DISSERTATION

COMMUNITY COLLEGE STUDENTS' EXPERIENCES OF MENTAL-HEALTH STIGMA:

A PHENOMENOLOGICAL STUDY

Submitted by

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ABSTRACT

COMMUNITY COLLEGE STUDENTS' EXPERIENCES OF MENTAL-HEALTH STIGMA:

A PHENOMENOLOGICAL STUDY

Campus acts of violence, student suicide, and the relative increase in mental-health incidents among college students are several reasons that mental health is a pressing issue for higher education. Unfortunately, negative stigma surrounding mental-health issues impacts college students and their choices about seeking help. The purpose of this study was to explore the lived experiences of stigma for college students enrolled at a medium-sized public community college who self-identified with a mental-health issue.

Research questions included the following:

- How do students who self-identify with some mental-health issue experience stigma?

- What kind of influence does stigma have on these students' willingness to seek help?

- How do these students view others who a have mental-health problem in relation to stigma?

- How do these students view themselves in relation to stigma?

Results from two interviews with and responses to online prompts of six students indicated that they experienced social distance through being seen as outside of the social norm, hearing negative talk about mental health, being treated as fragile, and experiencing frequent bullying in high school. For these students, making the decision to seek help entailed navigating external pressure and internal denial. Students found support through connecting with others with mental-health struggles. Despite being seen as dangerous and facing stereotypes based on

gender and diagnosis, all students in the study held a positive view of themselves and expressed compassion for others with mental-health problems. Results from the study confirm previous research and reveal emergent findings related to students' changes in beliefs in self-stigma and a hierarchy of stigma based on diagnosis. The study concludes with a discussion of implications for practice and future research.

Keywords: college students, mental health, stigma, help-seeking behavior

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CHAPTER 1: BACKGROUND

Student mental health is an increasingly important issue in higher education as college students present on campuses with more serious issues and needs for services (Gallagher, 2012; Hunt & Eisenberg, 2010). In addition, campus tragedies such as that at Virginia Tech in 2007 and media coverage of the topic raise legitimate questions about how the mental-health needs of students are being met and point out the tragic consequences unmet needs can have on a campus communities (Benton & Benton, 2006).

Over the past five to ten years, many college campuses have focused attention on mental health, building an understanding of the increasing needs of students (Benton & Benton, 2006). Institutions of higher education have worked to incorporate this new realm of student mental health into their existing campus structures and cultures, often while dealing with budget reductions and unclear guidelines of liability and responsibility for student safety (Dickerson, in Benton & Benton, 2006). Advice for administrators now addresses an array of campus improvements that relate to mental health, including but not limited to peer-led education programs, targeted ratios of psychologists to students, and the emergence of threat-management and behavior-intervention teams (IACS, 2010; Jed Foundation, 2015; Sokolow & Hughes, 2008). Benton and Benton state,

> The Center for Disease Control and Prevention defines an epidemic as "the occurrence of cases of an illness in a community or region which is in excess of the number of cases normally expected for that disease in that area at that time. If depression, anxiety, and suicidal ideation were infectious diseases, they would easily be considered epidemics on today's college and university campuses. (p. 233)

In short, mental health has become a central issue for campuses to consider and ultimately address.

Problem Statement

We can understand the extent of the increasing mental-health needs of students by looking at several key indicators. Students are presenting to college counseling centers with more severe mental-health issues (Benton, 2006; Gallagher, 2012). An annual survey of college counseling-centers conducted by Gallagher (2012) provides detail into recent trends. Gallagher found that 92% of directors reported their centers are seeing more students with severe psychological problems, a trend that began approximately ten to fifteen years ago. Over the past 6 years, a majority of centers have experienced an increase in students in crisis who required immediate response (73%) and students with psychiatric medication issues (67%). Counseling-center directors report that more than one-third (39%) of the centers' clients have severe psychological problems. Finally, counseling centers report that student hospitalizations, as well as the numbers of clients taking a psychotropic medication, have increased threefold since 1994.

The 2013 National College Health Assessment, with more than 123,000 college student respondents, found that in the previous 12 months 31% of college students felt so depressed they found it difficult to function, 7.4% had seriously considered suicide, and 1.5 % had attempted suicide (ACHA, 2013). In addition, Benton findings indicate that 15.5% of female students and 7.8% of male students noted they had been treated for or diagnosed with anxiety in the past year. Further, 12.8% of female students reported treatment for or diagnosis of depression, compared to 7.3% of males. Finally, 9.1% of females and 4.6% of males reported both depression and anxiety.

The increase in the serious mental-health needs of college students points out the importance of academic institutions providing for and connecting students to appropriate professionals for support and treatment. Help seeking for college students is additionally critical

because it can be a matter of life and death. Of the 69 completed student suicides on 203 college campuses in 2012, 80% of the deceased students had never received treatment at the campus counseling center (Gallagher, 2013). Although the need for services is obvious, college students with mental-health issues, even those at risk for suicide, are often not connected to psychological resources on campuses (Downs & Eisenberg, 2012; Monk, 2004; Quinn, Wilson, MacIntyre, & Tinklin, 2009). Unfortunately, students frequently indicate a fear of being labeled or stigmatized as a reason for not seeking psychological help or counseling, even though they know they can benefit from it (Drum, Brownson, Denmark, & Smith, 2009; Martin, 2010; Quinn et al., 2009). Students' fear of being seen in a negative light because of a mental-health struggle is not unfounded. In fact, many individuals hold negative attitudes about others with mental-health issues or problems (Arrgarwal, 2012; Chung, Chen, & Liu, 2001; Eisenberg, Downs, & Golberstein, 2012; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Pinfold et al., 2003). Thus, students with mental-health issues on college campuses seem to be facing a difficult dilemma. If they seek the help they need, they may be stigmatized; but if they don't seek help, they are likely to continue to struggle.

Several studies have focused on identifying the reasons students give for not seeking professional support. Findings indicate that skepticism about treatment, or not thinking it is needed, and the preference to deal with problems on their own are some of the most common reasons students provide, even those at risk or those who are experiencing suicidal thoughts (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013; Downs, & Eisenberg, 2012; Eisenberg et al., 2011).

Studies have examined the role of stigma in influencing help-seeking behavior. Findings indicate that students fear being stigmatized (Drum et al., 2009; Quinn et al., 2009). Findings,

including those from a meta-analysis of 19 studies, indicate that higher rates of stigma seem to be associated with lower rates of help-seeking and, in turn, that lower levels of stigma are associated with positive attitudes toward help-seeking (Downs & Eisenberg, 2012; Nam et al., 2013). Two qualitative studies have explored the ways in which students with mental-health disorders recognize and think about stigma; these studies found that students are aware that they may be viewed in a negative light if others know about their mental-health difficulties, and further, that they express a desire to be considered individuals rather than "disorders" (Aggarwal, 2012; Martin, 2010). In spite of recent important findings, the relationship between stigma and help-seeking as it relates to specific student experiences is unclear.

Previous studies have not examined the lived experience of stigma or explored the kinds of interactions students are having in which they feel stigmatized. To fill this gap and to build on recent studies of help-seeking and stigma, the current study sought to provide a basis for understanding college students' experiences of stigma. My specific focus was on those students who identified with a mental-health issue, to gain an understanding of their experience of stigma and how those experiences influenced the students' attitudes about seeking help.

Purpose Statement

The purpose of this phenomenological study was to explore the lived experiences of stigma for college students enrolled at a medium-sized public community college who self-identified with a mental-health issue. To explore student experiences of stigma, I began with a constructivist paradigm and utilized a qualitative, interpretative, phenomenological approach and analysis. It has been my hope that this study would provide rich descriptions of the lived experiences of stigma, which will in turn lead to a better understanding by professionals of the impact stigma has on today's college students.

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Research Questions

The overarching research question was "What are the lived experiences regarding stigma of community-college students who self-identify with a mental-health issue?" To support the overarching question, I also pursued the following questions:

- Question 1: How do students who self-identify with some mental-health issue experience stigma?

- Question 2: What kind of influence does stigma have on these students' willingness to seek help?

- Question 3: How do these students view others who a have mental-health problem in relation to stigma?

- Question 4: How do these students view themselves in relation to stigma?

Definition of Terms

The purpose of this section is to identify specific terms I have used throughout this study.

- *Mental health:* A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2001).

- *Mental illness:* "…collectively all diagnosable mental disorders" or "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." For the current study, mental-health struggles and challenges were used synonymously with mental illness (U.S. Department of Health and Human Services, 1999).

- *Stigma:* A belief that certain individuals possess some attribute or characteristic that conveys social identity; is contrary to a social norm, and that is devalued in social

context. Stigma also involves an attribute, mark, or signal that leads to a stereotype, which in turns leads to discrimination. (Crocker, Major, & Steele, 1998; Link & Phelan, 1999; Stafford & Scott, 1986).

Significance of the Study

College-student mental health is a critical issue for higher education and has even been described as an epidemic (Benton & Benton, 2006). Nearly one third of students have indicated they felt so depressed sometime in the previous year that it was difficult for them to function (ACHA, 2013). In addition, 80% of students who completed suicides in 2012 were not current or former clients of campus counseling centers (Gallagher, 2012). Unfortunately, many students who need professional help have not sought it out (Czyz et al., 2013; Downs & Eisenberg, 2012; Eisenberg et al., 2011). Finally, students frequently mention stigma as a reason for not seeking out professional help (Drum et al., 2009; Martin, 2010; Quinn et al., 2009).

