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Mental Health Stigma and Help-Seeking in a College Sample: Barriers and

Potential Motivators for Action

An Honors Thesis submitted in partial fulfillment of the requirements for Honors

in the Department of Psychology

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Under the Direction of Jessica J. Brooks, Ph.D.

Abstract

Stigma surrounding mental health is one of many barriers impeding help-seeking behavior. This study had two aims: (1) to examine the relationships between mental wellbeing, internalized stigma, help-seeking attitudes, and demographic variables such as race, gender, socioeconomic status, and marital status, and (2) to explore what hinders students in the help-seeking process and determine what would make students more likely to seek psychological help if they perceive a need for it. It was hypothesized that the relationship between internalized stigma and help-seeking attitudes would be moderated by gender, and the relationship between mental wellbeing and help-seeking attitudes would be mediated by internalized stigma. Participants ($N = 242$) completed an online survey through Qualtrics, and data was analyzed using quantitative methods for Aim 1 and qualitative methods for Aim 2. Neither the moderation model nor mediation model was statistically significant; however, statistically significant relationships were found between demographics and mental wellbeing, internalized stigma, help-seeking attitudes, and openness towards various therapeutic interventions. In addition, trends regarding the second aim are reported.

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Mental Health Stigma and Help-Seeking in a College Sample: Barriers and Potential

Motivators for Action

Facets of help-seeking in the mental health domain are extensively studied, and

research consistently indicates help is not always sought when it is needed (Amarasuriya,

Jorm, & Reavley, 2018; Biddle, Donovan, & Sharp, 2007; Goodwin, Behan, Kelly,

McCarthy, & Horgan, 2016; Snell-Rood et al., 2017). Often times stigma is found to be a

primary barrier to help-seeking behavior (Amarasuriya et al., 2018; Biddle et al., 2007;

Rüsch et al., 2013; Snell-Rood et al., 2017). Two main views of mental health stigma

include: (1) one avoiding the stigma from others resulting from seeking help, receiving

counseling, and/or being prescribed medication, and (2) one may be avoiding help

because the individual has negative, stigmatized views of mental health and wants to

personally avoid associating with that "label." These viewpoints can essentially be boiled

down to interpersonal stigma and individual internalized stigma, respectively.

With regard to interpersonal stigma, people want to avoid looking "crazy,"

"weak," or "non-genuine" to others (Biddle et al., 2007; Snell-Rood et al., 2017).

Particularly in the United States, people living in the South report being raised to be

independent and to lean on religion for support; not doing so results in both self-judgment

and perceived judgment from others (Snell-Rood et al., 2017). On the other hand, many

choose to not seek help because they personally do not want to identify with the heavily

stigmatized portion of the population with mental health problems, and seeking help only

makes it "real" and "official" to them (Biddle et al., 2007). In this case, it is less about

what others think and more about internalized judgments, though the two facets may be

connected.

One additional facet to stigma, whether interpersonal or internalized, is coping resources to deal with stigma. Though one may face perceived judgment from others, they may also have resources to push through and seek help anyway. Rüsch et al. (2013) viewed "stigma stress" as the difference between the "appraisal of stigma as harmful" and the "appraisal of resources to cope with stigma" (p. 1314). When the difference is small, or when coping resources are almost equal to the amount of stigma, attitudes toward psychiatric medication and psychotherapy are predicted to be more positive. In contrast with previous findings, Rüsch et al. (2013) found no relationship between perceived stigma (i.e., interpersonal stigma) and help-seeking, and thus encouraged increasing resources to cope with stigma, which would decrease "stigma stress" and increase help-seeking behaviors.

In addition to stigma stress, other reasons for not seeking help include feeling like one does not need it (i.e., an illusion of normalcy), lack of resources, and lack of trust in professionals (Biddle et al., 2007; Snell-Rood et al., 2017). Biddle and colleagues (2007) introduced the *cycle of avoidance* to conceptualize barriers to seeking help; that is, individuals do not want to acknowledge their distress as "real" or "serious" and keep pushing the threshold for help-seeking farther and farther back until a crisis occurs. In some cases, that threshold may be pushed so far back individuals may struggle with initiating the help-seeking process. And often times, though participants in this study cited their experiences as "normal," the number and types of symptoms endorsed were at clinically significant levels. In other words, participants were normalizing their experiences, and thus rejecting the notion that there may be something "wrong" with them. However, some evidence suggests the opposite has been shown to hold true. For

example, Rüsch et al. (2013) found that when young people labeled themselves as "mentally ill" they had more positive attitudes toward treatment, specifically psychiatric medication and psychotherapy, though less so with the latter. That is, when individuals accepted having a mental illness, they were more likely to view treatment in a positive light as opposed to denying any sort of issue.

Research demonstrates willingness to seek help may not only be related to internalized stigma regarding mental health, but also other demographic characteristics. For example, internalized stigma regarding mental health issues is evidenced to affect men more than women. It is postulated that men may perceive asking for help or admitting a problem as threatening to their social role of masculinity, which stresses independence, strength, and emotional control, and thus men seek help less than women do (Addis & Mahalik, 2003; Erkan, Özbay, Cihangir-Çankaya, & Terzi, 2012). Boysen and Logan (2017) found traditionally and stereotypically "masculine" disorders, like alcoholism and antisocial personality disorder, are associated with higher stigma than stereotypically "feminine" disorders, such as bulimia nervosa and dependent personality disorder. Specifically, participants viewed "masculine" disorders as disingenuous and highly deviant character flaws within their control which tend to affect others, not just the individual who possesses the disorder. This is supported by Corrigan, Markowitz, Watson, Rowan, and Kubiak (2003) in that disorders viewed as under one's control are associated with higher stigma rates.

The college population seems to be at particular risk for mental health issues. Recent statistics estimate almost half have had a diagnosable psychiatric disorder in the last year, but less than 25% of these individuals sought treatment (Blanco et al., 2008);

however, what separates college students from their same-aged peers is mental health

care accessibility. While the average person cites accessibility, such as insurance,

transportation, or lack of nearby professionals, as a hurdle to receiving help (Snell-Rood

et al., 2017), college students often do not have those same hurdles. Many colleges have

counseling centers and psychology clinics on campus, making it accessible from a

logistical standpoint. Specific to Georgia Southern University, the counseling center is

within the main hub of campus and provides twelve free sessions to full-time students.

