

**THE EFFECTS OF COLLEGE STUDENTS' PERCEPTIONS AND
KNOWLEDGE OF MENTAL ILLNESSES AND MENTAL HEALTH
SERVICES ON HELP-SEEKING BEHAVIOR**

Senior Thesis

by

Erica Meier

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fulfillment of the requirements for the degree of Degree in Major with Distinction

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ABSTRACT

College presents students with many exciting opportunities to grow socially and academically. Students may choose to enroll in courses that explore topics they've never studied, interact with people who are very different from their friends back home, and join new clubs and social groups. While all of these collegiate activities offer invaluable opportunities for enrichment and growth, they also operate within institutions that are, in many cases, unfamiliar and far from home. Students who are unable to adjust to these unfamiliar institutions in a healthy manner are at a greater risk of developing poor mental health or exacerbating an already existing condition.

In addition to the stress of being in an unfamiliar and constantly changing institution, students who have mental health concerns may also experience personal and/or other stigma, which may decrease their ability to cope in a healthy manner or to seek professional help. College students may also be unaware of—or may have a negative perception of—the mental health services that are available to them, which may also decrease the likelihood that they will seek help. This paper seeks to explore students' perceptions and knowledge and mental health, with an emphasis on co-occurring depression and substance abuse and depression with suicidal ideation.

INTRODUCTION

Further research on mental health concerns and stigmatization on college campuses indicates that these populations may be especially at risk for using alcoholic beverages to cope with mental health concerns. Mubayi writes, “More than 50% [of individuals studied] experienced the onset of alcohol dependence between the ages of 18 and 24 [...], during their college ages. Moreover, only 25.5% of them received some form of treatment for their alcohol problems” (Mubayi 3). This research suggests that students may be at a greater risk of developing substance use issues and of being stigmatized for such concerns. Additional research suggests that those who typically externalize problems (usually males) are at a greater risk of abusing substances in order to cope with emotional concerns, whereas those who typically internalize problems (usually females) are more likely to report greater anxiety and depression, but less substance use (Rosenfield 1). Given these assertions, it makes sense for future studies to focus on how stigmatization of mental health concerns is gendered and how institutions should address this issue to ensure that the greatest number of students in need seek care.

In addition, alcohol use may mask mental health concerns, while decreasing the likelihood that individuals seek help and increasing the likelihood that they contemplate suicide. Kilmer writes, “1.2% of students seriously considered suicide in the past 12 months as a consequence of drinking” (Kilmer 3). This paper will consider why students may turn to alcohol rather than professional help, whether or not gender is a factor in determining how likely peers are to recommend help for subjects who exhibit symptoms of alcohol abuse or suicidal ideation, and how male and female students perceive mental health services and those who use them. The hope is that this knowledge will inform future efforts to increase college students’ help-seeking

behaviors, which, in all likelihood, would reduce mental health concerns and suicide rates. Kilmer writes, “On US college campuses, out of 103 suicides reported by counseling center directors, only 19% were former or current counseling center clients” (Kilmer 8). This study suggests that perhaps the most important thing we can do to improve students’ likelihood of surviving through mental health concerns is simply increasing their utilization of services.

This paper will examine how male and female students perceive and understand general mental health concerns and mental health services on college campuses, with an intentional emphasis on the co-occurrence of substance use mental illness and/or suicidal ideation. Methods include a literature review of stigmatization and knowledge on college campuses and of people of different genders, races, and socioeconomic groups; and a survey and vignette availability study of 143 students at the University of Delaware. The results for this study will be presented in three sections: One on a gendered analysis of stigmatization of mental health concerns, one on students’ general knowledge of mental health concerns and services, and one on how these two work together to inform how likely individuals are to seek or to recommend professional mental health services.

Chapter 1

Literature Review: Prevalence of Mental Illnesses on College Campuses

A survey of college counseling centers has found that more than half of counseling clients have severe psychological problems, an increase of 13 percent between 2012 and 2014. Anxiety and depression, in that order, are now the most common mental health diagnoses among college students, according to the Center for Collegiate Mental Health at Penn State (CCMH). This study also notes that 1 out of 3 college students has taken a psychiatric medication; 1 out of 4 college students has self-injured; 1 out of 3 college students has seriously considered suicide; and 1 in 10 college students has been hospitalized for psychiatric reasons. Additionally, nearly 1 in 10 has made a suicide attempt; 1 out of 5 has experienced sexual assault; 1 out of 3 has experienced harassment or abuse; and 1 out of 3 has experienced a traumatic event (CCMH).

Even a cursory review of literature on the prevalence of mental illnesses on college campuses would suggest that many students experience some sort of mental distress. Kilmer writes, “80% of students felt exhausted (not from physical activity), 60% felt very sad, 56% felt very lonely, 46% felt things were hopeless, 30% felt so depressed it was difficult to function, and 6% seriously considered suicide” (Kilmer 3). The message behind the percentages is clear: There is much room to improve college students’ general mental well-being.

In addition to the excessive prevalence of mental illness among this population, college students' mental health is unique in two other ways: Alcohol abuse and suicidal ideation are common in this population. Unsurprisingly, co-occurring mental illness and alcohol abuse is more common in students attending college than it is in their same-age peers who do not attend universities. In the national analysis by Blanco et al, college students had a higher prevalence of alcohol use disorders than their same-age peers but a lower prevalence of drug use disorders and nicotine use (Blanco et al 2). This is a troubling finding, considering research indicates that the risk of having major depression is about three times higher for those with an alcohol use disorder. Similarly, depressed mood has been associated with increased risk of problematic alcohol use (Kilmer 4). Kilmer's study also finds that college students are not likely to seek help for any kind of alcohol disorder. He writes, "Though 20% of college students in the 2002 NSDUH met the criteria for an alcohol disorder, only 3.9% of students with an alcohol use disorder had received alcohol services in the past year" (Kilmer 7). Is this lack of help-seeking a product of the heavy drinking culture on college campuses, stigmatization, some combination of the two, or something entirely different? This paper will investigate the roles gender, knowledge of mental health, and stigma play in determining how likely individuals are to seek or recommend care for those who struggle with co-occurring mental health concerns and substance use.

Another common symptom of many mental illnesses is suicidal ideation. While not everyone who thinks about committing suicide has been diagnosed with a mental illness, suicidal ideation is an indicator that a person is not mentally well, and it may be one of the most obvious signs that someone should seek professional help.