The current study is intended to provide the basis for a more informative understanding of the phenomenon of stigma for community-college students. The aim of the study has been to provide rich descriptions and a thorough analysis of the phenomenon of stigma as experienced by community-college students with mental-health issues. In addition, the study has sought to provide a basis for understanding the specific ways stigma may have impacted these students' help-seeking behavior. I anticipated that the findings would offer insight into how to reduce stigma in the college-student population. That is, my hope is that college professionals will be able to utilize the study results to guide and enhance peer efforts to teach students to act in ways that do not contribute to stigma, and to optimize supportive and helpful responses to peers in need. Another goal of the current study is to provide an improved foundation for professionals to understand the phenomena of stigma. Professionals working in higher education may find the

study helpful in their efforts to make better decisions about programs and strategies to encourage students to seek counseling and other mental-health support.

Delimitations

The scope of the current study included the examination of the lived experience of stigma among community-college students who self-identified as having some level of mental-health struggle at a medium-sized public college in the western region of the United States. Students in the study self-identified as having some degree of mental struggle by having sought counseling at the campus counseling center. In addition, the students participated because they believed they had had experience with stigma. Participants in the study represent a convenience sample of community-college students from only one college in the local area of the researcher.

Assumptions and Limitations

The study sample was limited by which students chose to be interviewed. The study may also be limited by the lack of participation from students who were not comfortable with the topic of stigma, the interview process, or talking about their experiences related to mental health.

Researcher's Perspective

As a researcher and individual, I have been drawn to this topic of study for distinct reasons. For the past 17 years, either as a disability specialist or in the role of coordinating resources for students in mental-health crisis, I have been working with students with mental-health issues. Over these years, I have worked with a few thousand students and have come to feel as though I know some of their stories. I am passionate about and desire to work to reduce negative stigma attached to mental-health issues. My experience with the topic of stigma and hearing students' stories is what drew me to this research. At the same time, my previous experience was perhaps the biggest challenge to me in relation to this study. The goal of this

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study has been to hear the voices of these particular individuals. My hope was that my experience working with students with mental-health issues would enhance my ability to see through their eyes and hear what their voices were saying, and that this experience wouldn't influence me to unconsciously attempt to predict their stories.

Conclusion

The mental health of college students has become a critical and somewhat complicated issue in higher education. While discussions continue about how best to address the increasingly serious mental-health needs of students, my hope has been that turning the focus to the experiences of those students might provide direct insight into barriers that may interfere with their seeking treatment. Stigma and fear of being seen in a negative light by peers can be a potent reason for students to avoid treatment and instead try to handle problems alone. Tragically, the absence of treatment is associated with the vast majority of college-student deaths by suicide each year in the United States (Gallagher, 2012). Understanding how students experience stigma and the impact that stigma can have on their willingness to seek help may assist institutions of higher education in enhancing their efforts to reduce such stigma and improve campus options to connect those students to the appropriate mental-health resources.

CHAPTER 2: LITERATURE REVIEW OF COLLEGE-STUDENT MENTAL HEALTH

Mental-health issues are a growing concern on college campuses. The rise in concern is likely the result of recent national tragedies and the increase in numbers of students with serious mental-health issues on campuses (Benton & Benton, 2006; Gallagher, 2012). The purpose of this chapter is to create a deeper understanding of issues relating to college-student mental health through a review of current literature. This review covers three main areas associated with college-student mental health. In the first section, I address the current state of mental-health issues in the college population. This discussion consists of a brief review of key points to illustrate the magnitude of the problem, prevalence rates for depression and anxiety; the incidence of college-student suicide, and the overall impact mental-health disorders can have on college students' experience. I examine trends over the past twenty to thirty years to ultimately suggest what has changed, including a discussion of whether there has been a legitimate change over time and whether this change is unique to college students. In the second section of the chapter, I provide an overview of literature on help-seeking behavior of college students. This section addresses help-seeking attitudes of both students in treatment and students not receiving treatment. In addition, I explore informal help seeking and student demographics related to help seeking. Finally, I outline a model for understanding help-seeking decisions. In the third section, I present literature on the topic of stigma by first exploring negative stigma and the impact stigma has on students with mental-health struggles. Next, I discuss perceived stigma and self-stigma. Finally, I examine strategies for decreasing stigma.

College-Student Mental Health

Anxiety and depression are the two most common mental-health disorders in the United States according the Centers for Disease Control (CDC) (2013). Worldwide, unipolar depression is the third most burdensome disease, and the first in most middle- and high-income counties (CDC, 2013). Lifetime prevalence rates for depression are higher for women (11.7%) than for men (5.6%), and slightly lower among Blacks (4.57%) and Hispanics (5.17%) (CDC, 2013). Approximately one fifth of adults in the United States have experienced a major depressive episode in the past year. Further, according to 2013 CDC data, the lifetime prevalence rate for anxiety disorders, including panic disorder, generalized anxiety, post-traumatic stress, phobias, and separation anxiety, is 15% and 10% for women and men, respectively. Anxiety disorders are more prevalent in developed than in developing countries. Similarly, anxiety is more common among women than men in both the college population and the general population (CDC, 2013). Finally, bipolar disorder is prevalent in 4% of the US population, but more common in women than men, with men having an earlier age of onset when compared to women (CDC, 2013). The lifetime hospitalization rate for all individuals diagnosed with bipolar disorder is nearly 40%, and the diagnosis is the most costly of all behavioral-health disorders, including costs to the individual with the diagnosis (CDC, 2013).

Over the past two decades, college students have come forward to seek help for mental-health issues in greater numbers and with more severe issues than ever before (Gallagher, 2013). A recent survey of counseling-center directors found that 95% of staff in centers are seeing more students with severe psychological problems, a trend that began approximately ten to fifteen years ago (Gallagher, 2013). In addition, a majority of center directors reported an increase in students in crisis who required immediate response (73%) and students with psychiatric

medication issues (66%) (Gallagher, 2012). Counseling-center directors indicated that more than one third (44%) of the center's clients have severe psychological problems (Gallagher, 2013).

Prevalence of Mental-Health Issues

Results from research conducted over the past 20 years regarding prevalence rates of depression in the college population have varied significantly (Ibranim, Kelly, Adams, & Glazebrook, 2012). In a comparison of 24 studies involving 48,650 college students, rates of depression ranged from 10% to 85%, with a mean weighted prevalence of 30% (Ibranim et al., 2012). Studies that utilized a random sampling resulted in a higher weighted mean of 35% of students having some level of depression. In addition, poor response rates were associated in several studies with higher rates of depression, which suggests possible underreporting. A majority of studies (n = 16) found higher rates of depression among female college students when compared with male college students, with weighted means of 29.6% and 24.9%, respectively. With regard to student age and depression rates, there was no clear consensus, with some findings to support that younger students experience higher rates and other studies to support the same conclusion for older students. Higher socioeconomic background was generally found to be associated with lower levels of depression; however, two studies noted higher rates of depression among students whose parents had higher education levels (Ibranim et al., 2012).

Anxiety prevalence rates among female college students have been found to be more than twice that of males, at 14% and 6%, respectively (ACHA, 2013 Eisenberg, Gollust, Golberstein, & Hefner, 2007). Monk (2004) found a significant relationship between higher levels of anxiety and being female but did not find a relationship between anxiety and age. A Web-based survey

of 2,843 randomly selected graduate and undergraduate students found that 15% of undergraduates and 13% of graduates screened positive for depression or anxiety, and the results offered additional insights into the co-occurrence of the two conditions (Eisenberg, Gollust, et al., 2007). In the Web-based study, results from the use of the Patient Health Questionnaire (PHQ) in general and PHQ-9 depression scale in particular, a validated screening tool based on DSM IV criteria, found that half of students who indicated symptoms of depression also noted symptoms of anxiety, while 30% of students with anxiety also screened positive for depression. For students who reported suicidal thoughts, 15% screened positive for anxiety, 20% for depression, and 20% for panic disorder (Eisenberg, Gollust, et al., 2007).

Eisenberg, Hunt, and Speer (2013) administered online surveys in 2007 and 2009 at 26 campuses to 14,175 students. Their findings indicate prevalence of positive screens for depression, 17%; panic disorder, 4%; generalized anxiety, 7%; suicidal ideation, 6%; and nonsuicidal self-injury, 15%. In addition, the results indicate that mental-health problems were significantly associated with sex, race/ethnicity, religiosity, relationship status, campus residency, and financial situation. Women had higher rates of depression, panic, and generalized anxiety than men. Overall, 35% of women had mental-health concerns, compared to 30% of men. When compared to White students, Asian students were higher in depression but lower in anxiety. Black students were high in depression but low in nonsuicidal self-injury. Hispanic students were high in depression. Multiracial/multiethnic students were high in depression, and students of each ethnic minority except Black were more likely to report that finances negatively impacted their mental health. Religious students, married students, or those in a relationship were less likely to report a mental-health difficulty; and students who were bisexual or gay had a substantially elevated risk for mental-health problems.