Students may make an appointment or may utilize the center's walk-in hours (Georgia

Southern University, n.d.a). Despite this increase in accessibility, college students

underutilize these services. For example, in one study of first year university students

(Goodwin et al., 2016), those with higher mental wellbeing were more likely to utilize

informal sources of help like family, friends, and relationship partners, but those with

lower levels of mental wellbeing were less likely to seek either informal or formal means

of help – even though 58.5% of a subsample said these sources would help if they sought

them.

The purpose of this present study is twofold: (1) To examine the extent to which

Georgia Southern University students experience mental health problems and attitudes

toward seeking help using quantitative methods, and (2) To explore reasons students are

not reaching out for help if they need it and determine likelihood of using services

available to them using qualitative methods. Specific to the first aim, it is hypothesized

the current findings will support previous research, specifically that a sizable percentage

of the sample will report not seeking mental health support when needed, specifically for

reasons of personal stigma against mental health, and that this relationship will be

moderated by gender (Blanco et al., 2008). Similarly, it is predicted the relationship between wellbeing and help-seeking attitudes will be mediated by internalized stigma. Due to the exploratory nature of the second aim, hypotheses will not be made regarding the outcomes.

Method

Participants

College students ($N = 242$) were recruited via SONA, an online database at Georgia Southern University. A variety of psychology classes require students to complete a research requirement as a portion of their grade, and others may offer participation as a means to receive extra credit in the course. Of note, those who do not wish to participate in research were offered alternative assignments as dictated by the instructor. In exchange for their participation, many students received class credit. Participants were required to be 18 years of age or older; no other exclusions applied.

Twenty-five participants did not answer the quality item questions correctly and were removed from final data analysis. Of the remaining 217 participants, 147 (67.74%) identified as female, 69 (31.8%) identified as male, and one (0.46%) identified as genderfluid. They ranged from 18 to 50 years old ($M = 19.81$). The majority were freshmen in college ($N = 102$; 47%), followed by 64 (29.49%) sophomores, 38 (17.51%) juniors, 11 (5.07%) seniors, one (0.46%) graduate student, and one participant who did not disclose their class standing. Regarding sexual orientation, 206 (94.93%) identified as heterosexual, five (2.3%) as bisexual, three (1.38%) as homosexual, one (0.46%) as pansexual, one (0.46%) as asexual, and one participant did not disclose. The majority of the sample identified as Caucasian ($N = 133$ participants; 61.29%), followed by

Black/African American (N =53; 24.42%), Hispanic/Latino (N = 8; 3.69%), Asian (N =

7; 3.23%), American Indian/Alaskan Native (N = 2; 0.92%), one (0.46%) was Native

Hawaiian or Pacific Islander, 10 (4.61%) were biracial or multiracial, and three

participants did not disclose their race.

      A majority of students (N = 175 participants; 80.64%) were raised in the

southeastern United States, 13 (5.99%) in the northeastern United States, five (2.3%) in

the southwestern United States, five (2.3%) in the midwestern United States, and three

(1.38%) in the northwestern United States. Ten participants (4.61%) were raised

internationally, five (2.3%) were raised in multiple geographical locations, and three did

not disclose this information. Most participants endorsed 'single' as their relationship

status (N = 171; 78.8%), followed by 41 (18.89%) as being in a serious relationship but

not married, four (1.84%) as married, and one who did not disclose their relationship

status. With regards to socioeconomic status, 24 participants (11.06%) identified as

working poor, 34 (15.67%) identified as working class, 51 (23.5%) identified as lower

middle class, 68 (31.34%) identified as upper middle class, five (2.3%) identified as

upper class, and 35 participants did not disclose their socioeconomic status. The majority

of the sample (N =170; 78.34%) identified as Christian, three (1.38%) as Jewish, two

(0.92%) as Catholic, two (0.92%) as Hindu, two (0.92%) as atheist, two (0.92%) as

spiritual, one (0.46%) as Buddhist, one (0.46`%) as Muslim, one (0.46%) as Jehovah

Witness, one (0.46%) as Wiccan, 21 (9.68%) as unaffiliated, and 11 participants did not

disclose their religious affiliation.

      In regard to mental health, 13 participants (5.99%) first formally learned about

mental health in elementary school, 63 (29.03%) in middle school, 79 (36.4%) in high

school, 36 (16.59%) in college, and 23 (10.6%) reported never formally learning about mental health in school; three participants did not disclose this information. 177 participants (81.57%) reported having never been diagnosed with a mental disorder, and 36 (16.59%) reported having been diagnosed with a mental disorder; four participants did not disclose this information. 19 participants reported being diagnosed with depression, 18 with anxiety or generalized anxiety disorder, 11 with ADHD, three with ADD, three with bipolar, three with OCD, two with PTSD, one with panic disorder, one with anorexia nervosa, one with borderline personality disorder, and one with oppositional defiant disorder. Some participants reported more than one diagnosis.

Procedure

Participants completed the survey through Qualtrics, an online data collection program, and the link to the specific survey was located on the SONA sign-up system webpage. The survey could be completed on any computer, anywhere, at any time during the duration of data collection. Participants first read the consent form, which broadly stated the study was about wellbeing and help-seeking. Once they agreed to complete the survey, participants were presented with three scales that measured mental wellbeing, help-seeking attitudes, and stigma towards mental health, all counterbalanced to reduce ordering effects. Then, participants were presented with seven interventions (animal-assisted therapy, music therapy, horticulture therapy, art therapy, psychodrama, self-help group, and outdoor recreation therapy), and asked to rate on a Likert-type scale how likely they were to seek help with a given approach. Similarly, open-ended questions assessed personal experiences regarding help seeking and opinions regarding specific interventions, such as: "What are your personal experiences with seeking help for

psychological problems?" or "What else would make you more likely to seek help?"

After the open-ended questions, participants entered their demographic information,

although no identifiers such as name or school ID number were taken; however,

participants emailed the researcher with identifiers to receive class credit, but these

emails were separate from their data. Lastly, information about where they could seek

help if they needed it was disseminated in the debriefing section.

Measures

All participants completed a demographic questionnaire, three preexisting

measures for stigma towards mental health, help-seeking attitudes, and mental well-

being, and one qualitative measure designed specifically for the purposes of this study.

The demographics questionnaire included gender, age, sexuality, race/ethnicity,

area where the participant grew up, marital status, individual or family financial standing,

religious affiliation, and year in college, as well as past mental health diagnoses and

knowledge of mental disorders.