Thus, when studying the prevalence of mental illness, it is worthwhile to examine the rates of suicide. Hunt writes, “More than one in three undergraduates reported ‘feeling so depressed it was difficult to function’ at least once in the previous year, and nearly one in 10 reported ‘seriously considering attempting suicide’” (Hunt 2). The National Institutes of Health 2013 confirms that suicide is a common cause of death among college students and their same-age peers. “Suicide is the third leading cause of death among 15-to-24 year olds and the second leading cause of death among college students” (National Institutes of Health 2013). To date, no studies have identified why there is such a significant difference in rates of suicide in the college population and the general population. Stigma, social and academic pressures, and availability of care are all possible contributing factors.

Efforts to establish effective intervention strategies, encourage and support appropriate help-seeking, and decrease stigma are still appropriate and relevant to college populations, as is demonstrated by the fact that many students whose mental health suffer do not seek help, for one reason or another. Lally writes:

Large-scale epidemiological research has shown that less than 25% of a college-aged population with mental disorders had received treatment in the past year. This is particularly pertinent as it has been estimated that approximately 75% of lifetime mental disorders have their onset before the age of 24 and the onset of mental disorders at a young age is associated with an adverse impact on educational and social outcomes, as well as impaired occupational functioning (Lally 8).

Why do so few mentally unhealthy students seek help? No one answer is available, and reasons may vary from person to person, but stigmatization is likely a factor that is maintained and perpetuated by actual or perceived low social support.

Barriers to seeking care, such as low social support and stigmatization, especially as they relate to students who struggle with alcohol abuse and suicidal ideation (which this study posits are particularly relevant to the college population), will be explored in the next sections.

1.1 Literature Review: Background on Societal-Level Perceptions of Mental Health and Mental Illness, Including: a) Stigmatization and b) Labeling

The Centers for Disease Control and Prevention defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Thus, mental health is not merely the absence of mental illness (though this is often how it is referred to); optimal mental health requires the presence of positive life factors and coping mechanisms. It is estimated that a mere 17% of Americans have reached optimal mental health (CDC 2012).

By contrast, the Centers for Disease Control and Prevention defines mental illness as “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” Biological, psychological, and/or social factors all contribute to mental illnesses. Whatever the cause for mental illness or poor mental health, it is important for those who suffer to seek help so that they may have a better chance at improving their mental (and physical) functioning. However, research indicates that many people who suffer from mental illness or poor mental health do not seek help. One potential reason people may not seek the help they need is that they fear others will dissociate

from them. This section of the paper will review the potential effects of stigmatization and labeling on people's willingness to seek formal mental health care.

Most studies on stigmatization explore two kinds of stigma: self-stigma and other stigma. Self-stigma focuses on how the individual who suffers perceives his/her mental health and potential need for help, whereas other stigma focuses on how the individual who suffers thinks others will perceive his/her mental health and potential need for help. The literature on self versus other stigma suggests the type of stigma may influence the kind of care individuals are most likely to seek. In a vignette study (a study that uses written descriptions that participants in the survey respond to) that included 728 participants, Pattyn found that respondents who had higher levels of self-stigma attached less importance to care provided by general practitioners or psychiatrists, whereas those with higher levels of perceived other stigma rated informal help seeking as less important (Pattyn 1). This finding suggests that people with less self-stigma may be more prepared to accept that their problems warrant professional intervention, and may therefore be more equipped to use problem-focused coping strategies. In addition to this, Talebi's study finds that greater endorsement of emotion-focused coping strategies was associated with high rates of self- and other-stigma for mental health help-seeking, whereas greater endorsement of problem-focused coping strategies was associated with less self- and other-stigma (Talebi 47). The fact that those who endorse emotion-focused coping strategies experience higher levels of stigmatization may be especially significant on college campuses, where emotion-focused coping strategies involving alcohol may mask mental health concerns, in the context of a heavy drinking culture.

Another vignette study found that seeking care for mental health is more highly stigmatized than seeking help for academic issues. Talebi reports higher levels of self-stigma regarding help-seeking for mental health, compared to academic issues were reported (Talebi 28). This indicates that seeking help for mental health concerns is something that is uniquely (and more severely) stigmatized.

On a more hopeful note, Lally's vignette study suggests that self-stigma is lower than public stigma, which, if it is in fact true that public stigma has less of an impact on individuals' likelihood to seek professional help, should mean that individuals are more likely to seek professional care and engage in problem-focused coping. Lally writes:

There were three main findings: (a) Perceived public stigma was considerably higher than personal stigma; (b) personal stigma was higher among students with any of the following characteristics: male, younger, Asian, international, more religious, or from a poor family; and (c) personal stigma was significantly and negatively associated with measures of help seeking (perceived need and use of psychotropic medication, therapy, and nonclinical sources of support), whereas perceived stigma was not significantly associated with help seeking. These findings can help inform efforts to reduce the role of stigma as a barrier to help seeking (Lally 6).

However, Lally's study points to another issue surrounding stigmatization for mental health help-seeking: it is more prevalent among certain races, genders, religions, and social classes. Hunt confirmed these discrepancies and found lower rates of mental health help-seeking in students of lower socioeconomic backgrounds, international students, and Asian American students (Hunt 8). Future studies should further examine how intensity of stigmatization differs based on demographics.

One of the most common and detrimental stigmas around mental illness is the idea that those who experience mental illness (or even less than ideal mental health)

are “weak.” Yap’s vignette study found that this “personal-weak-not-sick stigma” reduced intention to seek help from a general practitioner for depression and PTSD—though it increased the likelihood that PTSD sufferers would seek help from friends (Yap 9). This tendency for those who believe they are “weak” and not sick to avoid professional help and instead look to their friends for support may put them at greater risk of further stigmatizing themselves. Those who start to internalize this idea that they are “weak” rather than sick may also be more likely to blame themselves for their condition, which could trigger feelings of guilt and shame (Pattyn 2).

In addition to stigmatizing themselves as “weak,” those who experience depressive symptoms are also more likely to perceive their peers as unsupportive, which may exacerbate their own personal stigmatization toward seeking help for both mental health and academic concerns (Talebi 2). However, the stigma associated with mental health help-seeking was not present when participants were exposed to vignettes in which depressive symptoms primarily comprised of physical, rather than psychological, symptoms (Talebi 2), which, again, suggests that there is a unique stigmatization associated with mental health concerns. Additionally, individuals who experienced heightened levels of depression perceived greater levels of help-seeking stigma, both self and other, regardless of the nature of the concern for which they sought help (Talebi 28). These results suggest that it may be beneficial for mental health advocates to engage in preventative measures, in order to reduce the risk that individuals will become so depressed that they feel unable to seek help or to distinguish supportive interactions from unsupportive ones.