In addition to depression and anxiety, suicide is also a critical issue for college students. The spring results from the National College Health Assessment (ACHA) indicate that suicidal thoughts and attempts continue to be a concern for from 10% to 20% of college students. Of the 123,078 students from 153 postsecondary institutions who responded to the survey, 7.4% revealed they had seriously considered suicide in the past 12 months. An additional 13% of students had seriously considered suicide, but not in the previous year. Thus, approximately 20% of students had seriously considered suicide at some point. Compared to males, females were slightly more likely to have experienced serious thoughts of suicide. The survey also asked about suicide attempts, with 1.5% of students responding that they had attempted suicide in the past year. Males were slightly more likely to have made an attempt, and 7.4% of students had attempted suicide but not in the past 12 months. Thus, about one tenth of students indicated they had attempted suicide at some point.

Gallagher (2013) conducted the National Survey of College Counseling, gathering data from 203 campuses in the United States. Of the 69 students who completed suicides in the previous year, the majority were male (71%), Caucasian (77%), and undergraduate (76%). Of individuals who completed suicide, 11% were of Latino decent. Of the students who completed suicide, 20% were current or former clients of centers. Gallagher reports that 48% of students were depressed, and of the 14 students who were center clients, only 2 indicated suicidal intent and 5 were considered at risk for suicide.

Drum et al. (2009) examined the nature of college-student suicide in a study involving 26,000 students from 70 colleges and universities. Students responded to statements regarding suicide in the previous 12 months and responded affirmatively at the following percentages: "I have thought, 'I wish this would all just end,'" 37% of undergraduates, 30% of graduates; "I

have thought, 'I wish I was dead,'" 11% of undergraduates, 8% of graduates; "I have seriously

considered suicide," 6% of undergraduates, 4% of graduates; and "I have attempted suicide,"

0.85% of undergraduates, 0.30 % of graduates (p. 216). Of students seriously considering

suicide, 14% of undergraduates and 8% of graduates had made an attempt in the previous 12

months. One alarming finding was that of the students who had attempted suicide in the

previous 12 months, 23% of undergraduates and 27% of graduates reported they were currently

considering making another attempt. Additionally, 69% of undergraduates and 63% of graduates

who had experienced suicidal thoughts in the previous 12 months reported suicidal thoughts as

recurrent during that time and experienced more than one period in the previous 12 months in

which they considered suicide. Students also reported that their periods of serious suicidal

ideation often lasted for 1 day or less, as reported by 56% of undergraduates and 58% of

graduates. Finally, half (50%) of undergraduates and 45% of graduates said their thoughts of

attempting suicide were strong or very strong.

Last, students have reported that mental-health struggles negatively impact their ability to

complete academic coursework (Drum et al., 2009; Eisenberg, Golberstein, et al., 2007; Monk,

2004). Students in the Drum et al. (2009) study found that, of students who had seriously

considered suicide in the previous year, 43% of undergraduates and 45% of graduates rated

academic struggles or school problems as having a large effect on their suicidal thoughts.

Likewise, 45% of undergraduates and 39% of graduate students who had seriously considered

suicide in the preceding year indicated that their thoughts had greatly interfered with their

academic performance. Another study of nearly three thousand college students found that, for

students who had considered suicide in the last month, 18% of undergraduates and 14% of

graduates had missed academic obligations (Eisenberg, Golberstein, et al., 2007). Perhaps even

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more significant, Eisenberg, Golberstein, et al. found that 44% of undergraduates and 41% of graduates reported that a mental or emotional difficulty had affected their academic performance in the preceding 4 weeks.

Unmet Mental-Health Needs of Students

The unmet mental-health needs of college students represent a significant issue in higher education. While annual surveys of counseling-center directors (Gallagher, 2013) demonstrate increases in both the numbers of students seeking counseling services and the severity of issues students bring forth, many students who screen positive for depression, anxiety, or suicidal thoughts are not receiving appropriate psychological support even when it is available on their campuses. (Drum et al., 2009; Eisenberg, Speer & Hunt, 2012; Hunt & Eisenberg, 2010; Monk, 2004; Zivin, Eisenberg, Gollust, Golberstein, & Hefner, 2007). In the Healthy Minds Study with approximately eight thousand student responses from 15 colleges, less than half of students who screened positive for major depression or anxiety disorders had received any treatment in the past year (Hunt & Eisenberg, 2010). Other studies have shown similar findings, to indicate that approximately half of students who needed professional help, including those seriously considering suicide, indicated they had not received help (Downs & Eisenberg, 2012; Drum et al., 2009; Eisenberg, Hunt, & Speer, 2012; Monk, 2004). Further, findings using a Web-based tool at a single university with an initial study and a follow-up 2 years later revealed that mental-health problems for students are persistent and often do not go away on their own, with 60% of students in the sample who had a mental-health problem at baseline still having the problem 2 years later (Zivin et al., 2009). In the Zivin et al. study, students indicated their own perceived need of assistance at baseline, in 2005, and again in the follow-up in 2007. Analysis of students' perceived need of assistance found that perceived need in 2005 was a strong predictor of need at

follow-up in 2007, even after controlling for severity of mental-health issues at baseline. This finding seems to indicate that students may have a keen perception of their own need.

The increase in the severity of issues and numbers of students presenting at counseling centers has been established (Gallagher, 2013); but further evidence to demonstrates an actual increase in students with mental- health disorders is now considered. According to the U.S. Department of Labor, in 2012, 71.3% of female and 61.3% of male high-school graduates ages 16 to 24 were enrolled in college (U.S. Department of Labor, 2013). In addition, college enrollment figures based on ethnic background were 82% of Asians, 66% of Whites, 58% of Blacks, and 70% of Hispanics (U.S. Department of Labor, 2013). Hunt and Eisenberg (2010) discussed and contextualized the state of college-student mental health by noting epidemiological findings that indicate increases in help-seeking in the general population over time, from 19% of respondents having received treatment in 1985 to 25% in 1992, and finally to 41% in 2002. Thus, Hunt and Eisenberg confirm increases in help seeking in the general population over the past several decades.

The National Comorbidity Study conducted in 1992 and again in 2002 investigated the prevalence of mental-health disorders of individuals ages 15 to 24 in the general population and did not find significant changes in the prevalence rates of mental illness (Kessler et al., 2005). Other studies have noted modest increases in the prevalence of depression in young adults, with increases from 6% in 1991 to 10% in 2001 (Conway, Compton, Stinson, & Grant, 2006). Thus, rates of depression for college students ranging from 30% to 35% in a recent review of 24 studies (Ibranim et al., 2012) seems to illustrate greater increases in rates of depression in the college student population relative to the general population. Additionally, given a three-fold increase among both young people and college students over the past 15 years in the use of

psychotropic medications, some authors hypothesize that medications may have helped students

manage symptoms that otherwise could have impeded their ability to attend college (Gallagher,

2013; Olfson, Marcus, Weissman, & Jensen, 2002). Hunt and Eisenberg (2010) explain,

> One potential factor is that youth are accessing effective treatments during adolescence, which may help them to function at a level that allows college attendance. …it seems plausible that increased treatment of these illnesses has led to larger numbers of youth with mental disorders attending college. (p. 6)

In summary, the current state of college-student mental health is marked by a rise in the

numbers of students who have sought counseling and the severity of the issues they are

presenting (Gallagher, 2013). Without appropriate treatment, mental-health problems

experienced by a majority of students are expected to persist and not improve on their own

(Gallagher, 2013; Zivin et al., 2009). Symptoms of depression or anxiety are likely to be

experienced by nearly 15% of students, with a possible high of 30% represented in a meta

analysis of studies that examine only depression (Eisenberg et al., 2007; Ibrahim, Kelly, Adams,

& Glazebrook, 2012). Many students who are in need of treatment are not receiving it, an issue I

will expand upon in the section of this review focused on help-seeking. Finally, of great interest

to those working in higher education is the reminder that mental-health issues often have a

negative impact on students' academic performance and their ability to complete coursework and

pursue their academic goals (Drum et al., 2009; Eisenberg et al., 2007; Monk, 2004).

Help-Seeking Behavior

To provide a better understanding of college-student behavior to seek out assistance for

mental-health concerns, this section highlights literature on college-student help seeking. I first

examine student attitudes about seeking professional help for mental-health concerns, including

reasons students give and the barriers they report regarding not seeking help. Additionally, I

discuss findings relating both to students who have not sought treatment and to those students

engaged in treatment. I also discuss help seeking related to informal or nonprofessional support.

Last, I examine specific findings that outline factors associated with greater help seeking or more

positive attitudes toward seeking help, including consideration of the theory of planned behavior.

A number of studies in the past few years have focused on the reasons students give for not

seeking help. I will discuss fear of being stigmatized in the next section; first, I focus on other

barriers and attitudes students report when asked about their help-seeking behavior or decisions

about whether or not to seek help.

Help-Seeking Attitudes of Students Not in Treatment

Several studies have examined the reasons students report for not seeking professional

help for mental-health struggles. Eisenberg, Golberstein, and Gollust (2007) found in a random

sampling of students at one college who screened positive for depression that their reasons for

not receiving help were lack of perceived need, being unaware of services or insurance, and

skepticism about treatment effectiveness. Czyz et al. (2013) utilized open-ended questions in a

Web-based survey to gather information about students' self-reported barriers to treatment. In

the study, of the 165 students who were not in treatment but were at risk for suicide, 66%

indicated that treatment was not needed, 26% said they lacked the time, 18% preferred to

manage problems on their own, and 12% mentioned stigma as a reason for not seeking care.

