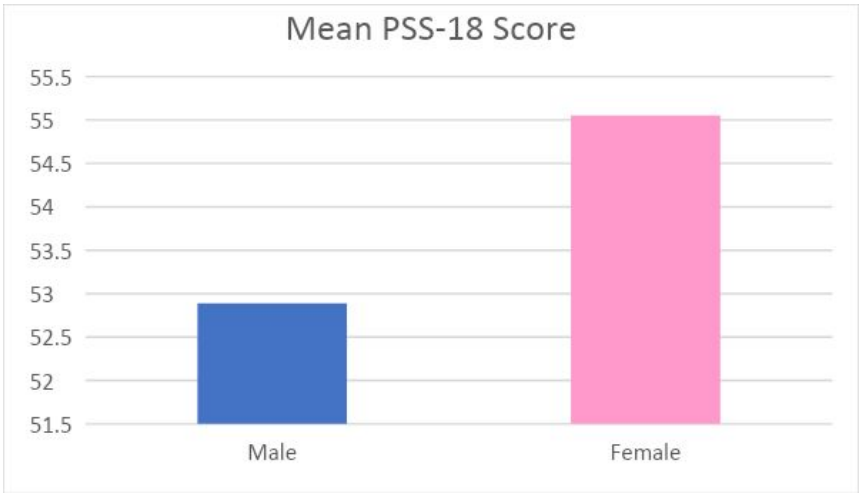

Figure 3

Hispanics had significantly higher depression scores than Caucasians (see Figure 4), $t(45) = -2.455$, $p = .009$. Hispanics mean score was greater than Caucasians, but standard deviation was lower ($M = 25.06$, $SD = 11.943$; $M = 16.10$, $SD = 12.275$, respectively).

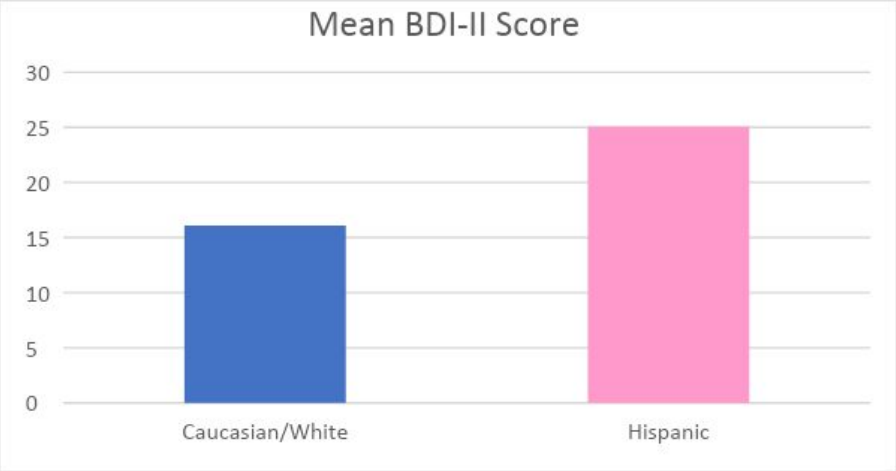

Figure 4

Discussion

The first hypothesis was not significantly supported by either type of public stigma; however, a negative relationship was found between perceived public stigma and active help-seeking (i.e., as perceived public stigma increased, active help-seeking decreased. This finding supports the relationship found in previous studies (Gulliver et al., 2010; Mojtabai, 2010; & Yap, 2011). In contrast to previous studies (Mojtabai et al., 2010; Yap et al., 2011), the results concerning personal stigma found a positive relationship between personal stigma and active help-seeking (i.e., as personal stigma increased, active help-seeking increased). This could be because these studies measured the participants anticipations concerning help-seeking rather than help actually received.

The second hypothesis was supported by perceived public stigma, but not personal stigma. There was a statistically significant positive relationship between perceived public stigma and self-stigma of both anxiety and depression (i.e., as perceived public stigma increased, self-stigma of anxiety and depression increased). Also, there was a negative relationship found

between personal stigma and self-stigma of both anxiety and depression (i.e., as personal stigma decreased, self-stigma increased). These findings do not support Yap et al.'s (2011) study concerning young people. The findings instead support Gulliver et al.'s (2010) and Mojtabai's (2010) study where perceived public stigma was more influential concerning help-seeking behavior.