Further, Yap’s study finds that those who have mental disorders that are highly stigmatized, such as psychosis and depression with alcohol abuse, are more likely to

distance themselves socially and to avoid seeking professional help (Yap 10), which may worsen their perceptions of others' intentions and their self- and other-stigmatization. However, Yap's study also finds that those who suffer from depression may be more likely to seek help if they believe others perceive them as dangerous (Yap 10), which suggests that perceived-dangerousness may be the only form of stigmatization that may actually increase the likelihood that individuals will seek care. Yap writes, "Perceived-dangerousness increased intention to seek help from a counselor for depression and PTSD, and from a mental health specialist or service for psychosis" (Yap 9). The research on this particular type of stigmatization is limited, and its effects may mostly apply to those who suffer from mental illnesses that are more intensely stigmatized.

Talebi argues that mental illness is a "discreditable stigma," in that it is a type of illness that is hard to identify on the surface and, thus, "forces individuals to make judgments through signals, including labels, psychiatric symptoms, deficits in social skills, and physical appearance" (Talebi 14). The fact that individuals must make their own judgments about how they perceive themselves and how others perceive them increases the likelihood that individuals who suffer from mental illnesses will associate more negativity with their "labels." Along with fear of being labeled and stigmatized, people may have trouble recognizing that they need help and may not believe that treatment will be effective (Hunt 8). This fear may, in part, be due to the fact that admitting that they need mental health care may feel more humiliating to individuals than simply acknowledging that they are not mentally well (Talebi 14).

This section of the literature review confirms that depression with co-occurring alcohol abuse is a highly stigmatized mental illness and that it may be especially

interesting to study its occurrence on college campuses, where there is a heavy drinking culture, and students may encourage this kind of emotion-focused coping. This section also notes that those who have less personal stigma are more likely to seek professional care, but those with higher levels of personal stigma are more likely to seek informal help from friends or family. Additionally, those with more extreme cases of illness (as seen in folks with suicidal ideation) are more likely to perceive others as unhelpful. Thus, this study's focus on university students' perceptions of their peers who have highly stigmatized mental illnesses, as well as their knowledge of services, is a gateway to a potential intervention strategy for those who most highly stigmatize themselves and their conditions: their peers. The next section of this chapter will review literature on mental health care services and college students' perceptions of them.

1.1.1 Literature Review: Mental Health Care Services on College Campuses and Students' Access (or Lack Thereof) to Them

Every university has some sort of mental health service available for students to access, and most are free for students. The mere fact that the services exist, however, does not guarantee that the students who are in need of them will take advantage of them. A few barriers come to mind when considering why a person with mental health concerns wouldn't seek help: long waiting periods for counselors, the restriction on number of sessions, lack of knowledge of mental health services, lack of understanding of mental health, costs, and unpleasant prior experiences.

The primary reason students may have to wait a long time before they're able to see a counselor is that many schools simply do not have enough trained counselors to meet the demands of large student populations. Hunt writes, "According to the

2008 survey, the overall ratio of students to psychological counselors is about 1,900:1, with even higher ratios at larger institutions” (Hunt 9). As colleges typically have only one place for mental health services, it would be difficult for them to take on larger staffs. Because services and time are limited, mental health counselors on college campuses often end up referring students to community counseling services for more long-term care, which may require a great deal of effort, depending on the students’ insurance and financial capabilities. Administrators at college counseling centers also experience “difficulty dealing with the growing demand of services without a concurrent increase in resources (60%), and the related challenge of handling an increasing number of students with serious psychological problems (50%)” (Hunt 10). With all of these items on their agendas, it may be difficult for mental health offices on college campuses to find time to promote their services—and, as a result, students have fewer opportunities to be exposed to these services.

Multiple studies indicate that untreated mental disorders are highly prevalent in student populations, which is consistent with the general population, with a median delay of 11 years noted between on-set of illness and presenting for treatment. Kilmer writes, “Up to 72% of college students who screened positive for major depression felt they needed help, but only 36% received services of any kind” (Kilmer 8). Because college mental health services currently have more demand for care than they could possibly fulfill within the counseling centers alone, many colleges are coming up with more community- and public health-based programs to help in their efforts to deliver care. More than 200 campuses have now adopted the QPR (Question, Persuade, Refer) program, which strives to educate faculty and staff on effective ‘gatekeeping’ strategies that help them identify and refer students with mental illnesses to

appropriate health care services. Programs such as QPR reduce some of the burden that mental health care services carry, specifically in regards to identification and management of mental illness (Hunt 10).

The American Foundation for Suicide Prevention's College Screening Project is another promising mental health intervention strategy that uses Web-based services to improve help-seeking behavior in college students (Hunt 9). Further expansion of this project (renamed the Interactive Screening Program) should lead to improved knowledge about interventions to increase identification of mental illness and help-seeking. The increased prevalence of community- and public health-based efforts such as these should help create a network in which there is a more compassionate understanding of mental health concerns and how they may impact those who suffer from them. Hunt writes of one more such effort: "The National College Depression Partnership, led by New York University, which represents a growing network of campuses collaborating in an effort to deliver screening, early intervention, and more continuous, integrated treatment of depression for students" (Hunt 9). Such interventions could help decrease the incidence of severe cases of mental illness, which would have positive effects for individuals and the college community at large.

Public health approaches to providing mental health care may also be better able to focus on promoting aspects of positive mental health care, in their recognition of mental health as a foundation for the well-being and success of students (Hunt 11). And the college environment may be the most ideal place to test these strategies, in that most of students' main activities are in one location, so there is room for health promoting services to permeate every aspect of their lives (Hunt 1).

Future efforts to expand use of care should also look to how mental health concerns that manifest themselves physically may not be recognized as mental health concerns, and, thus, may not elicit suggestions to seek help from mental health professionals (Talebi 57). Students who exhibit these physical symptoms (as opposed to emotive symptoms) have an advantage in that they are less likely to be stigmatized (Talebi 66), but they run the risk of being improperly treated or failing to recognize the root cause of their symptoms.