The *Community Attitudes Toward the Mentally Ill* (CAMI; Taylor & Dear, 1981)

scale contains four subscales measuring stigma towards mental health: Authoritarianism,

Benevolence, Social Restrictiveness, and Community Mental Health Ideology. For the

purposes of this study, the community mental health ideology section was excluded, and

20 questions from the remaining three sections was used (Authoritarianism: 6;

Benevolence: 5; Social Restrictiveness: 9). This scale has been shown to have

satisfactory reliability and high external validity (Taylor & Dear, 1981). In the current

study, two of the three scales demonstrated adequate reliability: Authoritarianism, $\alpha =$

.64; Benevolence, α = .72; Social Restrictiveness, α = .80. Thus, results including the

authoritarianism subscale should be interpreted with caution.

To measure help-seeking attitudes, the *Attitudes Toward Seeking Professional*

Help (ATSPH; Fischer, 1995) scale was used. The demographic portion was excluded,

and the remaining ten questions asked participants to rate how much they agree with

statements about their attitudes and intentions to seek psychological help if they needed

it. This measure has demonstrated adequate internal consistency (α = .84), and high test-

rest reliability (α = .80; Fischer, 1995). In the current study, the scale did not

demonstrate adequate reliability (α = .65); thus, results including the Attitudes Toward

Seeking Professional Help Scale should be interpreted with caution.

The *Warwick-Edinburgh Mental Well-being Scale* (WEMWS; Tennant et al.,

2007) assessed participants' overall mental well-being. This scale asks questions about

mood, feelings, and energy levels over the last two weeks, and has shown adequate levels

of internal consistency (ranging from α of 0.89 to 0.91) and test-rest reliability (α = 0.83;

Tennant et al., 2007). In the current study, the scale continued to show adequate

reliability (α = 0.89).

To assess potential motivators of help-seeking behavior, a Likelihood to Seek

Help Scale, developed for the purposes of this study, presented participants with seven

questions assessing the likelihood of their seeking help depending on modifications to

conventional one-on-one therapy (i.e., "How likely would you be to seek help for

psychological problems if _____ was included in the treatment process?"). The

seven interventions included animal-assisted therapy, outdoor recreation therapy,

horticulture therapy, expressive therapies (art therapy, music therapy, and psychodrama),

and a self-help group. Participants rated these items on a Likert-type scale, ranging from 1 ("not at all likely to utilize this service") to 7 ("extremely likely to utilize this service"). The Likelihood to Seek Help Scale showed adequate reliability ($\alpha = 0.81$) in the current study.

Lastly, participants provided written responses to open-ended questions inquiring about their previous experiences with mental health help seeking, as well as about any interventions or modifications to treatment that would make them more likely to seek help.

Alternative Therapies

Animal-assisted therapy is a type of animal-assisted intervention. An animal-assisted intervention (AAI) utilizes a human-animal team in diverse settings, with various intended outcomes. Animal-assisted therapy (AAT) can be defined as "a goal oriented, planned and structured therapeutic intervention directed and/or delivered by health, education and human service professionals." It is "delivered and/or directed by a formally trained (with active licensure, degree or equivalent) professional with expertise within the scope of the professionals' practice" and "focuses on enhancing physical, cognitive, behavioral and/or socio-emotional functioning of the particular human client" (International Association of Human-Animal Interaction Organizations, 2014, p. 5).

Music therapy can be defined as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." It is intended to address emotional, physical, cognitive, and social needs, and also provides an

outlet for clients that find it difficult to express their thoughts in words (American Music Therapy Association, n.d., para. 1-2).

Horticulture therapy is defined by the American Horticultural Therapy Association (2017, p. 2) as "the participation in horticultural activities facilitated by a registered horticultural therapist to achieve specific goals within an established treatment, rehabilitation, or vocational plan." Therapeutic gardens are specifically designed to meet specific needs, whether they be physical, vocational, or emotional.

Art therapy can be defined as a therapeutic process that supports individuals and groups "through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" (American Art Therapy Association, 2017, para. 1). Art therapy aids in achieving treatment goals, which can be physical, cognitive, emotional, behavioral, or relational.

Psychodrama is defined by the American Society of Group Psychotherapy and Psychodrama (n.d., p. 1) as a therapeutic process that "employs dramatic action to examine problems and issues." After the problem is acted out, participants are encouraged to share their thoughts. Psychodrama aids in physical, emotional, mental, and behavioral growth.

Self-help groups can be defined as "informal groups of people who come together to address their common problems" (Khasnabis et al., 2010). Self-help groups are generally formed to address a specific issue, and thus members can relate to one another.

Outdoor recreation therapy, sometimes referred to as adventure therapy, is the use of outdoor physical activity and recreation to aid in psychosocial wellness. Benefits include increased social skills, self-confidence, empowerment, and family cohesion.

Outdoor recreation therapy makes an intentional effort to be inclusive for those with physical and mental disabilities, who especially benefit from physically active lifestyles (Dorsch, Andrew, Richards, Swain, & Maxey, 2016).

Statistical Plan

All quantitative data was analyzed using SPSS (v. 25). Initially, preliminary bivariate correlational analyses, t-tests, and ANOVAs tested relationships between demographic variables (e.g., gender, race), mental health, internalized stigma, help-seeking attitudes, and openness towards therapeutic interventions. Secondly, to test the first hypothesis of Aim 1, a moderation analysis via multiple regression determined the extent to which gender moderates the strength and direction of the relationship between individual internalized stigma and help-seeking attitudes. See Figure 1 for an illustration of the proposed moderation relationship. Thirdly, to test the second hypothesis of Aim 1, a mediating model using PROCESS assessed the relationship between mental wellbeing and help-seeking attitudes, with individual internalized stigma as the mediator. See Figure 2 for an illustration of the proposed mediation relationship. Lastly, to address Aim 2, an exploratory qualitative analysis analyzed themes from participants' narratives regarding experiences with help-seeking in the past, and identified methods of increasing college students' willingness to seek help in the future if needed.
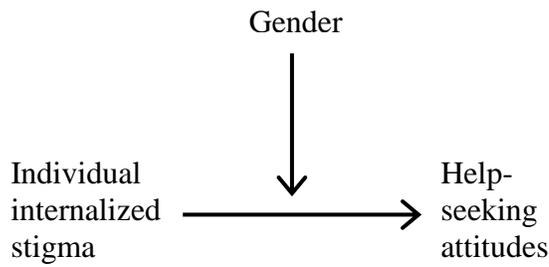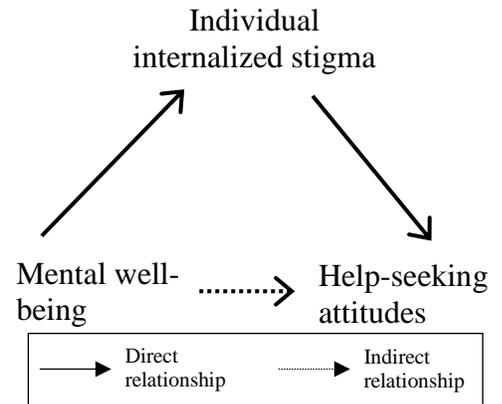
Figure 1. Proposed moderation relationship.