Eisenberg, Speer, et al. (2012) conducted a retrospective analysis of the Healthy Minds Study

data, including 13,105 participants at 26 campuses. Participants had responded to a Web-based

survey in 2007 and 2009 that examined attitudes about treatment among students with untreated

depression, anxiety, or suicidal ideation. Somewhat in contrast to previous findings, the results

indicated that a majority of untreated students (65%) reported low stigma and positive beliefs

about effectiveness of treatment, including 42% who perceived a need for help and 23% who did

not. Although many students in the studies with untreated depression, anxiety, or suicidal ideation reported positive attitudes about treatments, students also questioned the seriousness of their issues, preferred to handle the issues themselves, believed that their distress was a normal part of the college experience, or reported not having time for mental-health services. In addition, the researchers state, "Although few students endorse stigmatizing attitudes, a greater number of students may implicitly agree with these attitudes" (Eisenberg, Hunt, et al., 2012, p. 226).

Help-Seeking Attitudes of Students in Treatment

Attitudes among students already in treatment also have been examined to help us understand the correlates to help seeking. Downs and Eisenberg (2012) conducted a random sampling of 543 students at 15 US colleges who reported serious thoughts of suicide in the previous year. Their findings indicated that treatment use correlated with perceived need, belief that treatment is effective, contact with service users, lower personal stigma, and higher perceived stigma. Personal stigma was defined as "one's own stigmatizing attitudes," and perceived stigma as "perceptions of others' attitudes" (p. 105). In a different study and using the Attitude Toward Seeking Professional Psychological Help Scale and other variables, Nam et al. (2013) conducted a meta analysis of 19 studies with 7,397 students. Included in the meta analysis were nine variables: anticipated benefit, anticipated risks, depression, distress, self-concealment, self-disclosure, social support, public stigma, and self-stigma. Variables with the largest effect size on help-seeking attitudes were self-stigma, anticipated benefits, and self-disclosure. Self-stigma negatively correlated with help-seeking attitudes and had the largest effect size of all the variables considered. Drum et al. (2009) found that, of students who had seriously considered suicide in the previous year and who sought professional help, 53% of

undergraduates and 60% of graduates rated the counselor as helpful or very helpful in preventing suicide. For students who sought out psychiatry, 39% of undergraduates and 44% of graduates rated that support as helpful or very helpful.

Informal Help Seeking

As one might expect, college students also seek help and support to a significant degree from nonprofessional resources. In the Healthy Minds Study involving more than 13,000 students from 26 campuses, 78% of student respondents with mental-health problems indicated they received support or counseling from a nonprofessional, 67% from a friend, and 52% from family members (Eisenberg et al., 2013). Drum et al. (2009) examined data from 26,000 students at 70 colleges and universities and found that, for students who seriously considered suicide in the preceding 12 months, 52% of students who confided in other people about their suicidal thoughts reported that telling that first person was helpful or very helpful. Of those who shared their thoughts, 58% of undergraduates and 50% of graduates were advised to seek professional help by the first person they told. Two thirds of students who shared their thoughts told a peer, romantic partner, or roommate. Interestingly, with 39% of undergraduates and 32% of graduates citing finishing school as a reason for not attempting suicide, this study found that, although school was important to students, almost no undergraduates and not a single graduate student reported telling a professor about their suicidal thoughts. In the same study, 46% of undergraduates and 47% of graduate students chose not to tell anyone about their thoughts. Reasons students gave for not telling others about their suicidal thoughts included fear of being stigmatized or judged, not wanting to burden others, knowledge that the problem was transitory, not having anyone to tell, and fear of consequences such as expulsion from school.

In addition to outside help, today's college students also seek support on social media. Moreno et al. (2011) examined informal help seeking on social media, specifically Facebook. In the study, 200 profiles were evaluated covering a 1-year period. Facebook profile owners were 43.5% female, with a mean age of 20 years. Overall, 25% of the profiles displayed depressive symptoms and 2.5% met criteria for major depressive disorder. Profile owners were more likely to reference depression if they averaged at least one online response from their friends to a status update that disclosed depressive symptoms, or if they used Facebook more frequently.

In a study that examined student experience of support, suicidality, and help seeking (Curtis, 2010), 1,896 students were mailed a survey comprising 22 questions regarding (a) support service awareness and attitudes, (b) personal experiences of service and suicidality, and (c) mental-health-promotion awareness. Findings included that students were more likely to seek help (by talking with a staff member, etc.) for another student than for themselves. More than half were concerned about suicide and emotional-health problems in general. Twenty-two percent had experienced suicidal thoughts or engaged in suicidal attempts, and around one fifth were aware of a fellow student who completed a suicide. Thirty percent of students in the Curtis study (2010) were aware of another individual's thoughts of suicide, with 18% of students stating they had supported someone who was struggling with suicide. Interestingly, only 15% of respondents had referred someone to professional help. Students with personal experience of others' emotional health were more likely to believe they could identify warning signs, would seek help, and felt that staff had a duty to care. Younger students had more confidence that they could identify someone at risk. However, the same students were not likely to seek help for themselves. Older students and those who had been at the university longer were more likely to say they would seek help for themselves. Negative stigma and being "tough" were reasons

students felt they could not seek help. Finally, students with personal experience with suicidal thoughts were less likely to believe that suicide can be prevented.

Help-Seeking Differences: Student Demographics

Eisenberg et al. (2007) conducted a random sampling of students at one college to examine help-seeking behavior. The findings indicate that, overall, mental-health-service use was much higher for students who screened positive for depression or anxiety; but still only 36% of those students had received medication or therapy in the past year despite nearly all of respondents having health insurance. Student demographic factors associated with perceived need for services (and ultimate use of services) included being female, being 31 years of age or older, being bisexual or gay/lesbian, or having "tight" financial situations. Students who reported growing up poor were less likely to use services than those who were well off while growing up. With regard to ethnicity, students of Asian Pacific Islander descent were less likely than White students to perceive a need for and report use of services. Similarly, international students were less likely to perceive a need for and use services than domestic students. Students in a relationship were also less likely to perceive a need for and use services compared to single students. For students who did perceive a need for services, those who screened positive for panic disorder or generalized anxiety were more likely to have used mental-health services than those with no positive screen for depression or anxiety. Students with probable depression were less likely to use services than students with no positive screen.

Downs and Eisenberg (2012) conducted a random sampling at 15 US colleges of 543 students who reported serious thoughts of suicide in the preceding year. Findings indicate that treatment use correlated with having fewer positive relationships, being in a sexual minority, and having a Caucasian ethnic identity. Czyz et al. (2013) found that, among suicidal or high-risk

nontreatment users, 33% of females compared to 13.7% of males reported lack of time to be a barrier to seeking help. In the study, 53% of students identifying as multiracial, Black, or "other" mentioned lack of time as a barrier, compared to 21% of Caucasians and 20% of Asian students. Also, heavier alcohol use was associated with students saying they didn't need mental-health services due to problems being minor or transient. Students with less-severe depression also were likely to say problems were transient or minor.

Models for Help-Seeking Behavior

Professionals in the field have used several models to understand help-seeking behavior. Eisenberg, Hunt, et al. (2012) provide an overview of help-seeking models, including the health-belief model initiated by Rosenstock in 1966, which takes an individual approach to explain perceived need and help-seeking behavior. The model asserts a direct relationship between knowledge and use of services. In 1995, Anderson developed the behavioral model to focus on the individual but also to highlight social and structural factors. Finally, the network-episode model, developed by *Pescosolido* in the early 1990s, sought to account for informal sources of help from nonprofessionals. Although none of these models completely addresses help seeking, each has incorporated a new aspect to be included in further inquiries and research in this area (Eisenberg, Hunt, et al., 2012).

In their discussion, Eisenberg, Hunt, et al. (2012) mention consideration of whether the treatment will pay off in a nonmonetary sense as an important factor in our understanding of help-seeking decisions: "Therefore, help-seeking decisions may rest on whether the net non-monetary benefits and costs of treatment are positive—that is, whether the expected improvement in health is viewed as more valuable than the non-monetary costs (e.g., time,

embarrassment, and shame)…." In addition, the authors state, "Many people may not realize that the standard treatments for depression and anxiety disorders are highly cost-effective" (p. 223).

Hess and Tracey (2013) utilized the theory of planned behavior, a model based on the theory of planned action, to seek to understand the help-seeking intention of students. Specifically, their study examined help-seeking decisions for three different concerns: depression/anxiety, career choice, and alcohol/drug use. One focus of the study was to investigate whether students made decisions about help seeking differently depending on the type of concern. The study also broke down decision making and focused on the following factors: attitude, subjective norms, perceived behavioral control, perceived behavioral control—self, and intention. In their model, the outcome Hess and Tracey sought to measure was intention to seek help. In the model, they defined factors in the following manner: (a) attitude: the individual's thoughts about the value, enjoyability/pleasantness, and decisions about seeking help on a good/bad scale; (b) subjective norms: "what others would think of me if I sought help"; (c) perceived behavioral control: whether the individual believes he can access or seek help; (d) perceived behavioral control—self: "How much do I think I can solve my problems on my own?"; and (e) intention: the decision to seek care. Study participants were 889 students from the Education and Psychology departments at a single university. Results did not indicate a difference in the function of factors across types of problems. That is, student decision making to seek help did not differ significantly depending on the type of concern, depression/anxiety, career choice, or drug or alcohol use. Rather, results suggest that attitudes about seeking help might be generalized and that individuals seem to carry over their attitudes across different types of issues. Attitude had a moderate and positive correlation with intention to seek help. Also, subjective norm was a significant negative antecedent to intention to seek help. Perceived

behavioral control to decide to seek care was not significant, suggesting that access was not a central issue in the study. Similar to attitude, perceived behavioral control—self had a moderate and negative correlation with intention, with stronger beliefs in solving problems on one's own correlating with lower intentions to seek help. "Individuals who have a belief that they can address their concerns on their own seem not as likely to intend to seek help from mental health professionals" (p. 328). The subjective norm, which the authors assert related to stigma, was the strongest predictor of a student's intention to seek help.