This study seeks to explore how students' knowledge and perceptions of mental health care and mental health care services, as well as their personal stigmatization, may influence their likelihood to seek or recommend help. The next section of this literature review will look at social support and environment as motivators or de-motivators to seek help.

1.1.1.1 Literature Review: Social Support and Environment as Motivators or De-motivators to Seek Help

In times of mental distress, friends and family members are often the first people individuals turn to for support. It is therefore fairly intuitive to explore how the nature of these interactions may impact individuals' likelihood to engage in problem-focused coping and to seek help. The literature on this topic suggests that supportive interactions encourage individuals to seek help and to engage in problem-focused coping strategies and that unsupportive interactions may increase self-stigmatization, decrease the likelihood to seek help, and decrease the likelihood that individuals will engage in problem-focused coping.

Talebi's study suggests that greater perceptions of peer support encourage individuals to engage in more problem-focused coping strategies, whereas those who

perceive greater levels of unsupport from their peers are less likely to use problem-focused coping and more likely to engage in emotion-focused coping (Talebi 49). These findings suggest that it may be beneficial to focus future efforts on educating community members about how to be supportive of and recommend professional help for someone with mental health concerns. Yap writes:

The findings that stigmatizing attitudes that generally hinder professional help seeking may increase young people's preference to seek informal help from family and friends also suggest the promise of equipping the general public with adequate skills to support young people and serve as a conduit to appropriate professional help seeking (Yap 14).

These efforts may prove especially promising in adolescents and young adults, who are likely to only reveal their mental health concerns to close friends (Hunt 10).

The degree of support an individual perceives is often influenced by the severity of his/her mental illness. Talebi found that students who experienced mild levels of depressive symptoms saw their peers' support as helpful and, in turn, were more likely to engage in problem-focused coping and help-seeking, whereas those with higher levels of depressive symptoms were more likely to perceive lower levels of social support and to engage in emotion-focused coping (Talebi 53). Individuals who suffer from mental health concerns also run the risk that those they confide in will undermine the validity of their depressive symptoms, and potentially elicit feelings of shame, blame, and self-pity (Talebi 34). These unsupportive elements of an individual's social network do more harm than good and may increase stigmatization and decrease likelihood to seek help.

In addition to forms of social support, social environment may also impact how likely individuals are to seek help and/or how they cope with their mental health concerns. Mubayi writes, “White male freshmen and students living in specific environments (e.g., fraternity and sorority houses, cooperatives; Sher et al., 2001) are most at risk for heavy drinking” (Mubayi 36), which is a form of emotional coping that prevents individuals from working through the crux of their problems. Just as heavy-drinking environments may encourage individuals to drink more, environments in which heavy drinking is discouraged decrease the likelihood that individuals will drink in and outside of those spaces (Barrientos-Gutierrez 8). Thus, the type of social support individuals receive and the environments in which they live can significantly impact how they will cope with stressors and what type of help (if they seek it at all) they are likely to utilize.

The following sections will report this paper’s unique efforts and contributions to the field.

1.2 Methods

In an effort to explore how students’ knowledge and perceptions of mental health care and mental health care services, as well as their personal stigmatization, may influence their likelihood to seek or recommend help, four vignettes were distributed to an availability sample of 143 students at the University of Delaware. A vignette is a short written description of a situation that researchers may use to explore how survey respondents feel about a given topic; the vignettes used in this study are attached to the Appendix. In two of the vignettes, alcohol abuse was defined, according to DSM-V standards, as drinking 3-4 alcoholic beverages per night for women and 4-5 alcoholic beverages a night for men. In each vignette, Jenny, a 20-

year old female, or John, a 20-year old male, was described as “having a difficult time concentrating in class,” “spending a lot of time by himself/herself,” “easily agitated,” and “losing interest in activities he/she used to find enjoyable.”

Gender was varied in order to determine whether participants would more heavily stigmatize males or females who were struggling with depressive symptoms. Alcohol use as an emotion-focused means to cope with depression was highlighted because the literature (Hunt, Talebi, Yap) suggests that this type of emotion-focused coping is especially common and highly stigmatized on college campuses. Though work by these researchers suggests that alcohol use as a form of coping is more common on college campuses and that students are not likely to seek help for this, none of these studies explores knowledge and stigmatization as barriers to help-seeking.

This study also compares how likely participants are to seek or recommend help for someone who struggles with depressive symptoms and suicidal ideation to someone who struggles with depressive symptoms and uses alcohol to cope. To see if gender has an influence, the subjects’ genders are also changed in these scenarios.

At the end of each of the four vignettes (one that features depressive symptoms and alcohol use in a female, one that features depressive symptoms and alcohol use in a male, one that features depressive symptoms and suicidal ideation in a female, and one that features depressive symptoms and suicidal ideation in a male), participants were asked a series of questions that they rated on a 10-point Likert scale—0 being “Not likely at all” and 10 being “Extremely likely.” Participants were asked, in order: how likely they thought the subject in the vignette would be to seek help from a 24-hour, anonymous (no one would know they called) hotline, how likely they thought

the subject would be to seek help from a 24-hour, confidential (administrators and parents would know they called) hotline, how likely they thought it would be for the subject to harm himself/herself if the subject did not seek help in the near future, how likely they thought it would be for the subject to harm others if the subject did not seek help in the near future, how likely the participant would be to feel comfortable recommending help for the subject (as the subject's friend), how likely the participant would be to consider the subject "weak," how likely the participant would be to seek help from a 24-hour, anonymous hotline if he/she were in the subject's position, and how likely the participant would be to seek help from a 24-hour, confidential hotline if he/she were in the subject's position. Responses were then entered into SPSS and organized by gender and subject; the most telling subjects being: anonymous help, confidential help, self-harm, and weakness. The anonymous help and confidential help categories each have eight responses, which represent respondents' answers to how likely the four subjects would be to seek help in each of the situations and how likely the respondents would be to seek help for themselves if they were in the subject's position. The self-harm and weakness categories each have only four responses, which represent only respondents' answers to how likely they thought it would be for the subject in each scenario to harm himself/herself and how likely the respondent would be to consider the subject in each scenario "weak."

Respondent Characteristics: In addition to the variables contained in the vignettes, respondents were asked a series of questions about their personal demographics, their knowledge of the services (mental health related and otherwise) available on campus, and their general knowledge, familiarity, and perceptions of mental health. This study's focus on how knowledge may impact likelihood to seek or

to recommend help is another way in which it is unique. A quick review of respondents' demographics indicated that this particular sample consisted of primarily white, middle-class students and that it made the most sense to study how participants might have responded differently based on their gender. This availability sample includes 88 females and 54 males, sourced primarily from an introductory geography course.