Figure 2. Proposed mediation relationship.

Results

Preliminary Analyses: Wellbeing, Help Seeking Attitudes, and Stigma

A MANOVA examined relationships between the independent variables of race (white vs. people of color) and gender (men vs. women) and dependent variables of mental wellbeing and attitudes towards seeking professional help. Since only one participant reported a gender different than male or female, that participant was not included in this particular analysis. Similarly, since a small percentage of the sample identified as non-white, participants who identified as a race other than white were collapsed into one group, labeled "people of color," for this analysis.

There was an overall statistically significant difference in mental well-being and attitudes towards seeking professional help based on gender, $F(2, 208) = 9.22$, $p < .001$, Wilk's $\Lambda = .92$, $\eta_p^2 = .08$. Specifically, gender had a significant effect on attitudes towards seeking professional help, $F(1, 209) = 4.18$, $p = .04$, $\eta_p^2 = .02$, with males reporting more negative attitudes towards seeking professional help ($M = 19.65$, $SEM = .64$) than females ($M = 21.22$, $SEM = .42$). There was also a significant effect of gender

on mental wellbeing, $F(1, 209) = 13.88$, $p < .001$, $\eta_p^2 = .06$, with males reporting higher

mental well-being ($M = 52.23$, $SEM = 1.04$) than females ($M = 47.59$, $SEM = .68$). Race

did not have a significant effect on mental wellbeing or attitudes towards seeking

professional help $F(2, 208) = 1.04$, $p = .36$, Wilk's $\Lambda = .99$, $\eta_p^2 = .01$.

A second MANOVA examined differences between race, gender, and the three

CAMI subscales (Authoritarianism, Benevolence, and Social Restrictiveness). Gender

had a significant effect on the CAMI subscales, $F(3, 207) = 6.78$, $p = .00$, Wilk's $\Lambda =$

0.91, $\eta_p^2 = .09$. Specifically, gender had a significant effect on benevolence ($F(1,209) =$

19.47, $p = .00$, $\eta_p^2 = .09$), with males having lower benevolence ($M = 19.54$, $SEM = .35$)

than females ($M = 21.40$, $SEM = .23$), and social restrictiveness, $F(1, 209) = 5.54$, $p =$

$.02$, $\eta_p^2 = .03$, with males having higher scores of social restrictiveness ($M = 19.15$, SEM

$= .56$) than females ($M = 17.56$, $SEM = .37$). Race also had a significant effect on the

CAMI subscales, $F(3, 207) = 5.00$, $p = .002$, Wilk's $\Lambda = 0.93$, $\eta_p^2 = .07$. Specifically, race

had a significant effect on benevolence, $F(1, 209) = 6.84$, $p = .01$, $\eta_p^2 = .032$, with

participants who identified as white having lower scores of benevolence ($M = 19.92$,

$SEM = .25$) than participants who identified as people of color ($M = 21.02$, $SEM = .34$),

and social restrictiveness, $F(1, 209) = 12.81$, $p < .001$, $\eta_p^2 = .06$, with participants who

identified as white having higher scores of social restrictiveness ($M = 19.56$, $SEM = .40$)

than participants who identified as people of color ($M = 17.16$, $SEM = .536$). There was

also a significant interaction between race and gender, $F(3, 207) = 3.08$, $p = .03$, Wilk's

$\Lambda = 0.96$, $\eta_p^2 = .04$, specifically within social restrictiveness, $F(1, 209) = 7.30$, $p = .01$,

$\eta_p^2 = .03$. See Figure 1.
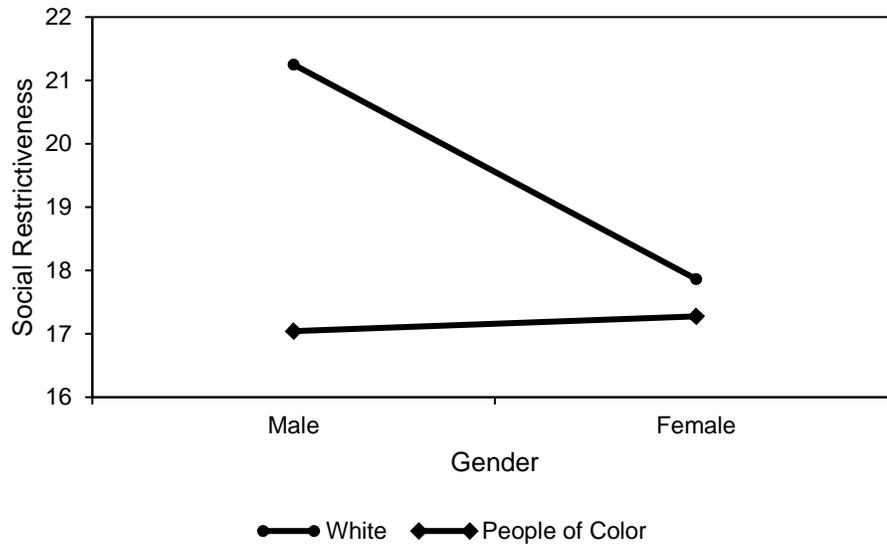
Figure 3. Interaction between gender and race within social restrictiveness.

A separate MANOVA examined differences between socioeconomic status and attitudes towards seeking professional help, attitudes towards the mentally ill, and mental well-being. For the purposes of this analysis, those who identified as working poor and working class were collapsed into a group labeled "lower socioeconomic status," and those who identified as lower middle class, upper middle class, and upper class were collapsed into a group labeled "middle-upper socioeconomic status." Socioeconomic status did not have a significant relationship with attitudes towards seeking professional help, attitudes towards the mentally ill, or mental well-being, $F(10, 358) = .36$, $p = .96$, Wilk's $\Lambda = 0.98$, $\eta_p^2 = .01$.