Stigma

In this section, I examine the role of negative stigma in the lives of college students. First, I discuss general attitudes about individuals with mental-health issues. Next, I examine the impact stigma has on individuals with mental-health issues. Finally, I consider perceived stigma and personal stigma.

Negative Stigma Related to Mental Health: Attitudes and Impact on Students With Mental-Health Struggles

It is well established that both the general public and college students hold some negative attitudes about individuals with mental-health challenges (Chung et al., 2001; Link et al., 1999; Pinfold et al., 2003). Although previous contact with an individual with mental illness tends to decrease one's negative attitudes, people with mental illness are often viewed as being potentially violent, and individuals tend to desire greater social distance from them (Chung et al., 2001; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Link et al., 1999). Specifically, Corrigan et al. (2001) found that community-college students in the study who were familiar with mental illness were less likely to believe individuals with psychiatric disabilities are dangerous. In their study, weaker perceptions of dangerousness were associated with less fear, which was in turn

associated with less desired social distance. Chung et al. (2001) measured university students'

attitudes toward individuals with recent mental-health hospitalizations by randomly assigning

undergraduates at the University of Hong Kong to read descriptions of a person with mental

illness and then measure their willingness to interact with them. Nearly half of the 308

participants were medical students, with the remainder in the science and social-sciences fields.

Findings indicated that students desired greater social distance from individuals if they had no

previous contact with mentally ill individuals, were in a nonmedical field of study, and were

female. Overall, students were more willing to interact when they had pervious contact with

individuals with mental illness. An interesting finding was that, for students in the medical and

dental fields, previous contact positively influenced their attitudes toward individuals with

mental illness, but the same was not true for students in the science and social-sciences fields.

Aggarwal (2012) utilized a mixed-methods approach to investigate student beliefs and

attitudes toward people with health disorders, the impact these beliefs have on students who have

mental-health disorders, and what teachers and organizations can do to better support students

with mental-health disorders. Seventy-six students in the health sciences completed surveys, and

five students with different mental-health disorders were interviewed. On survey responses,

students with mental-health disorders tend to be viewed by their peers in a generally negative

light and described as somewhat "weak, dependent, incompetent, unreliable, and strange" (p.

39). In interviews of students in the health sciences, three of five individuals expressed concern

about disclosing information to others for fear that they would be treated differently,

discriminated against, or socially excluded. In addition, one student with obsessive compulsive

disorder (OCD) pointed out that OCD is often ridiculed, when in reality it is a "really distressing

illness" (p. 40). In contrast, another student indicated he is open about his diagnosis of

schizophrenia once he feels comfortable with individuals, and he believes it is helpful to him to

explain his condition and "clear up any misconceptions," which allows people to understand him

better and what he might need from them (p. 40). Another student expressed frustration with

her peers, stating that

> …the other day, in one of the groups, someone said: [*sic*] people with mental disorders
> shouldn't work with other people with mental disorders, but it's so individual… and I
> think it's not always true. You can have a mental ill health problem but be stable. We
> have more empathy with people with mental disorders—we don't just get things out of
> text books! We know what it's really like. (p. 40)

Another student expressed her concerns about negative responses from others:

> There is just so much ignorance around here in the college and outside … it's not the
> same as having a physical illness. People hear the words mental health disorder and they
> want to run. They make the link between mental ill health and axe murders. It's so
> frustrating. (p. 40)

In the context of greater numbers of college students experiencing mental-health

challenges, we need to understand the impact stigma is having on them. Students with mental-

health challenges frequently indicate both an awareness of stigma and a desire to be treated as

persons instead of disorders (Aggarwal, 2012; Martin, 2010). Between 66% and 82% of these

students are aware that they need support or professional help (Drum et al., 2009; Monk, 2004).

Further, a majority of the students are likely to experience significant help from professional

campus resources (Martin, 2010).

Martin (2010) conducted a study at an Australian university with a focus on the

experiences of students who self-disclosed that they experienced mental-health difficulties that

impacted their studies. Fifty-four student participants responded to anonymous online questions

regarding disclosure, impact on studies, and support. Study findings indicated that a majority of

students rated the resources at the university as the most helpful to them, exactly twice as many

as rated family and friends as the most helpful. In contrast, students indicated strong reluctance

to be open about mental-health issues because of negative stigma. Nearly two thirds of students noted they had not disclosed to staff about their mental-health condition or the impact it was having on their studies in spite of their experiencing significant difficulties. About one third of students who did not disclose were concerned they would be seen as "telling lies or wanting privileges" (p. 265). Students also said they were fearful of being judged or stigmatized if they disclosed. Finally, just more than one third of students stated there was no need to disclose, even though all but one student also noted their mental-health condition was negatively impacting their studies.

Martin's findings (2010) seem to suggest that students may minimize their need for services as a way of avoiding stigma. Or, in other words, when asked whether there's an impact or they are struggling, students may answer honestly and admit they are struggling; but when asked whether they need help, they may hesitate in their responses, whether the hesitation is related to their sense of stigma around mental health or the stigma of admitting they need help. Finally, of students who did disclose to a staff member, three quarters indicated such disclosure was helpful. Thus, students with mental-health issues on college campuses seem to be facing a difficult dilemma: If they seek the help they need, they may be stigmatized; but if they don't seek help, they are likely to continue to struggle.

Quinn et al. (2009) conducted a mixed-methods study to better understand factors that influence students' disclosure of mental-health difficulties and ability to seek help, to determine student experiences of support within the university, and to identify implications for improving services to students who are experiencing mental-health problems. The study comprised 12 student interviews and a focus group with six students pursuing a Master's in Social Work. In addition, 48 students were invited to participate in an interactive Web space. Researchers sent an

email to students already utilizing counseling services, and more students responded than could

be interviewed within the scope of the project. Several themes emerged in the study. First,

students were generally reluctant to disclose on their university application that they had a

mental-health problem, and they indicated that fear of stigma was a main reason for not

disclosing. Some students noted that if they could apply again they would disclose and be

clearer about their needs to increase their connection to appropriate support. At the same time,

some students who did disclose were disappointed that the university did not contact them to

provide support or resources. A second theme in the Quinn et al. findings was that often students

expressed a reluctance to seek help for their problems, saying it was hard to admit to themselves

and others that they needed help, and that they didn't want to bother other people with their

problems. Students specifically mentioned stigma as a major reason for not seeking help.

Although students were hesitant to ask for academic support, they reported that it was very

helpful to them especially that of tutors and academic accommodations such as notes for lectures

through the campus disability office. Finally, study results stressed that students desire a culture

in which they can be more open in talking about their mental-health problems without feeling

stigmatized. Students also suggested more programs to raise awareness among the student body

about mental-health issues.

Perceived Stigma and Self-Stigma

To facilitate a more complex analysis, some professionals have described stigma in terms

of personal or self-stigma and perceived public stigma (Eisenberg, Downs, Golberstein, & Zivin,

2009; Golberstein, Eisenberg, & Gollust, 2008; Nam et al., 2013). Eisenberg et al. (2009)

defined perceived public stigma as "negative stereotypes and prejudices about mental illness held

collectively by people in a community" and personal stigma as when "an individual identifies

himself with a stigmatized group and applies corresponding stereotypes and prejudices to the self" (p. 523). Nam et al. (2013) conducted a meta analysis of 19 studies that included 7,397 participants and explored findings that compared personal stigma, perceived stigma, and willingness to seek psychological help. The overall findings indicated that perceived public stigma was significantly higher than perceived personal stigma. Of the nine factors in the study, personal stigma was the most strongly correlated with negative attitudes about help seeking. That is, in the meta analysis, negative beliefs about one's self based on mental health was associated with negative attitudes about seeking help. Perceived stigma was not significantly associated with help-seeking attitudes. Finally, findings in the Nam et al. study and others indicated that students who were male and of Asian, Pacific Islander, or Hispanic decent were a particular concern because they tended to report higher rates of both self-stigma and perceived public stigma (Eisenberg et al., 2009; Golberstein et al., 2008; Nam et al., 2013).

Understanding the relationship between perceived stigma, personal stigma, and willingness to seek psychological help appears to be an important next step in the field of stigma research. Some findings support a model in which perceived stigma seems to be driving personal stigma (Eisenberg et al., 2009). Specifically, Eisenberg et al. (2009) conducted a random sampling of 5,555 students from 13 universities regarding stigma. The study results contribute to data that might lead to a better understanding of the possible relationship between personal and perceived stigma. Findings that measure both types of stigma indicate that participants generally reported substantially higher rates of perceived stigma than of personal stigma. Additionally, a scatter-plot analysis of responses revealed that many students in the study reported high rates of perceived stigma and low rates of self-stigma, but nearly no students reported high levels of personal or self-stigma and low levels of perceived stigma. When they

directly compared affirmative statements that related to perceived stigma and personal stigma, the majority of students agreed with the perceived-stigma version, "Most people would think less of a person who has received mental-health treatment"; they disagreed with the personal-stigma statement, "I would think less of someone who has received mental-health treatment" (pp. 531–532). Levels of personal-stigma responses varied more than those of perceived-stigma responses. Finally, in this study, personal stigma was associated with a lower likelihood of each measure of help seeking, while higher levels of perceived stigma were associated with a higher likelihood of a perceived need for help, although not with actual use of help.