1.2.1 Results

As is depicted in Table 1, both male and female respondents perceive the female who abuses alcohol to cope as slightly weaker (receiving ratings of 1.84 and 2.76 from female and male respondents, respectively, as opposed to the male subject's ratings: 1.07 and 2.37). This difference cannot be generalized as statistically significant, as this study is only exploratory, but nonetheless appears to be consistent with gender norms that depict women as more empathetic and likely to internalize rather than externalize emotions (Rosenfield 2, 5). Because of these norms, most people do not expect women to cope with their emotions by drinking or externalizing anger. These data also support the notion that prominent gender norms that depict women as more likely to internalize their emotions and men as more likely to externalize their emotions discourage men and women from expressing symptoms in ways that are inconsistent with those prevailing norms and that observers may view behavior as more worrisome when it is inconsistent with such norms (Horwitz 1). Kauffman's study suggests that women's wariness about alcohol use may prompt them to use other illicit substances more, for fear of social stigma (Kauffman 5). Additionally, both male and female respondents perceive the male who abuses alcohol as more likely to harm himself (receiving a rating of 7.55, as opposed to 6.9 for female

subjects), which, although not statistically significant, is consistent with findings that males are more likely to externalize stress through engaging in drinking or antisocial behaviors (Rosenfield 14). Further, male respondents generally think both the male and female subjects depicted in all the vignettes are slightly more weak, and female respondents generally think both male and female subjects are slightly more likely to harm themselves. Kauffman writes, “Undergraduate college women evaluated the daily use of alcohol [...] as being much more risky than did their male counterparts” (Kauffman 2). These findings support long-held beliefs that males generally tend to view emotional displays as more weak, and females tend to be more concerned about those who are emotionally distressed.

Surprisingly, both male and female respondents hypothesize that the male subject who is using alcohol to cope with depressive symptoms is more likely to seek either confidential or anonymous help than the female subject who is using alcohol. Again, the difference seen on a 10-point Likert scale is not significant, but there is a difference, with an average of 4.31 for males’ likelihood to seek anonymous help and an average of 3.2 for females’ likelihood to seek anonymous help. This may also point to the potentially harmful nature of gender norms that stigmatize women who externalize stress (Horwitz 2) in that, because excessive drinking is seen as unfeminine, females who struggle with heavy alcohol use may be less likely to seek care. Interestingly, male respondents consistently rate themselves as slightly more likely to seek help if they were in the subject’s position than female respondents. This finding is counterintuitive, considering females are generally more likely to seek help for all psychological disorders except co-occurring alcohol abuse and depression (Kauffman 4).

According to the data presented in Table 2, both male and female respondents also think that the male who struggles with depression and suicidal ideation is more likely to seek help than the female who is described in exactly the same way. These reports are inconsistent with studies that suggest women are more likely to seek help (Horwitz 5). Future studies should look into possible reasons for this bias.

Unsurprisingly, both male and female respondents report they believe the male who has suicidal ideation is slightly more likely to harm himself (7.82 versus 6.48 average) than the female subject, which is consistent with findings that males tend to externalize more using violent means, despite the fact that women are more likely to attempt suicide.

Knowledge

One question after each vignette reads: “What is the likelihood that, as Jenny’s [or John’s] acquaintance, you would feel comfortable reaching out to her [or him] in this situation?” This question attempts to gauge how comfortable the respondents feel interacting with (and potentially recommending help for) each of the mentally unwell subjects. Because one focus of this study is how one’s knowledge of mental health concerns may impact the likelihood that he/she will recommend or seek help, Table 3 attempts to explore how respondents’ self-reported knowledge of mental health concerns relates to how comfortable they feel interacting with those who exhibit symptoms of mental illness. In order to make the results simpler to read, responses that had been represented on a 10-point Likert scale are classified into four different groups. The High Distance and High Knowledge group represents those who report they feel uncomfortable interacting with the vignette subject (0-4 on Likert scale) and have a lot of knowledge about mental illnesses (5-10 on the Likert scale). The High

Distance and Low Knowledge group represents those who report they want a lot of distance from the vignette subject (0-4 on the Likert scale) and that they have low knowledge of mental illnesses (0-4 on the Likert scale). The Low Distance and High Knowledge group represents respondents who feel most comfortable interacting with distressed subjects (5-10 on the Likert scale) and who report they are most knowledgeable about mental illnesses (5-10 on the Likert scale). The final group is for represents those who report they feel comfortable interacting with distressed vignette subjects (5-10 on the Likert scale) and report they know little about mental illnesses (0-4 on Likert scale). These are imperfect categories and, again, are not generalizable but instead seek to highlight general trends.

Promisingly, the highest number of respondents in each case appears to want the least amount of distance from the subject, which is to say they report that they feel, by and large, comfortable interacting with the subject in each vignette. In addition, there are more respondents who report they have high knowledge and would like low distance in each case. While not generalizable, these results hint that greater knowledge of mental illnesses could increase the likelihood that students feel comfortable interacting with—and, again, hopefully recommending help for—their peers who exhibit symptoms of mental illnesses.

Despite the generally positive results, a surprisingly high number (46, which equates to 32% of 143) of respondents who reported high knowledge of mental illnesses reported that they would also like to maintain the most amount of distance between themselves and the male subject who uses alcohol to cope. Why are the most knowledgeable respondents more likely to want distance from the male subject who drinks (32%) than the female who drinks (7.7%), despite the fact that most

respondents consider the female to be slightly more “weak” in this case? One possible explanation is respondents are afraid that males who drink will become violent (Rosenfield 8), which is something they don’t believe they need to worry about when it comes to females who drink. In addition, according to Mubayi’s study, universities’ current intervention strategies, which focus on increasing the number and intensity of educational (e.g., lectures, meetings) programs, have not reduced the consequences of alcohol use by students (Mubayi 4). Instead, the NIAAA’s 2002 Task Force report suggests universities can most effectively reduce alcohol problems by specifically targeting high-risk groups (Mubayi 5).

1.3 Discussion

This paper has explored how students’ knowledge and perceptions of mental health, particularly as they relate to co-occurring depression and alcohol abuse and/or suicidal ideation, affect their likelihood to seek or recommend help. The most interesting and telling findings relate to how gender norms impact stigmatization and likelihood to seek help and how respondents’ knowledge of mental health impacts how comfortable they feel interacting with (and potentially recommending help for) each of the subjects. This section will explore how this study may inform future intervention strategies and research in the field.