A separate MANOVA examined differences between relationship status and attitudes towards seeking professional help, attitudes towards the mentally ill, and mental well-being. Since only four participants reported being married, participants who reported being in serious relationships and participants who reported being married were collapsed

into one group (labeled "committed relationships") for this analysis. Relationship status did not have a significant effect on attitudes towards seeking professional help, attitudes towards the mentally ill, or mental wellbeing, $F(5, 210) = 2.16$, $p = .06$, Wilk's $\Lambda = 0.95$, $\eta_p^2 = .05$.

Openness Toward Alternative Therapeutic Interventions

Means and standard errors were calculated for the seven proposed therapeutic interventions (animal-assisted therapy, self-help group, outdoor recreation therapy, horticulture therapy, art therapy, music therapy, and psychodrama. Lower scores indicate more openness.

Participants reported being most open to animal-assisted therapy ($M = 2.6$, $SEM = .115$), followed closely by music therapy ($M = 2.86$, $SEM = .11$), then outdoor recreation therapy ($M = 3.1$, $SEM = .11$), art therapy ($M = 3.39$, $SEM = .13$), a self-help group ($M = 3.83$, $SEM = .12$), horticulture therapy ($M = 4.06$, $SEM = .11$), and finally psychodrama ($M = 4.51$, $SEM = .10$).

Intervention Preferences by Gender, Race, Relationship Status, and Socioeconomic Status

The first MANOVA examined potential differences and interaction effects between gender, race, and the seven proposed therapeutic interventions (animal-assisted therapy, self-help group, outdoor recreation therapy, horticulture therapy, art therapy, music therapy, and psychodrama). Main effects were found in both gender, $F(7, 197) = 8.01$, $p < .01$, Wilk's $\Lambda = 0.78$, $\eta_p^2 = .22$, and race, $F(7, 197) = 5.27$, $p = .00$, Wilk's $\Lambda = 0.84$, $\eta_p^2 = .16$.

Gender had a significant effect on animal-assisted therapy, $F(1, 203) = 6.21$, $p =$ .01, $\eta_p^2 = .03$, horticulture therapy, $F(1, 203) = 8.502$, $p = .004$, $\eta_p^2 = .04$, art therapy, $F(1, 203) = 46.272$, $p = .00$, $\eta_p^2 = .186$, music therapy, $F(1, 203) = 5.73$, $p = .02$, $\eta_p^2 = .03$, and psychodrama, $F(1, 203) = 5.04$, $p = .03$, $\eta_p^2 = .02$. Overall, women reported being more open to animal-assisted therapy, horticulture, art therapy, music therapy, and psychodrama than men. See Table 1.

Table 1

Gender and Therapeutic Interventions

Therapeutic Intervention	Female Mean	Standard Error	Male Mean	Standard Error
Animal-assisted therapy*	2.479	0.141	3.11	0.21
Self-help group	3.676	0.146	4.021	0.218
Outdoor recreation therapy	3.062	0.135	3.194	0.201
Horticulture therapy**	3.842	0.132	4.532	0.196
Art therapy**	2.768	0.145	4.541	0.216
Music therapy*	2.622	0.135	3.204	0.202
Psychodrama*	4.315	0.127	4.828	0.19
* $p < .05$. ** $p < .01$				

Race had a significant effect on animal-assisted therapy, $F(1, 209) = 10.75$, $p =$ .001, $\eta_p^2 = .05$, self-help group, $F(1, 209) = 7.57$, $p = .006$, $\eta_p^2 = .04$, art therapy, $F(1, 209) = 5.78$, $p = .017$, $\eta_p^2 = .03$, music therapy, $F(1, 209) = 5.807$, $p = .02$, $\eta_p^2 = .03$, and psychodrama, $F(1, 209) = 6.42$, $p = .01$, $\eta_p^2 = .03$. Overall, participants who identified as white reported being more open to animal-assisted therapy than people of color, and participants who identified as people of color reported being more open to a self-help group, art therapy, music therapy, and psychodrama. See table 2.

Table 2

Race and Therapeutic Interventions

Therapeutic Intervention	White		People of Color	
	Mean	Standard Error	Mean	Standard Error
Animal-assisted therapy**	2.379	0.152	3.21	0.203
Self-help group**	4.209	0.157	3.488	0.209
Outdoor recreation therapy	2.99	0.146	3.266	0.194
Horticulture therapy	4.15	0.142	4.224	0.189
Art therapy*	3.968	0.157	3.341	0.208
Music therapy*	3.206	0.146	2.62	0.194
Psychodrama*	4.861	0.137	4.283	0.182
* $p < .05.$ ** $p < .01$				

A second MANOVA was used to compute the relationship between relationship status (single vs. committed relationship) and openness to the seven therapeutic interventions. Relationship status did not have a significant effect on openness to any of the seven therapeutic interventions, $F(7, 202) = .95$, $p = .47$, Wilk's $\Lambda = 0.968$, $\eta_p^2 = .03$.

A third MANOVA was used to compute the relationship between socioeconomic status (lower SES vs. middle-upper SES) and openness to the seven therapeutic interventions. Socioeconomic status did not have a significant effect on openness to any of the seven therapeutic interventions ($F(14, 344) = 1.12$, $p = .339$, Wilk's $\Lambda = 0.915$, $\eta_p^2 = .044$).

Moderation Model: Stigma, Help-Seeking Behavior, and Gender

In order to examine whether gender moderates the relationship between stigma and help-seeking attitudes, a hierarchical multiple regression analysis was used. Stigma was measured by the Community Attitudes Towards the Mentally Ill scale (CAMI; Taylor & Dear, 1981), which was further divided into Authoritarianism, Social Restrictiveness, and Benevolence. For the purposes of this analysis, two separate tests

analyzed Social Restrictiveness and Benevolence. Authoritarianism was not included in this analysis due to the low reliability score in this sample.

The first regression analysis testing moderation assessed gender as a moderator in the relationship between social restrictiveness (stigma) and help seeking attitudes. Prior to analysis, an interaction term was created for social restrictiveness and gender. In the first step of the model, social restrictiveness and gender were entered separately and accounted for a significant amount of variance in help-seeking attitude, $R^2 = .038$, $F(2, 213) = 4.21$, $p = .02$; however, the interaction term of social restrictiveness and gender failed to account for significantly more variance taken together, $\Delta R^2 = .01$, $F(1, 212) = 3.695$, $p = .11$. Thus, gender was not found to have a moderating effect on social restrictiveness and help-seeking attitudes.