The third hypothesis was partially supported. A marginally significant negative relationship was found between self-stigma concerning anxiety and active help-seeking (i.e., as self-stigma concerning anxiety increased, active help-seeking decreased), with a *p*-value of .057. Also, an extreme statistically significant negative relationship was found between self-stigma concerning depression and active help-seeking (i.e., as self-stigma concerning depression increases, active help-seeking decreases).These results support Hansson et al. (2016), who proposed self-stigma as the reason more than half of those with mental illness take preventative measures, like not seeking help, to avoid feeling embarrassed about their disorder.

The fourth hypothesis was also partially supported. A marginally significant positive relationship was found between presence of clinical depression and perceived public stigma (i.e., as depression scores increased, perceived public stigma increased). This finding could possibly be due to the common depression symptoms such as guilty feelings, worthlessness, and self-dislike, whereby the sufferer projects their own feelings onto the public. A statistically significant positive relationship between presence of clinical anxiety and perceived public stigma (i.e., as clinical anxiety scores increased, perceived public stigma increased), with a *p*-value of .021. This finding could be due to an increased worry about what others think.

The fifth hypothesis was not supported. A nonsignificant positive relationship was found

between personal stigma and active help-seeking (i.e., as personal stigma increased, active help-seeking increased). This finding is contrary to the previously mentioned study by Yap et al. (2011).

Limitations

One limitation of this study is that it is not a representative sample of the general population. In order to be representative, there need to be more males and minority group members. The people represented in this study may not have answered as representative to the general population.

A second limitation is the campus population itself. The study was conducted at a small, private, Catholic university in the South. The people who choose to go to such a university may have different ideas than those who chose to go to a larger university.

A third limitation is the need for more people in general. To create statistical significance with more power, the number of people needs to be increased.

A fourth limitation is the possibility of participants giving socially desirable responses. The participants could have been afraid to answer as truthfully as possible due to fear of stigma concerning their depression and anxiety scores, as well as fear of judgment for having stigma towards the mentally ill.

A fifth limitation is that there was no measure that specifically contained both aspects of public stigma, so previously specific hypotheses including public stigma needed to be further specified for reliability's sake; however, because of this, general statements about public stigma cannot be made. Also, because self-stigma was measured with two separate measures, generalizations about self-stigma and mental illness as a whole may not be reliably made.

Directions for Future Research

Future research could be conducted with a more representative sample of participants (i.e., equal number of males and females, representative minorities). More detailed research should also be conducted on different mental illnesses, perhaps using the Minnesota Multiphasic Personality Inventory 2 or a measure like it, to see the self-stigma and public stigma levels of each class of disorders. Another interesting study would test the perceived public stigma levels of individuals with psychopathologies before and after successful treatment in order to see if inflated perceived public stigma is a common experience or perhaps even a symptom of such disorders. Further research must be done to create a reliable and valid public stigma scale that encompasses both perceived public stigma and personal stigma to allow for more general correlations concerning public stigma as a whole.

Conclusions

A positive relationship was found between the PSS-18 and self-stigma concerning anxiety (i.e., as perceived public stigma increased, self-stigma concerning anxiety also increased). Likewise, a positive relationship was found between the PSS-18 and self-stigma concerning depression (i.e., as perceived public stigma increased, self-stigma concerning depression also increased). A marginally significant negative relationship was found between self-stigma regarding anxiety and active help-seeking (i.e., as self-stigma concerning anxiety increased, active help-seeking decreased). Also, a negative relationship was found between self-stigma regarding depression and active help-seeking (i.e., as self-stigma regarding depression increases, active help-seeking decreases). A positive relationship between presence of clinical anxiety and perceived public stigma (i.e., as clinical anxiety scores increased, perceived

public stigma increased).

Implications

One implication of this research is its helpfulness for counselors and those who advocate for people with mental illness. Knowing the mentally ill perceive a large amount of public stigma paves the way for improvement by way of community education. For example, on a college campus the counselor can create programming events addressing stigma towards the mentally ill, including treatment options. Changing the public's opinion of the mentally ill could lead to less stigmatizing comments in the presence of the mentally ill, creating a safer environment to facilitate active help-seeking.

A second implication of this research is its helpfulness for those with mental illness themselves. Being made aware of their own self-stigma can open the gateway for positive improvements, like affirmations and self-love. If the individual cannot stop the public from stigmatizing them, they can at least try to combat those statements with self-positivity. By being positive towards themselves, the mentally ill could decrease their self-stigma, thus increasing their own active help-seeking.