The results of this study indicate that male and female respondents think each male subject is more likely to harm himself than each female subject, all other things equal. Eleven respondents in this study who reported that they had the highest amount of knowledge surrounding mental illnesses also reported that they would want the most amount of distance from the male who abuses alcohol to cope with depressive symptoms, which could suggest that respondents are generally afraid that men will

externalize their depression in violent ways, or that respondents do not view excessive alcohol use as a mental health concern for men, because it is considered more socially acceptable for males to drink (Kauffman). If Yap's study finds that perceived dangerousness is likely to increase formal help-seeking behaviors in those who suffer from depression and PTSD (Yap 16), which is likely one reason males seek help for alcohol problems at higher rates than women. Kauffman's study also suggests that alcohol intervention programs are designed mostly by men and for men, and encourage participants to take responsibility for their actions, which may not be the best approach for women, who are more likely to internalize their negative emotions and place more blame on themselves, anyway (Kauffman 6).

A broader public health approach, in which universities attempt to shift the heavy drinking culture, especially in fraternity and sorority houses, could be part of a longer-term, preventative effort, as students on college campuses are particularly vulnerable to social pressures to consume excessive amounts of alcohol (Mubayi 6). According to the results of this study, it appears that it would also be worthwhile to educate students on mental health concerns, with a specific focus on the co-occurrence of alcohol abuse and depression: how to recognize the symptoms, where to find services, how to recommend services, and how to encourage and engage in more problem-focused coping strategies. By and large, this study supports the notion that greater education about mental health concerns promotes greater acceptance of those who suffer and more willingness to engage with those individuals. The only exception to this rule is in the case of the male who abuses alcohol, which is why it may be especially beneficial for universities to work to shift the drinking culture and educate

students specifically about alcohol use as a means to cope with depression and as a gendered problem.

In addition, universities might consider piloting programs that seek to question gender norms that are most damaging to mental health concerns: that females who abuse alcohol are more weak and less likely to seek care, that males are more likely to be self-sufficient and seek help on their own, and that males who suffer from depression are more likely to become violent. Such programs may focus on showing videos, pictures, or performing skits and reading stories that depict people from all genders and races struggling with alcohol abuse in unique ways. Kauffman's study also suggests that women in recovery may be better helped by groups that focus on building self-esteem and perceptions of personal power and that challenge the sex-role stereotyping and power differentials experienced by women (Kauffman 7). These interventions should strive to demonstrate that students of any gender can exhibit internal or external symptoms of mental illnesses. They should also teach students to refer their peers to mental health centers or, if they feel uncomfortable doing so themselves, how to talk to an administrator or residence life staff person about referring them.

Future studies should continue to explore the effectiveness of gender-specific mental health intervention strategies. Further research should also look into strategies that are most effective at challenging the heavy-drinking culture and promoting more problem-focused coping strategies. Finally, it may be informative to explore how demographics other than gender impact likelihood to seek or recommend care. With each intervention and subsequent research study, we will hopefully get just a little bit closer to creating college environments that promote optimum mental health.

This study is limited by the fact that it's a small, availability sample, as well as the fact that each participant in this study responded to every vignette, rather than just one vignette at random, which could manipulate responses because participants are familiar with the vignette set-up. That said, this study may still be used to highlight general trends and inform potential for future research on the topic.

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Table 1: Gender and Alcohol Use

Vignette Female's Drinking			
	Total Mean Rating	Female Respondent Mean Rating	Male Respondent Mean Rating
Anonymous Help	3.2	2.22	2.74
Confidential Help	1.7	1.09	1.89
Self-Harm	6.9	5.28	5.09
Respondent Would perceive Vignette Subject as Weak	1.5	1.84	2.76
Respondent Would seek Anonymous Help	4.2	4.06	4.37
Respondent Would seek Confidential Help	2.7	2.20	3.41
Vignette Male's Drinking			
Anonymous Help	4.31	4.18	4.52
Confidential Help	2.52	2.08	3.24
Self-Harm	7.55	7.69	7.33
Respondent would Perceive Vignette Subject as Weak	1.56	1.07	2.37
Respondent would Seek Anonymous Help	5.84	5.74	6.02
Respondent would Seek Confidential Help	3.50	3.30	3.83

Table 2: Gender and Suicidal Ideation

Vignette Female with Suicidal Ideation			
	Total Mean Rating	Female Respondent Mean Rating	Male Respondent Mean Rating
Anonymous Help	3.26	3.28	3.22
Confidential Help	1.70	1.56	1.94
Self-Harm	6.48	6.47	6.06
Respondent would Perceive Vignette Subject as Weak	1.52	1.08	2.24
Respondent would Seek Anonymous Help	4.29	4.20	4.43
Respondent would Seek Confidential Help	2.38	2.35	2.44
Vignette Male with Suicidal Ideation			
Anonymous Help	4.50	4.38	4.70
Confidential Help	2.31	1.92	2.94
Self-Harm	7.82	7.89	7.70
Respondent would Perceive Vignette Subject as Weak	1.58	1.11	2.35
Respondent would Seek Anonymous Help	5.45	5.34	5.63
Respondent would Seek Confidential Help	3.42	2.99	4.13

Table 3: Respondents' Knowledge of Mental Illnesses and Preferred Social Distance

Level of Preferred Social Distance vs. Knowledge of Mental Illnesses	Vignette Female Drinking	Vignette Male Drinking	Vignette Female Suicidal Ideation	Vignette Male Suicidal Ideation
High Distance (0-4) and High Knowledge (5-10)	11	46	14	20
High Distance (0-4) and Low Knowledge (0-4)	27	20	30	31
Low Distance (5-10) and High Knowledge (5-10)	76	41	73	67
Low Distance (5-10) and Low Knowledge (0-4)	29	36	26	25

Appendix A

SURVEY

Consent Form

You are being asked to take part in a research study of how college students' perceptions and knowledge of mental health and mental health services may influence their help-seeking behaviors. I am asking you to participate because you are enrolled at the University of Delaware, and you are 18 years of age or older. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What we will ask you to do: If you agree to be in this study, you will respond to a confidential survey that includes demographic questions, basic questions about your knowledge and use of mental health services, and four vignettes.