The second regression analysis testing moderation assessed gender as a moderator in the relationship between benevolence (stigma) and help seeking behavior. Prior to analysis, an interaction term was created for benevolence and gender. In the first step of the model, benevolence and gender did not independently account for a significant amount of variance in help-seeking behavior, $R^2 = .02$, $F(2, 213) = 2.31$, $p = .10$. Therefore, gender was not found to have a moderating effect on benevolence and help-seeking behaviors.

Mediation Model: Well-Being, Help Seeking Attitudes, and Stigma

To test the relationship between well-being and help-seeking attitudes, specifically with stigma as a mediator between well-being and help-seeking attitudes, a mediator analysis using PROCESS within SPSS was conducted. Well-being was not a significant predictor of help-seeking attitudes, $b = -.004$, $t(215) = -.09$, $p = .93$, or stigma,

$b = .05$, $t(215) = 1.23$, $p = .22$). Stigma was a significant predictor of help-seeking attitudes when controlling for well-being, $b = -.20$, $t(215) = -2.6738$, $p = .0081$. Well-being in the presence of the mediator, stigma, was not statistically significant, $b = .01$, $t(215) = .14$, $p = .89$. Overall, stigma as a mediator of well-being and help-seeking attitudes was not supported.

Experiences with Seeking Professional Help

Participant responses to the following question—What are your experiences with seeking formal help for psychological problems—were coded for common themes. Of the sample, 98 participants reported having never sought professional help for psychological problems while 83 participants reported seeking some sort of formal help in their lifetime. Of those receiving help, 70 reported attending traditional therapy, nine reported taking medication, two reported seeing a physician, one reported being involuntarily hospitalized, and two did not specify the type of assistance received.

Of the 70 participants receiving traditional therapy, 41 reported that therapy helped. Participants reported it helped to "talk it out" or have someone listen ($N = 12$), that the therapist was a positive presence ($N = 4$), that the therapist had helpful things to say ($N = 3$), and that the therapist aided in developing coping mechanisms ($N = 3$). Twenty participants reported therapy did not help for a variety of reasons, including: participants felt forced to attend ($N = 3$), participants were too reserved ($N = 2$), and the therapist had a negative presence ($N = 2$).

Of the nine participants who reported taking medicine for psychological problems, six reported that it helped. One participant reported they disliked the effects of the drug, one reported it "was not for them," and one reported that they did not like to

rely on medication. One participant did not specify whether the medication helped or did not help.

An exhaustive list of responses to this question can be found in Appendix A.

Reasons for Not Seeking Help

To assess barriers to help-seeking, participants' qualitative responses to the open-ended question: "If you perceived a need for help in the past, or if someone else suggested that you seek help, but you did not seek help, what reasons can you identify for that decision?" were analyzed and coded for common themes.

The most common response surrounded the desire to handle problems alone ($N = 22$). Other responses include: problem severity was not high enough to warrant professional help ($N = 14$), financial burdens ($N = 14$), finding other solutions that helped ($N = 9$), discomfort associated with discussing one's problems ($N = 8$), and the assumption that therapy would not help ($N = 7$).

An exhaustive list of reported reasons for not seeking professional help can be found in Appendix B.

Suggestions to Make Help-Seeking More Likely

In order to identify what would make participants feel more comfortable in the help-seeking process, the following open-ended question was presented: "What else would make you more likely to seek help if you needed it?" Responses were coded for common themes.

The two most common answers surrounded only seeking help if it were absolutely necessary ($N = 11$) and having loved ones involved in the therapeutic process ($N = 11$). Other common responses include: involving exercise or sports ($N = 10$), such as dance,

basketball, skateboarding, and surfing; utilizing group therapy to find others who relate to one's concerns ($N = 10$); food ($N = 9$); a welcoming, nonjudgmental, safe environment ($N = 9$), and animals ($N = 8$), specifically turtles, dogs, and horses.

An exhaustive list of suggestions can be found in Appendix C.

Discussion

This study aimed in part to examine the relationships between mental wellbeing, internalized stigma, and help-seeking attitudes. The purpose of this aim was to identify the role that internalized stigma plays in the help-seeking process in order to make help-seeking a realistic option for those who are hesitant or fearful. In order to assist with this goal, a second aim of this study was to explore participants' past experiences with help-seeking and identify their reasons for not seeking help and suggestions to make help-seeking more likely.

Wellbeing, Internalized Stigma, and Help-seeking Attitudes

Gender was expected to moderate the strength of relationship between internalized stigma and help-seeking. Our analysis did not support this specific hypothesis. It is possible that gender affects internalized stigma and help-seeking independently as suggested in previous research (Addis & Mahalik, 2003; Erkan et al., 2012), but that gender does not play a significant role in the interaction of stigma and help-seeking.

Internalized stigma was also predicted to mediate the relationship between mental wellbeing and help-seeking attitudes; in other words, that mental wellbeing has a direct relationship with internalized stigma, and internalized stigma has a direct relationship with help-seeking attitudes. Our analysis did not support this hypothesis.

Individual Differences in Wellbeing, Stigma, and Help-seeking Attitudes

Statistically significant relationships were found between demographics and mental wellbeing, internalized stigma, and help-seeking attitudes. Specifically, gender had a significant relationship with mental wellbeing, with women reporting lower levels of mental wellbeing than men, and help-seeking attitudes, with women reporting more positive attitudes towards help-seeking than men. Gender also had a significant effect on two measures of mental health stigma: benevolence, with women having higher levels of benevolence than men, and social restrictiveness, with men having higher levels of social restrictiveness than women. Previous research has suggested that a potential reason for these phenomena is the social pressure for men to hide their emotions and show traits of strength and resiliency (Addis & Mahalik, 2003).

Race had a significant relationship with benevolence and social restrictiveness, with participants who identified as white having lower scores of benevolence and higher scores of social restrictiveness than participants who identified as people of color. Gary (2005) suggests that minorities face "double stigma" – stigma associated with their group affiliation, and stigma associated with possible mental health related problems. This potential to be on the receiving end of stigma may increase awareness of the effects of stigma, and thus possibly lower the amount of stigma that minorities express towards mental health.

Based on the current findings, participants' willingness to consider therapeutic services increased with the addition of alternative methods, and gender and race seemed to differentially relate to an individuals' rating of willingness. Overall, participants reported being most open to animal-assisted therapy and music therapy, and moderately

open to outdoor recreation therapy and art therapy, with women being more open to the

various types of interventions than men. It is possible that these trends are due to women

being generally more open to help-seeking than men, regardless of age, nationality, race,

social background, presented problem, or type of intervention (Addis & Mahalik, 2003).