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Appendix A

Last 4 Digits of Your 899 Number: _____

Mental Health Services Utilization Form

Instructions: All answers will be kept *strictly confidential*, so *answer honestly*. Please indicate whether you have used a specific mental health service in your lifetime for *your* mental health.

Yes **No** 1. I stayed in a psychiatric hospital for overnight/short-term care.

Yes **No** 2. I stayed in the psychiatric unit of a general hospital for overnight/short-term care.

Yes **No** 3. I stayed in a psychiatric residential center for long-term care.

Yes **No** 4. I stayed in an alcohol rehabilitation facility.

Yes **No** 5. I stayed in a drug rehabilitation facility.

Yes **No** 6. I had to attend a partial hospitalization program/day program for six or more hours a day every day or most days of the week.

Yes **No** 7. I had to attend an intensive outpatient program for three to four hours once to a few times a week.

Yes **No** 8. I went to a community mental health center.

Yes **No** 9. I went to a private clinician regarding my mental health.

Yes **No** 10. In the past year, I have called a mental health help-line.

Yes **No** 11. I have used the internet to talk to clinicians via e-mail, online chat, or video-conferencing about my mental health (e.g., counselingresource.com).

Yes **No** 12. I have been prescribed psychotropic medication for my mental health (e.g., Prozac).

Yes **No** 13. I have received individual therapy for my mental health.

Yes **No** 14. I have received group therapy for my mental health.

Yes **No** 15. I have received family therapy for my mental health.

Appendix B

Last 4 Digits of Your 899 Number: _____

Other People's Beliefs and Feelings of Mental Illness (PSS-18)

Instructions: All answers will be kept *strictly confidential*, so please *answer honestly*. Please read the answer options carefully. For each question, please mark one answer.

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

1 2 3 4 5 1. Most people would blame someone for having a severe mental illness.

1 2 3 4 5 2. Most people regard a severe mental illness as rare or unusual.

1 2 3 4 5 3. Most would think that being around someone with a severe mental illness is risky.

1 2 3 4 5 4. People generally view a severe mental illness as affecting all parts of a person's life.

1 2 3 4 5 5. Most people are afraid of people with a severe mental illness.

1 2 3 4 5 6. Many people feel sorry for those who have a severe mental illness.

1 2 3 4 5 7. Most people react to people who have a severe mental illness with indifference.

1 2 3 4 5 8. Most people try to keep a distance when interacting with someone with a severe mental illness.

1 2 3 4 5 9. People are often overly nice to someone with a severe mental illness.

1 2 3 4 5 10. People generally hold someone with a severe mental illness personally responsible for it.

1 2 3 4 5 11. Most people believe that they are unlikely to encounter someone with a severe mental illness.

1 2 3 4 5 12. Many people believe that spending time with someone who has a severe mental illness is dangerous.

1 2 3 4 5 13. Most people think that a severe mental illness has severe consequences.

1 2 3 4 5 14. People are often fearful of someone with a severe mental illness.

1 2 3 4 5 15. Most people would have sympathy toward someone with a severe mental illness.

1 2 3 4 5 16. People generally don't care whether or not someone has a severe mental illness.

1 2 3 4 5 17. People generally will not include someone with a severe mental illness in their social activities.

1 2 3 4 5 18. People generally go out of their way to try to help someone with a severe mental illness.

Appendix C

Last 4 Digits of Your 899 Number: _____

Beliefs and Attitudes of Mental Illness (PSS)

Instructions: All answers will be kept *strictly confidential*, so please *be honest*. Please circle the answer that best fits your opinion.

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

1 2 3 4 5 1. People with mental health issues could "snap out of it" if they wanted.

1 2 3 4 5 2. Mental health issues are a sign of personal weakness.

1 2 3 4 5 3. Mental health issues are not real medical illnesses.

1 2 3 4 5 4. People with mental health issues are dangerous.

1 2 3 4 5 5. It is best to avoid people with mental health issues so that you don't develop the problem yourself.

1 2 3 4 5 6. People with mental health issues are unpredictable.

1 2 3 4 5 7. If I had a mental health issue, I would not tell anyone.

Appendix D

Last 4 Digits of Your 899 Number: _____

Beliefs and Attitudes Regarding Anxiety (ISMI-10)

Instructions: All answers will be kept *strictly confidential and anonymous*, so please *be honest*.