One explanation for the differences in student responses regarding perceived stigma versus personal stigma is that perceived stigma may be driving personal stigma. That is, students may be aware of the negative attitudes about mental health and without much thought adopt those values as their own. In contrast, some students may be very aware of perceived stigma but think critically about it; they also may have a greater understanding of mental-health issues and self-acceptance in that regard, which results in lower rates of personal stigma. I located no studies that examined either the interaction between personal stigma and perceived stigma or the reasons behind high levels of perceived stigma and low levels of self-stigma in college students.

Strategies for Decreasing Stigma

In the area of stigma-reduction strategies, there is reason for professionals to consider augmenting the traditional approach, which focuses solely on education through the presentation of facts about mental illness (Corrigan et al., 2001). Corrigan et al. compared college-student responses to several awareness approaches, which included education alone and personal contact with individuals with mental-health diagnoses; they found that personal contact had the greatest positive impact on student attitudes. In addition, studies have found that previous contact with

individuals with mental-health struggles is associated with fewer negative attitudes about those with mental-health issues.

Pinfold et al. (2003) examined the attitude of high-school students in the United Kingdom, before and after an educational workshop, toward individuals with mental-health problems. The workshop focused on developing in participants an understanding of mental health and mental illnesses, promoting positive well-being and challenging stereotypical labels, and finally the sharing of direct experiences of individuals with mental-health struggles, including a question-and-answer session. Students completed pre- and posttests and a 6-month follow-up. The study revealed that participants possessed extensive vocabulary to describe mental health, the majority of the terms being derogatory. One quarter of the students utilized almost no derogatory language and "applied only sensitive descriptions focusing on people's emotions and positive characteristics" (p. 343). At the 6-month follow-up, 37% of students said the aspect they remembered most from the workshop was about language used to describe mental-health problems, compared with 15% who most remembered a video that was shown.

Pinhold et al. (2003) found that high-school students' mean attitudes, measured on a -5 to +5 point scale, were improved from 1.2 at baseline to 2.8 posttest, to 2.3 at the 6-month follow-up. At each time measure, personal contact was associated with more positive attitudes. Being female and younger was also associated with more positive responses. A majority of students (74%) rated their own attitudes as more positive toward people with mental illness on the posttest, and 61% retained the improved self-assessment at 6 months. For social-distance scales, overall attitudes improved marginally over the assessment periods, with previous contact and inclusion of the personal-experience talk being the two key variables associated with reductions in social-distance scales at baseline and follow-up. Finally, participant levels of mental-health

literacy, defined as being able to correctly recognize signs of mental illness, were assessed. At baseline, 1% of students responded correctly to factual statements, followed by 24% one week after the workshop and 6% at the 6-month follow-up. We can note the following limitations in the study: (a) All schools in the study had identified concerns over the well-being of their students; (b) there was no control group; and (c) participants were not college age.

To further increase our understanding of the effectiveness of stigma-reduction strategies, consider two studies Mann and Himelein (2008) conducted that compared classroom interventions. At one small public university, 53 students enrolled in introductory psychology classes received either an experimental humanizing program that emphasized first-person narratives and idiographic characteristics, or a traditional diagnostic approach to how they were taught basic information about mental illnesses. Each class used the same textbook and had similar amounts of in-class activities. The experimental humanizing program included a video documentary that presented three young adults' perspectives and experiences related to mental health, and a poetry assignment in which students were to write from the perspective of an individual with schizophrenia or bipolar disorder. In the class taught with the traditional approach, students read content written by doctors rather than patients; and instead of the poetry assignment, their task was to attempt to correctly diagnose an ambiguous case using DSM criteria.

Results at baseline in the Mann and Himelein (2008) study indicated there were no significant differences to participants' stigma attitudes related to race, age, or religion, although for gender, being female was associated with less stigmatizing attitudes, just below the significant level. Also at baseline, in general, stigma levels were higher in relation to a diagnosis of schizophrenia than of bipolar disorder. Posttest results indicated no significant change in

stigma attitudes of students in the traditional diagnostic group. Students in the experimental humanizing group on the posttest indicated a significant positive change in stigmatizing attitudes, and compared to the traditional diagnostic group they rated the poetry assignment as more enjoyable and thought provoking. There was no difference between the two groups in student performance on exams. Mann and Himelein (2008) conducted a follow-up study to confirm their initial results. In the follow-up, both groups received the experimental humanizing intervention. Findings were similar and again indicated that participants held less stigmatizing attitudes following the intervention, and they rated the poetry assignment as enjoyable and thought provoking.

Eisenberg, Downs et al. (2012) investigated stigma in a naturalistic setting by examining random roommate match-ups of first-year students at two universities. Student levels of stigmatizing attitudes toward mental-health treatment were examined at the beginning and end of the academic year. The major finding from this study was that levels of stigmatizing attitudes for students with an assigned roommate with a history of mental-health treatment or diagnosis actually increased significantly by the end of the year. Students with roommates who were using medications for treatment of mental-health-related issues showed less stigma than those with roommates with a previous diagnosis or who were receiving therapy or counseling. Students without previous treatment who had a roommate with a treatment history showed significant increase in stigmatizing attitudes, and students with no prior knowledge of mental-health issues showed the largest increase. Overall, the study results, namely that interpersonal contact with someone who was experiencing or had experienced mental-health issues was associated with an increase in students' stigmatizing attitudes, contradict previous studies. The design of this study was helpful because previous studies have examined attitudes of students who have self-selected

to participate, or of students in situations in which their contact with other students experiencing

mental-health issues was short and purposeful.

CHAPTER 3: METHODOLOGY

In this chapter, I discuss my rationale for using the phenomenological approach. In addition, I address how I recruited participants and collected the data, the approach I used to analyze the data, the trustworthiness of the study, and ethical considerations.

The purpose of this phenomenological study was to explore the lived experiences of stigma for college students at a medium-sized public community college who self-identified with a mental-health issue. To simplify language in the current study, I have used the word *stigma* to refer to stigma associated with mental health. The overarching research question was "What are the lived experiences regarding stigma of community-college students who self-identify with a mental-health issue?"

To support the overarching question, I also pursued the following questions:

- Question 1: How do students who self-identify with some mental-health issue experience stigma?

- Question 2: What kind of influence does stigma have on these students' willingness to seek help?

- Question 3: How do these students view others who a have mental-health problem in relation to stigma?

- Question 4: How do these students view themselves in relation to stigma?

Creswell (2014) has described qualitative research as focused on the research participants' meaning, and as being inductive as well as deductive, emergent, holistic, and placing the researcher as a key instrument in the study. When I considered the overarching research question, "What are the lived experiences regarding stigma for community-college

students who self-identify with a mental-health issue?", the qualitative method was the best match because it focused on the experiences of individual students based on their descriptions, statements, and senses of meaning. This study embraced a constructivist view as well since the research was based upon the supposition that I was discovering the experiences of a group of students. Inherent in this view is the belief that truth is realized differently through different experiences. Creswell explains,

> Social constructivists believe that individuals seek understanding of the world in which they live and work. Individuals develop subjective meaning from their experiences— meanings directed toward certain objects or things. These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrowing meaning into a few categories. (p. 8)

Finally, as stated, I selected phenomenology as my approach. Creswell explains that phenomenology is focused on describing experiences, making meaning, and finally on revealing an essence of a particular phenomenon (2007). According to Moustakas, using a phenomenological approach entails asking participants what they have experienced in terms of the phenomena, and what contexts or situations have influenced their experience of the phenomena (1994). Thus, phenomenology fit well with the question of how students experienced the stigma of dealing with some level of personal mental illness.

To consider the primary research question, "What are the lived experiences regarding stigma of community-college students who self-identify with a mental-health issue?", I conducted two in-person interviews with students. I also collected responses to three online prompts to explore their experiences with stigma around the issue of mental health.

Participants

To explore college-student experiences of stigma around the issue of mental health, I recruited students at a community college in my local area. Students who had sought support from the counseling center were made aware of my study by counselors or by picking up an

informational flyer. I targeted this subset of the campus population because some, but not all, of these students were likely to have had experiences of stigma. These students were likely to have sought mental-health treatment or to have been diagnosed with a mental-health disorder, or both; but neither was a requirement for the study. In addition, when possible, class announcements were made to recruit students not already working with the counseling center. Wording in the initial informational flyer (Appendix A) made clear that students needed to believe they had had experiences with stigma based on their own mental-health status, to be current students, to be willing to participate in two in-person interviews to discuss their experiences of stigma, and to respond to three online messages. At the completion of the study, I provided participants a $25 gift certificate in the campus bookstore in exchange for their participation time. Students with an interest in participation were asked to respond via email or phone. My response to them provided more information about the study and time commitment, and also requested some demographic and treatment information (Appendix B). I then selected six students to be interviewed based on my efforts to obtain a diverse sample in terms of gender and ethnic and cultural identity. Finally, I sent the selected students a consent form and scheduled interviews (Appendix C). I sent an email to all students I did not select, thanking them for their interest (Appendix D).