Risks and benefits:

There is a small risk that some of the questions will trigger an emotional response. If you experience any trauma or anxiety while completing this survey, please stop the survey and seek professional help.

There are no benefits to you, other than helping to expand the general knowledge of mental health services and perceptions of help-seeking at the University of Delaware.

Your answers will be confidential. The records of this study will be kept private, and the signed portion of your consent form will be detached from the results. In any sort of report we make public we will not include any information that will make it possible to identify you. Only the researchers will have access to the records.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your relationship with University of Delaware. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researcher conducting this study is Erica Meier. If you have questions, you may contact Erica Meier at eem@udel.edu. If you have any

questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) at 302-831-2137.

You will be given a copy of this form to keep for your records.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____ Date _____

Your Name (printed) _____

Signature of person obtaining consent _____
Date _____

Printed name of person obtaining consent _____
Date _____

Section I—Vignette Section:

Instructions: In the following vignettes, I will describe scenarios, and then ask you to respond to the questions that follow each vignette, using a Likert scale. Please read each scenario and the questions that follow thoroughly, and respond to the questions truthfully. All responses will be anonymous.

1) Jenny, a 20-year-old female college student, has had a difficult time concentrating in classes, spends a lot of time by herself, is more easily agitated, and has lost interest in activities that she used to find enjoyable. She has also been drinking three or four alcoholic beverages per night to cope.

- a) What is the likelihood that Jenny will seek help from a 24-hour anonymous hotline?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

- b) What is the likelihood that Jenny will seek help if there is a 24-hour hotline available, but she must report her current emotional state to her parents and school officials, upon calling?

0 1 2 3 4 5 6 7 8 9 10

Not at	Extremely
All Likely	Likely

- c) What is the likelihood that Jenny will harm herself in the near future if she doesn't receive help?

0 1 2 3 4 5 6 7 8 9 10	
Not at	Extremely
All Likely	Likely

- d) What is the likelihood that Jenny will harm others in the near future if she doesn't receive help?

0 1 2 3 4 5 6 7 8 9 10	
Not at	Extremely
All Likely	Likely

- e) What is the likelihood that, as Jenny's acquaintance, you would feel comfortable reaching out to her in this situation?

0 1 2 3 4 5 6 7 8 9 10	
Not at	Extremely
All Likely	Likely

- f) What is the likelihood that you would perceive Jenny as "weak" for feeling this way?

0 1 2 3 4 5 6 7 8 9 10	
Not at	Extremely
All Likely	Likely

- g) What is the likelihood that you would seek help for yourself if you were in Jenny's position, and there were a 24-hour anonymous hotline available to you?

0 1 2 3 4 5 6 7 8 9 10	
Not at	Extremely
All Likely	Likely

- h) What is the likelihood that you would seek help for yourself if you were in Jenny's position and a 24-hour hotline were available, but you would have to report your current emotional state to your parents and school officials?

0	1	2	3	4	5	6	7	8	9	10
Not at						Extremely				
All Likely						Likely				

2) John, a 20-year-old male college student, has had a difficult time concentrating in classes, spends a lot of time by himself, is easily agitated, and has lost interest in activities that he used to find enjoyable. He has also been drinking four or five alcoholic beverages per night to cope.

a) What is the likelihood that John will seek help from a 24-hour anonymous hotline?

0	1	2	3	4	5	6	7	8	9	10
Not at						Extremely				
All Likely						Likely				

b) What is the likelihood that John will seek help if there is a 24-hour hotline available, but he must report his current emotional state to his parents and school officials, upon calling?

0	1	2	3	4	5	6	7	8	9	10
Not at						Extremely				
All Likely						Likely				

c) What is the likelihood that John will harm himself in the near future if he doesn't receive help?

0	1	2	3	4	5	6	7	8	9	10
Not at						Extremely				
All Likely						Likely				

d) What is the likelihood that John will harm others in the near future if he doesn't receive help?

0	1	2	3	4	5	6	7	8	9	10
Not at						Extremely				
All Likely						Likely				

e) What is the likelihood that, as John's acquaintance, you would feel comfortable reaching out to John in this situation?

0	1	2	3	4	5	6	7	8	9	10
Not at						Extremely				

All Likely

Likely

- f) What is the likelihood that you would perceive John as “weak” for feeling this way?

0 1 2 3 4 5 6 7 8 9 10

Not at

Extremely

All Likely

Likely

- g) What is the likelihood that you would seek help for yourself if you were in John’s position, and there were a 24-hour anonymous hotline available to you?

0 1 2 3 4 5 6 7 8 9 10

Not at

Extremely

All Likely

Likely

- h) What is the likelihood that you would seek help for yourself if you were in John’s position, and the 24-hour hotline were not anonymous?

0 1 2 3 4 5 6 7 8 9 10

Not at

Extremely

All Likely

Likely

3) Jenny, a 20-year-old female college student, has had a difficult time concentrating in classes, spends a lot of time by herself, is easily agitated, and has lost interest in activities that she used to find enjoyable. She has also had suicidal thoughts for a week now.

- a) What is the likelihood that Jenny will seek help from a 24-hour anonymous hotline?

0 1 2 3 4 5 6 7 8 9 10

Not at

Extremely

All Likely

Likely

- b) What is the likelihood that Jenny will seek help if there is a 24-hour hotline available, but she must report her current emotional state to her parents and school officials, upon calling?

0 1 2 3 4 5 6 7 8 9 10

Not at

Extremely

All Likely

Likely

c) What is the likelihood that Jenny will harm herself in the near future if she doesn't receive help?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

d) What is the likelihood that Jenny will harm others?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

e) What is the likelihood that, as Jenny's acquaintance, you would feel comfortable reaching out to her in this situation?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

f) What is the likelihood that you would perceive Jenny as "weak" for feeling this way?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

g) What is the likelihood that you would seek help for yourself if you were in Jenny's position, and there were a 24-hour anonymous hotline available to you?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

h) What is the likelihood that you would seek help for yourself if you were in Jenny's position and a 24-hour hotline were available, but you would have to report your current emotional state to your parents and school officials?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

4) John, a 20-year-old male college student, has had a difficult time concentrating in classes, spends a lot of time by himself, is easily agitated, and has lost interest in activities that he used to find enjoyable. He has had suicidal thoughts for a week now.

a) What is the likelihood that John will seek help from a 24-hour anonymous hotline?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

b) What is the likelihood that John will seek help if there is a 24-hour hotline available, but he must report his current emotional state to his parents and school officials, upon calling?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

c) What is the likelihood that John will harm himself in the near future if he doesn't receive help?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

d) What is the likelihood that John will harm others in the near future if he doesn't receive help?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

e) What is the likelihood that, as John's acquaintance, you would feel comfortable reaching out to John in this situation?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Likely Likely

f) What is the likelihood that you would perceive John as "weak" for feeling this way?