Please mark the appropriate answer regarding your own anxiety.

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

1 2 3 4 5 1. Anxious people tend to be violent.

1 2 3 4 5 2. People with anxiety make important contributions to society.

1 2 3 4 5 3. I don't socialize as much as I used to because my anxiety might make me look or behave "weird."

1 2 3 4 5 4. Having anxiety has spoiled my life.

1 2 3 4 5 **5**. I stay away from social situations in order to protect my family or friends from embarrassment.

1 2 3 4 5 6. People without anxiety could not possibly understand me.

1 2 3 4 5 7. People ignore me or take me less seriously just because I have anxiety.

1 2 3 4 5 8. I can't contribute anything to society because I have anxiety.

1 2 3 4 5 9. I can have a good, fulfilling life, despite my anxiety.

1 2 3 4 5 10. Others think that I can't achieve much in life because I have anxiety.

Appendix E

Last 4 Digits of Your 899 Number: _____

Beliefs and Attitudes on Depression (ISMI-10)

Instructions: All answers will be kept *strictly confidential and anonymous*, so please *be honest*.

Please mark the appropriate answer regarding your depression. Circle one answer per question.

1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree

1 2 3 4 5 1. Depressed people tend to be violent.

1 2 3 4 5 2. People with depression make important contributions to society.

1 2 3 4 5 3. I don't socialize as much as I used to because my depression might make me look or behave "weird."

1 2 3 4 5 4. Having depression has spoiled my life.

1 2 3 4 5 5. I stay away from social situations in order to protect my family or friends from embarrassment.

1 2 3 4 5 6. People without depression could not possibly understand me.

1 2 3 4 5 7. People ignore me or take me less seriously just because I have depression.

1 2 3 4 5 8. I can't contribute anything to society because I have depression.

1 2 3 4 5 9. I can have a good, fulfilling life, despite my depression.

1 2 3 4 5 10. Others think that I can't achieve much in life because I have depression.

Appendix F

Last 4 Digits of Your 899 Number: _____

Reactions to Situations Scale (STICSA)

Instructions: All answers will be kept *strictly confidential and anonymous*, so please *answer honestly*. Please read each statement carefully and clearly circle the number which best indicates *how often, in general*, the statement is true of you.

1 = Not at all 2 = A little 3 = Moderately 4 = Very much so

1 2 3 4 1. My heart beats fast.

1 2 3 4 2. My muscles are tense.

1 2 3 4 3. I feel agonized over my problems.

1 2 3 4 4. I think that others won't approve of me.

1 2 3 4 5. I feel like I'm missing out on things because I can't make up my mind soon enough.

1 2 3 4 6. I feel dizzy.

1 2 3 4 7. My muscles feel weak.

1 2 3 4 8. I feel trembly and shaky.

1 2 3 4 9. I picture some future misfortune.

1 2 3 4 10. I can't get some thought out of my mind.

1 2 3 4 11. I have trouble remembering things.

1 2 3 4 12. My face feels hot.

1 2 3 4 13. I think that the worst will happen.

1 2 3 4 14. My arms and legs feel stiff.

1 2 3 4 15. My throat feels dry.

1 2 3 4 16. I keep busy to avoid uncomfortable thoughts.

1 2 3 4 17. I cannot concentrate without irrelevant thoughts intruding.

1 2 3 4 18. My breathing is fast and shallow.

1 2 3 4 19. I worry that I cannot control my thoughts as well as I would like to.

1 2 3 4 20. I have butterflies in the stomach.

1 2 3 4 21. My palms feel clammy.

Appendix G

Last 4 Digits of Your 899 Number: _____

Wellbeing Scale (BDI-II)

Instructions: This questionnaire consists of 21 groups of statements. Please read each groups statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite)

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all of the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I need to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

11. Agitation
- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.

Appendix H

Last 4 Digits of Your 899 Number:

Demographics

Please fill in the blank accordingly.

Age: _____

Major: _____

Please **circle** the information according to your status.

How do you identify? Female Male Intersex

Classification: Freshman Sophomore Junior Senior 5th Year

How do you identify? African American/Black

Asian

Caucasian/White

Hispanic

Latino/Latina

Middle Eastern

Multiracial

Native American or American Indian

Pacific Islander

Other (Please Specify):

Would Rather Not Say