Participants of color were significantly more open to a self-help group, art therapy, music

therapy, and psychodrama, but less open to animal-assisted therapy than participants who

identified as white. Research has produced conflicting conclusions about the relationship

of race and help-seeking; some studies suggest that minorities are more open to seek help

(Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001; Shim, Compton, Rust,

Druss, & Kaslow, 2009), and other studies have found the opposite to hold true (Nadeem,

Lange, Fongwa, Belin, & Miranda, 2007). There are many potential facets that may be at

the root of these discrepancies, and this finding suggests that types of therapy can also

lead to differences between races.

Experiences of Treatment

Of the participants who reported seeking professional psychological help, the

majority reported having a positive experience. Of the participants who reported going to

traditional therapy, it was reported that it was helpful to talk and have the therapist listen,

and that the therapist had an overall positive presence. Similarly, it was reported that the

therapist had helpful suggestions and introduced the client to coping mechanisms. In

contrast, negative experiences were characterized by feeling coerced, guarded, and

negatively perceived by the therapist. It was also reported that therapy took too much

time, which has been shown to be a particular concern for college students (Eisenberg,

Golberstein, & Gollust, 2007).

Barriers to Seeking Treatment

Participants commonly endorsed not seeking professional psychological help due to a desire to handle their own problems—or a belief that they were capable of doing so independently—or their symptom severity did not warrant formal help. This finding supports previous research proposing that individuals continuously make the circumstances under which they would seek help more extreme, until they potentially could not seek help anymore (Biddle et al., 2007; Snell-Rood et al., 2017). This finding also supports the notion that the ability to recognize symptoms for what they are, potentially a diagnosable mental illness, is associated with a higher likelihood of being open to professional help (Amarasuriya et al., 2018).

It was also reported at a high frequency that participants did not seek help because of financial burdens or barriers. Though this is an unfortunate common theme in research surrounding barriers to mental healthcare (Snell-Rood et al., 2017), this is an especially concerning finding due to the nature of this sample. All participants were students at Georgia Southern University, a large public university in the southeastern United States that offers 12 free counseling sessions to students (Georgia Southern University, n.d.a). Additionally, if students use all 12 free sessions, or if the counseling center is booked during the time that an individual seeks help, the university offers low-cost counseling through the Psychology Clinic (Georgia Southern University, n.d.b). Though the report of financial burdens in a college sample with access to free or low-cost mental healthcare may be surprising, previous research has cited that students are often unaware of the resources available to them (Eisenberg et al., 2007).

Considerations for Increasing Help-seeking Behaviors

Contrary to expectations, the most popular response did not include suggestions, but rather the sentiment that seeking professional help was a last resort. This is consistent with previous research suggesting that some individuals delay help-seeking until there are "few other choices" (Snell-Rood et al., 2017). Among the suggestions to make help-seeking more likely, one of the most common responses surrounded having loved ones included in the therapeutic process. This finding is consistent with previous research that social support is a significant predictor of help-seeking attitudes (Erkan et al., 2012), Participants also reported at high rates that they would be more likely to attend therapy that includes exercise or sports. Physical activity is evidenced to have a positive relationship with emotional wellbeing (Galper, Trivedi, Barlow, Dunn, & Kampert, 2006), and it is possible that sports could facilitate social interaction and act as a primary step in creating trust between the client and clinician.

Participants reported that they would be more likely to seek help if they could participate in group therapy and meet people who have similar experiences. Of note, the university where this sample was drawn offers both group therapy, which requires a completed intake session prior to participation, and open workshops, which do not require an intake session prior to participation (Georgia Southern University, n.d.a). Similarly, participants reported that they would be more likely to seek therapy if music, bonding activities, animals, art, and yoga/meditation were included in the treatment process, and the university presently offers all of these services and adjuncts to traditional therapy (Georgia Southern University, n.d.a). This observation, along with participant reports that financial burdens are a barrier to help-seeking, suggests that there could be a

disconnect between the university and its students. It seems that at least some students are

unaware of the services offered to them, most of which are free.

Limitations

Some notable limitations of this study should be considered when interpreting

results. Primarily, all participants were Georgia Southern students enrolled in psychology

classes. It is likely that some, but not all, participants were psychology majors. Thus, it is

possible the sample is biased in that participants may have generally been: (1) more

knowledgeable about mental health than the average college student, and (2) less biased

towards those with mental disorders and those who seek psychological help. Moreover,

the sample was also comprised of primarily white, heterosexual, single, middle class,

Christian females who were raised in the southeastern United States. Some demographic

variables were collapsed to provide adequate power for statistical analysis, and some

demographic variables were so infrequent they could not be included in analysis (e.g.,

those identifying as gender and sexual minorities). In order for results to be generalizable,

a more representative sample is needed.

Regarding design considerations, this was a cross-sectional study relying on self-

report of participant experiences. Self-report measures are subject to desirability effects,

therefore participants may have altered their true answers in order to be perceived a

particular way. Furthermore, related to the Likelihood to Seek Help Scale, participants

were asked to rate on a Likert-type scale how likely they would be to seek help with

seven proposed therapeutic interventions in the absence of definitions of these

interventions. In hindsight, it is possible the differences in results may be at least be in

part due to differences in prior knowledge or interpretation.

Future Directions

Should this study be replicated, a more representative sample should be obtained. This would aid in the ability to analyze all demographic variables, including the variables that could not be analyzed in this study. Similarly, with a more representative sample, groups within specific demographic variables would not have to be collapsed. Likewise, the sample should include students from various majors and disciplines to avoid skewing toward a knowledge of psychological concepts.

This study addressed why students do not seek help if they perceived a need for it, and also what would make students more comfortable in the help-seeking process. Though these questions were addressed, a new problem was presented: a shortage of mental health resources. Participants reported that if they did utilize the counseling center on campus, that the counseling center was often booked and could not accept intakes immediately. It is suggested that future research evaluate potential solutions to this problem of accessibility.

Lastly, participant responses indicated that students seem unaware of the services that their university provides, and that this disconnect is serving as a barrier to help-seeking behavior. It is suggested that future research explore possible means to educate the student body about the resources available to them.

Conclusion

Though our initial hypotheses regarding (1) gender as a moderator of stigma and help-seeking and (2) stigma as a mediator of well-being and help-seeking were not confirmed, valuable relationships and trends regarding help-seeking in a college sample were reported. In order to have a more thorough understanding of the processes

underlying help-seeking, further research should investigate the ways that wellbeing,

stigma, help-seeking, and demographic variables such as gender and race relate. It is

similarly important to address the presented concerns, such as student unfamiliarity with

resources on campus, in order to make help-seeking a viable option to those who may be

in need.