0 1 2 3 4 5 6 7 8 9 10
 Not at Extremely
 All Likely Likely

g) What is the likelihood that you would seek help for yourself if you were in John's position?

0 1 2 3 4 5 6 7 8 9 10
 Not at Extremely
 All Likely Likely

h) What is the likelihood that you would seek help for yourself if you were in John's position and a 24-hour hotline were available, but you would have to report your current emotional state to your parents and school officials?

0 1 2 3 4 5 6 7 8 9 10
 Not at Extremely
 All Likely Likely

Section II—Background and Demographics:

Instructions: Please answer the following questions by circling the answer or answers that apply to you, or by filling in your own response, where applicable. All responses will be anonymous.

1) How old are you? _____

2) What is your race? (Circle all that apply.)

- a) White
- b) Black
- c) American Indian or Native American
- d) Asian
- e) Native Hawaiian or other Pacific Islander
- f) Other (please specify): _____

3) What is your ethnicity?

- a) Hispanic origin
- b) Non-Hispanic
- c) Other (please specify): _____

4) What's your gender identity?

- a) Female
- b) Male
- c) Other (please specify): _____

5) Do you identify as LGBT?

- a) Yes
- b) No

6) What is your relationship status?

- a) Single
- b) In an open relationship
- c) In a monogamous relationship
- d) Other (please specify): _____

7) What is your student status?

- a) Full-time student
- b) Part-time student

8) What is your field of study? (Check all that apply)

- a) Humanities (English, language, history, philosophy, anthropology, etc.)
- b) Social science (Economics, psychology, sociology, political science, etc.)
- c) Natural science and mathematics (Math, biology, chemistry, physics, etc.)
- d) Art and Design
- e) Business
- f) Education
- g) Engineering
- h) Music
- i) Natural Resources and Environment
- j) Nursing
- k) Public Policy
- l) Undecided
- m) Other (please specify): _____

9) How religious would you say you are?

- a) Very religious
- b) Fairly religious
- c) Not very religious
- d) Not religious at all

10) How would you characterize your current financial situation?

- a) It's a financial struggle
 - b) It's tight but I'm doing fine
 - c) Finances aren't really a problem
- 11) Which of the following best describes your family's financial situation growing up?
- a) Very poor, not enough to get by
 - b) Had enough to get by but not many "extras"
 - c) Comfortable
 - d) Well to do
- 12) What is the highest level of education completed by your mother?
- a) Eighth grade or lower
 - b) Between 9th and 12th grade (but no high school degree)
 - c) High school degree
 - d) Some college (but no college degree)
 - e) Associate's degree
 - f) Bachelor's degree
 - g) Graduate degree
 - h) Don't know
- 13) What is the highest level of education completed by your father?
- a) Eighth grade or lower
 - b) Between 9th and 12th grade (but no high school degree)
 - c) High school degree
 - d) Some college (but no college degree)
 - e) Associate's degree
 - f) Bachelor's degree
 - g) Graduate degree
 - h) Don't know
- 14) Where do you live?
- a) Campus residence hall
 - b) Fraternity or sorority house
 - c) Other University housing
 - d) Off-campus, non-university housing
 - e) Parent or guardian's home
 - f) Other (please specify): _____
- 15) What year are you in your current degree program?
- a) 1
 - b) 2
 - c) 3

- d) 4
- e) 5
- f) 6
- g) 7+

16) I have heard about these services at UD. (Check all that apply.)

- Student Health Services
- Student Wellness and Health Promotion
- Office of Academic Enrichment
- Office of Equity and Inclusion
- Office for International Students and Scholars
- Office of Disabilities Support Services
- Center for Counseling and Student Development

17) I have used these services at UD. (Check all that apply.)

- Student Health Services
- Student Wellness and Health Promotion
- Office of Academic Enrichment
- Office of Equity and Inclusion
- Office for International Students and Scholars
- Office of Disabilities Support Services
- Center for Counseling and Student Development

18) Where do you live when school is in session?

- a) On campus
- b) Off campus
- c) Other (please specify): _____

19) How would you rate your knowledge of mental health services offered at the University of Delaware?

- | | | | | | | | | | | |
|-------------|---|---|---|---|-----------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at | | | | | Extremely | | | | | |
| All Helpful | | | | | Helpful | | | | | |

20) How would you rate your knowledge of mental illnesses?

- | | | | | | | | | | | |
|-------------------|---|---|---|---|---------------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at | | | | | Extremely | | | | | |
| All Knowledgeable | | | | | Knowledgeable | | | | | |

21) How would you rate your knowledge of treatments for mental illnesses?

- | | | | | | | | | | | |
|-------------------|---|---|---|---|---------------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at | | | | | Extremely | | | | | |
| All Knowledgeable | | | | | Knowledgeable | | | | | |

22) How would you rate the mental health services that are offered at the University of Delaware, in terms of their helpfulness to students in need?

0 1 2 3 4 5 6 7 8 9 10
Not at Extremely
All Helpful Helpful

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

0 1 2 3 4 5 6 7 8 9 10
Strongly Strongly
Disagree Agree

24) Most people feel that receiving mental health treatment is a sign of personal failure

0 1 2 3 4 5 6 7 8 9 10
Strongly Strongly
Disagree Agree

25) Most people think less of a person who has received mental health treatment

0 1 2 3 4 5 6 7 8 9 10
Strongly Strongly
Disagree Agree

26) I would willingly accept someone who has received mental health treatment as a close friend

0 1 2 3 4 5 6 7 8 9 10
Strongly Strongly
Disagree Agree

27) I would think less of a person who has received mental health treatment.

0 1 2 3 4 5 6 7 8 9 10
Strongly Strongly
Disagree Agree

28) I feel that receiving mental health treatment is a sign of personal failure.

0 1 2 3 4 5 6 7 8 9 10
Strongly Strongly
Disagree Agree

29) As far as you know, how many of your close friends or family have ever sought professional help for an emotional or mental health problem?

- a) None
- b) At least 1 or 2
- c) 3 or more
- d) Don't know

Thank you for participating!