Students in the study represented a convenience and purposeful sample. I selected community-college students instead of university students at my home institution to avoid any role conflicts with the students.

Data Collection

I interviewed, in person, college students at a medium-sized, public community college and asked them to share their experiences with stigma around the issue of mental health

(Appendix E). The interviews were semistructured and focused on research questions translated into interview format and with probes included.

As noted, I scheduled two in-person interviews with each participant. The setting for the interviews was the counseling center. Student participation took place over 2 to 3 weeks in the following format, as much as possible based on student availability: week 1: initial interview, 45 minutes to 1 hour; week 2: student responses to three online prompts regarding stigma; week 3: second (and final) interview, 45 minutes to 1 hour. During the first interview, I asked students to select a pseudonym to be used for the remainder of the study, to keep their names confidential.

The first interview served to introduce the topic of stigma and explore participants' experiences of and thoughts about stigma. I gathered additional information about students' thoughts and experiences relating to stigma through the online prompts.

I sent the online prompts (Appendix E) to students using Survey Monkey. The first prompt queried students about their additional observations and thoughts about stigma since the first interview. The second prompt asked students about what they had noticed, if anything, about stigma in the media. The third and final prompt asked students to consider whether stigma had ever had an impact on their feelings and decisions about seeking help in the form of counseling or other social support. I reviewed participants' online responses prior to the second interview so that I could follow up with them about their responses to the online prompts.

In the second interview with students, I followed up on the online prompts and explored the impact stigma had had on their decisions to seek help. In addition, I asked students about their own views of individuals with mental-health struggles, including themselves. All interviews were audio recorded and the audio file was transcribed verbatim. Last, I emailed the participants a transcript of both interviews to allow member checking (Appendix F).

Pilot Study

During the summer of 2013, I had conducted a previous pilot study comprising interviews of students regarding their experiences of stigma. The interviews of four students provided rich descriptions of their experiences and served to confirm the general study design.

At the same time, I noted challenges with my efforts to identify student participants. Although the difficulty may have been the result of timing the study when students were away for the summer, it also may have been an indication that the topic of stigma is more taboo than I had previously understood. The population sample for the pilot study was White female college students who also were holding or had held leadership roles connected to mental health, and thus who represented a significantly homogenous sample.

Online Journal/Prompts

I used online journals between the first and second interviews to assist students in noticing and recording their thoughts and experiences related to stigma. Based on the previous pilot study and literature review on the topic of stigma, it seemed likely that even students experiencing some level of mental illness may not have thought specifically about stigma or how it impacted them. Thus, my intention was that an opportunity for participants to think about stigma between the two interviews and respond to electronic prompts in an online format might facilitate their insight and responses.

Previous research supported the use of this approach in the current study. Journals and diaries are recognized as and have been used for data collection for topics that are not commonly discussed or may be considered "taboo" (Alaszewski, 2006; Day & Thatcher 2009). Solicited diaries can be used to document more intimate experiences that individuals may not feel comfortable discussing in person, as well as behaviors and experiences they may not regularly

consider (Alaszewski, 2006; Breakwell, 2006). "Diaries can be used not only to identify patterns of behavior but also to provide greater insight into how individuals interpret situations and ascribe meaning to actions and events…" (Alaszewski, 2006, p 37). "The method can be used to open areas of investigation and to identify the broad parameters of the issues involved that may need to be explored later in greater detail with more intrusive techniques" (Breakwell, 2006, p. 260). In addition, diaries or journals minimize retrospective recall, specifically the time between the participants' experiences, thoughts, or events and the corresponding recording of the information; thus, they provide more accurate accounts (Alaszewski, 2006). Finally, diaries seek to minimize "distortions created by the research process" and emphasize the naturalist setting (Alaszewski, 2006).

In-Depth Interview

"A qualitative research interview is often described as 'a conversation with a purpose' … which permits participants to tell their own stories, in their own words" (Smith, Flowers, & Larkin, 2009, p. 57). In this way, the purpose of the interview is to see the issue through the participants' eyes, making them the experts; as the researcher, I would be simply the vehicle for the participants' perspective, expression, and, if possible, reality. Subsequently, to facilitate the interviews for this study, I utilized an interview protocol to guide the inquiry process. I was ready to improvise and follow unexpected concerns or paths during the interviews because those alternatives might be informative to the process (Smith et al., 2009).

The goal of the phenomenological interview is to understand the lived experiences of participants and the meaning they make from those experiences (Seidman, 2013). Further, as the researcher in the current study, I knew I must go beyond a cursory or casual conversation. "Unless one has engaged deeply with the participant and their concerns, unless one has listened

attentively and probed in order to learn more about their lifeworld, then the data will be too thin for analysis" (Smith et al., 2009, p 58). My study design was centered on the importance of exploring student experiences of stigma related to mental health in a way that would provide ample time and focus for me to truly hear and attempt to understand each student's unique story.

Data Analysis

Interpretative phenomenological analysis (IPA)

> …is concerned with the detailed examination of human lived experience. And it aims to conduct this examination in a way which as far as possible enables that experience to be expressed in its own terms, rather than according to predefined category systems. (Smith et al., 2009, p 32)

My role as researcher was to bear witness as the participants made meaning of their experiences, tapping into empathy and focusing entirely on those experiences (Smith et al., 2009). At the same time, IPA acknowledges the need for me to think critically and question each participant's experience. Indeed, successful IPA includes elements of empathy and questioning (2009). In addition, I held a position in the meaning-making circle by considering how my experiences impacted the analysis. Therefore, the interaction of the analyses in the current study was both cyclical and iterative, working from and back to both the participants' and my experiences (2009).

In the current study, I utilized the steps for IPA for each case, as provided by Smith et al. (2009). Reading and rereading the interview transcript slowly, resisting the urge to draw quick conclusions, and then making some initial notes of my thoughts as interviewer were all part of applying the first step of IPA. Although the picture of the interview might have been broad and perhaps muted, I also noticed patterns and any particular qualities.

The second step in the IPA of the current study was initial coding, a process that "begins to identify specific ways by which the participant talks about, understands, and thinks about the

issue" (p. 83). I reviewed the transcript and make exploratory comments, including descriptive, linguistic, and conceptual comments. This phase was open-ended and came close to a free textual analysis. It was fluid and led me into the phase of interpretation.

In step three of the IPA, developing emergent themes, I built upon my exploratory notes as I attempted to "reduce the level of detail whilst maintaining complexity, in terms of mapping the interrelationships, connections, and patters between exploratory notes" (p. 91). In this phase, I became more active in working with the text, breaking it into discrete chunks and emerging themes. I created the parts of the whole, while the whole still guided the parts. I embarked on the iterative process in which I was part of the hermeneutic circle, engaging with the text and merging the participant's words with my analysis. I developed a list of emergent themes for each participant.

In step four, I searched for connections across emergent themes through a process of abstraction. In this phase, I engaged with essential statements from the interviews and explored how they fit together, might be ordered, and sought to understand their importance in relation to the participants' accounts.

In step five, I went to the next case and conducted steps one through four again, treating each new case as independent from the others and maintaining the idiographic basis of IPA. As Smith et al. (2009) recommend, the final step of IPA in this study was to look for patterns across cases.

Representing the IPA findings was my final task. The final account of the analysis continued the iterative or dual processes of working with the parts and the whole, through finally using the parts to illustrate the whole. As Smith et al. (2009) explain, after examining the whole,

the researcher may be drawn back into the specific, which leads to a deeper analysis or understanding of the case.

Trustworthiness

"Validity is one of the strengths of qualitative research and is based on determining whether the findings are accurate from the stand point of the researcher, the participant, or the readers of an account" (Creswell & Miller, 2000). In the current study, I employed several strategies to strengthen validity and enhance the consistency of procedures and findings. First, I used several data sources, including two interview transcripts, the journal entries, and my researcher notes. The journals allowed for triangulation of responses to interview questions, which increased the trustworthiness of the subsequent analysis and findings. In addition, utilizing multiple sources of data assisted me in establishing converging themes because I could compare several data sources to strengthen the validity of the study (Creswell, 2014). Next, I employed member-checking by sharing the interview transcripts with participants for their review and to check for accuracy. I incorporated any modifications or clarifications by participants within the data analysis. Finally, the analysis included rich, thick descriptions of identified themes. I enhanced the validity of the findings by including detailed accounts and descriptions of the participants' experiences, (Creswell, 2014).

Ethical Considerations

Confidentiality of student identity was a vital commitment of this study; I took steps to protect student identities and keep findings anonymous. Each participant name was known only to me. As noted previously, students chose pseudonyms during the first interview, which we then used for the remainder of the study. A second important consideration of this study involved the topic of mental health. Because students were asked to recall experiences about

stigma, and some of those experiences might be sad or painful, or might activate unexpected feelings, I informed all students that they could speak with a counselor for free at the school health office. In addition, because sampling strategies involved students who already were working with the campus counseling services, I anticipated that student participants may have additional vulnerabilities and fragility. By virtue of being recruited to participate, these students were connected to both of these campus offices, where professional counseling and support was readily available. This connection provided some structure for existing support, which I supplemented with verbal referrals. Finally, I discussed exceptions to confidentiality with participants. These exceptions include harm to self, harm to others, and elder or child abuse. I explained to all participants that their responses would be kept confidential unless those responses involved any of these exceptions.