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Appendix A

"What are your experiences with seeking formal help for psychological problems?

I.e. if you sought formal help, what kind of help was it, and what were your

experiences in the process?"

Participant has never sought professional psychological help	N = 98
Participant reported seeking help of an unspecified kind and did not specify whether the experience was positive or negative	N = 1
Participant reported seeking help of an unspecified kind and reported that the experience was positive	N = 1
Participant saw a physician and did not report whether the experience was positive or negative	N = 2
Participant has been involuntarily hospitalized; reported positive experience	N = 1
Participant saw a therapist; did not specify whether experience was positive or negative	N = 9
Participant saw a therapist; reported positive, helpful experience	N = 41
Helped to talk; therapist listened	N = 12
Therapist had a positive presence; therapist was comforting, welcoming, and kind	N = 4
Therapist had helpful things to say	N = 4
Therapist helped participant develop coping mechanisms	N = 3
Therapist saved the life of participant; therapy prevented suicide	N = 2
Therapist felt like a friend	N = 1
Participant felt more open and confident due to therapy	N = 1
Participant felt less alone due to therapy	N = 1
Participant no longer needed additional help over time	N = 1
Participant felt that suggestions from therapist were unbiased	N = 1

Therapist helped participant to understand more about him/herself	N = 1
Participant reported enjoying animal-assisted therapy	N = 1
Participant saw a therapist; reported negative, unhelpful experience	N = 20
Participant reported being forced to go by family	N = 3
Participant reported being too reserved	N = 2
Therapist had a negative presence; therapist was judgmental	N = 2
Therapy did not help the presented problem(s), but was not a negative experience	N = 2
The experience was overall negative and unenjoyable	N = 2
Participant reported being too independent	N = 2
Participant reported one isolated bad experience, but does not view therapy in a negative way	N = 2
Therapist did not address presented problem(s)	N = 1
Participant reported feeling uncomfortable during therapy	N = 1
Participant reported that it was a positive experience to talk in the short-term, but therapy did not help in the long-term	N = 1
Therapy took too much time	N = 1
Therapist disclosed private information to participant's family	N = 1
Participant could not connect to therapist	N = 1
Participant has taken medication for psychological problems	N = 9
Medication helped	N = 6
Participant did not like the way medication made him/her feel	N = 1
Participant reported that medication was "not for me"	N = 1
Participant did not like relying on medication	N = 1
Participant did not specify whether medication did or did not help the presented problem	N = 1

Appendix B

"If you perceived a need for help in the past, or if someone else suggested that you seek help, but you did not seek help, what reasons can you identify for that decision?"

Participant reported a desire to or belief that they could handle the presented problem(s) on their own	N = 22
Participant did not think their problem(s) was severe enough; participant did not think they needed professional help; participant was in "denial"	N = 14
Financial burdens or barriers	N = 14
Participant found other solution(s) that helped	N = 9
Discomfort or fear surrounding talking about one's problems	N = 8
Belief that therapy will not help	N = 7
Participant reported that no one suggested therapy to them	N = 7
Desire to be "normal," participant did not want anything to be "wrong" with them	N = 6
Embarrassment	N = 6
Lack of or not enough time	N = 6
Afraid of being judged	N = 4
Scared to seek help	N = 4
Did not want to be perceived as overdramatic	N = 2
Would feel "stupid" in therapy	N = 2
Did not want to be a "burden"	N = 2
Fear of being prescribed medication	N = 1
Fear of involuntary hospitalization	N = 1
Participant reported being "too stubborn"	N = 1

Did not know how to ask for help	N = 1
Feelings of shame	N = 1
Desire to not be "overdramatic"	N = 1
Would feel like an "outsider"	N = 1
Participant did not feel that they deserved help	N = 1
Participant perceived a loved one's suggestion to seek help as a joke	N = 1
Does not want attention	N = 1
Worry that they will not be believed	N = 1
Does not want to be reminded of presented problem(s)	N = 1
Too upset to talk to someone	N = 1
Lack of motivation	N =1
Unsure where to go	N = 1
Apathy	N = 1
Fear that counseling records will be used against them	N = 1
Participant reported that they cannot help others if they cannot help oneself	N = 1
Previous negative experience(s) in therapy	N = 1
Participant reports looking "weak" by seeking professional psychological help	N = 1
Fear of being looked at differently by loved ones	N = 1
Feeling alone in process of seeking professional psychological help	N = 1

Appendix C

"What else would make you more likely to seek help if you needed it?"

Participant would only seek professional psychological help as a last resort	N = 11
Having loved ones involved in the process	N = 11
Therapy involving exercise or sports	N = 11
Dance	N = 3
Basketball	N = 1
Skateboarding	N = 1
Surfing	N = 1
Group therapy; finding someone who relates	N = 10
Food	N = 9
Welcoming, nonjudgmental, safe environment	N = 9
Animals	N = 8
Turtles	N = 1
Dogs	N = 3
Horses	N = 1
Enjoyable activities/hobbies, unspecified	N = 6
One-on-one interactions	N = 5
Privacy, confidentiality	N = 5
Proof of the efficacy of therapy	N = 5
Incentives, unspecified	N = 5
Participant would seek help if a loved one suggested it	N = 4
Free therapy	N = 4
Inclusion of religion/faith in therapeutic process	N = 4
Art therapy	N = 2

Trust in the clinician	N = 2
If mental illness and help-seeking were not stigmatized	N = 2
A "less serious" environment	N = 2
Movies	N = 2
Writing, poetry	N = 2
Music	N = 2
Meditation, yoga	N = 2
Cooking, baking	N = 2
Bonding activities	N = 1
Therapy that is not face-to-face	N = 1
Feeling "normal" in the process	N = 1
A structured plan	N = 1
Fishing, going to a lake	N = 1
Shopping	N = 1
Openness/education about hospitalization	N = 1
Knowing what to expect	N = 1
Knowing that they would not be a burden	N = 1
Horticulture	N = 1
Empathy from people in general	N = 1
Seeing people who look like them	N = 1
An experienced clinician	N = 1
If help could come to them (i.e. to their home)	N = 1
Co-ed and gender-specific group therapy	N = 1
Understanding and education surrounding mental illness	N = 1
Counseling resort	N = 1

If participant had help in reaching out for professional help   N = 1

Natropathic medicine and techniques   N = 1

Games (i.e. board games)   N = 1

More free time   N = 1

Gun therapy   N = 1