Conclusion

The purpose of this study was to explore the lived experiences regarding stigma of college students at a medium-sized, public community college who self-identified with a mental health issue. I accomplished this objective by identifying student participants through the college health and wellness offices and making announcements in several psychology classes. Utilizing two in-person interviews and three online prompts with from 6 students, I explored participants' experiences of stigma.

CHAPTER 4: FINDINGS

In this chapter, I discuss the analysis of the lived experiences of stigma for community college students who self-identified as having a mental-health struggle. In my analysis of the data collected from six participants in two interviews and one online prompt from each participant, I used interpretative phenomenological analysis (IPA) as Smith et al. (2009) have described it.

Overview

My overarching research question was "What are the lived experiences regarding stigma of community-college students who self-identify with a mental-health issue?" To further explore this question, I pursued the following additional questions:

- Question 1: How do students who self-identify with some mental-health issue experience stigma?

- Question 2: What kind of influence does stigma have on these students' willingness to seek help?

- Question 3: How do these students view others who a have mental-health problem in relation to stigma?

- Question 4: How do these students view themselves in relation to stigma?

In my interviews of participants to explore the above research questions, I found six distinct themes. Several of these themes also had subthemes (Table 1). In this chapter, I present those findings in detail.

Table 1

Research Questions and Theme Overview

Research Question 1: "What are the lived experiences regarding stigma of community-college students who self-identify with a mental-health issue?"

    Theme 1: Social distance
        Subtheme 1: Being outside the social norm
        Subtheme 2: Experiencing negative talk
        Subtheme 3: Being treated as fragile
        Subtheme 4: Recognizing differences between high school and college

    Theme 2: Social connection
        Subtheme 1: Making decisions to disclose
        Subtheme 2: Finding support through self-disclosure

    Theme 3: Social misunderstandings
        Subtheme 1: Being seen as dangerous
        Subtheme 2: Experiencing gender and diagnosis stigma
        Subtheme 3: Recognizing a stigma hierarchy

Research Question 2: "What kind of influence does stigma have on these students' willingness to seek help?"

    Theme 4: Stigma's negative impact
        Subtheme 1: Navigating external pressure and internal denial
        Subtheme 2: Experiencing an internal process in deciding to seek help
        Subtheme 3: Building and maintaining strength

Research Question 3: "How do students view others with mental-health problems in relation to stigma?"

    Theme 5: Compassion and empathy for others

Research Question 4: "How do students view themselves in relation to stigma?"

    Theme 6: The process of shedding stigma

Participants

The participant sample was moderately diverse in terms of age and diagnosis; however, the sample was less diverse with regard to gender and cultural background (see Table 2). The number of participants was relatively small (N = 6), with age ranges from 18 years to 30 years, and diagnoses including depression, bipolar disorder, dysthymia, Asperger's syndrome, anxiety, and attention-deficit/hyperactivity disorder (ADHD). Two participants identified as males and four as females. Four participants identified as being of Caucasian decent, while one was of Korean descent and one was half Mexican and half Caucasian/European. Participants self-identified as having a mental-health struggle. To participate in the study, they were not required to have been formally diagnosed with a mental-health disorder, or even to have sought professional help. Once selected for the study, participants were asked to choose a pseudonym, which I have used in the final results to protect their privacy.

Table 2

Participant Demographics

Pseudonym	Gender	Age	Ethnicity	Mental-Health Diagnosis/Struggle
Anastasia	Female	29	Caucasian	Bipolar Disorder
Esme	Female	19	Caucasian	Depression
Heather	Female	18	Korean	Depression/Anger
Joshua	Male	30	Caucasian	Bipolar Disorder, Dysthymia, AD/HD
Kurt	Male	19	Caucasian	Depression, Anxiety, Asperger's Syndrome
Maria	Female	19	Mexican/Caucasian	Depression

The following brief descriptions of each participant provide further detail about their background, including some family and community contexts:

Anastasia

Anastasia was a 29-year-old Caucasian female diagnosed with bipolar disorder during her teen years. She had participated in inpatient programs and also therapy and other recovery programs. Her family had been very supportive regarding her mental-health struggles.

Esme

Esme was a 19-year-old Caucasian female. She first began in therapy in the upper elementary grades. She started taking medication for depression when she was in high school. Her mother struggled with depression, and her father was somewhat against Esme taking medications. She grew up in a tight-knit community that experienced several community-wide tragedies while she was in high school.

Heather

Heather was an 18-year-old Korean female. She self-identified as having a mental-health struggle with depression and anger. She received support from a high-school counselor although she had never formally been diagnosed. Heather's father had had problems with substances, which impacted her and had been the focus of her anger. Her father was in recovery at the time of her participation in the research.

Joshua

Joshua was a 30-year-old Caucasian male who had been diagnosed with bipolar disorder, dysthymia, and ADHD. He self-disclosed that he also was bisexual. Joshua believed his father had a mental-health struggle. Joshua's mother was supportive and understanding regarding Joshua's mental-health struggles.

Kurt

Kurt was a 19-year-old Caucasian male. He had been diagnosed with and was taking medication for depression and anxiety. He also had been diagnosed with Asperger's syndrome. Kurt's family had been supportive during his struggles. He had been a participant in competitive sports.

Marie

Marie was a 19-year-old female of half Mexican and half Caucasian/European descent. She first attended therapy in early adolescence after a traumatic event. She had attempted suicide in the past and still cut herself regularly. Two of her grandparents had been diagnosed with depression. She reported being depressed for as long as she could remember.

Research Question 1

In this section, I provide participant responses to research question 1, "How do students who self-identify with some mental-health issue experience stigma?" In the analysis of the results, three themes emerged: (a) social distance, (b) social connection, and (c) social misunderstandings. In addition, the theme of social distance was further delineated into the subthemes of (a) being outside of social norms, (b) experiencing negative talk, (c) being treated as fragile, and (d) recognizing differences between high school and college. The social connection theme was composed of the subthemes of (a) making decisions to disclose and (b) finding support through self-disclosure. Finally, the social misunderstandings theme included the subthemes of (a) being seen as dangerous, (b) experiencing gender and diagnosis stigma, and (c) recognizing a stigma hierarchy.

Theme 1: Social Distance

During the first part of the interview, I asked participants to define and describe stigma. Social distance emerged as a main component of their definitions. Most participants defined stigma as a negative view of a person or people who belong to a certain identified group or have a specific a condition. The stigma may be the result of ignorance, but the impact is fear and isolation for people in the identified group. One participant, Joshua, defined stigma as "the negative prejudices that people will project upon you because they hear that you have X, Y, or Z condition."

Anastasia describe stigma as "thinking that these people don't belong, thinking that these people are aliens, and then treating them according to that." Another participant, Esme, described stigma as "There was always like food in my teeth or something like that. Someone is just like not telling me something, and I could never really figure out what it was." Words the participants used to describe stigma included *isolation, fear, secrecy, ignorance, hate, judgmental, outcast, weirdo, awkwardness, tension,* and *unacceptable.* Finally, several participants included references to other groups in history who have been the target of stigma, including the witches of Salem, "the struggles [of] gays and lesbians throughout history," and adulterers.

Subtheme 1: Being outside of social norms. Participants articulated this subtheme in several forms, which I explore in this section. Joshua described how revealing mental-health struggles can result in people seeing you differently and in a negative light.

> That's why I've actually been very quiet about some of the problems I've faced and some of the things about me, is because the public can seem like they're just nice, normal, peaceful people, but the wrong thing came out, and they'll turn on you like a pack of jackals. That's always the impression I got, and I mostly based it on stigmas. Like, "Oh, if you're out of line on this, everyone's going to turn on you."

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Participants emphasized that it is common for individuals to understand and apply stigma to others from a young age. Joshua explained,

> Also, even from a young age, you very much get the picture that people will turn on you if you're different, and then anything that's different about you, you try and hide. I think that's the foundation of this cage of fear that people build for themselves, which I think is one of the consequences of stigma.

Marie's personal experiences of stigma began in childhood.

> When I was younger I felt embarrassed, really embarrassed, because I was different. People find out, they find out that you have a problem when you have to go and see someone. Someone will see you talking to someone, or they'll ask, "What's wrong with her?," and then they'll say stuff, and that's how rumors get spread. It doesn't feel like I shared it with someone; it feels like they pushed their way into my life. There was no privacy when I was younger; I feel like it was always open, and everyone always found out. It made me hate going to my therapist because I felt abnormal, and I felt like I get made fun of, and I did; I got picked on a lot.

Participants also discussed how stigma impacts people with mental-health struggles. For example, Anastasia explained how stigma increases the suffering of people with mental-health struggles:

> I think the stigma of mental health is a new thing. It's growing and it's dangerous for people who suffer from mental illness because it makes them suffer harder. With mental illness, it's easy to get down into the very worst part of it and get suicidal if you feel so outcasted [*sic*] and there is no hope. Having a stigma is really sad.

Joshua described his view on stigma in terms of social norms:

> I think it's very much people are not comfortable with deviations from the norm, which is strange because people are constantly deviating from the norm, thus creating new norms. I think there is very much this perception that I have to fit in. I need to fit in. I need to belong to a group, and then you see someone not doing that. What is wrong with them? What are they doing? It's not quite articulated in those terms. It's more of an emotion. I used to feel like that. I used to think there's someone not trying to fit in this particular pigeon hole. What are they doing? I think that kind of attitude is at the root of it and that these people are experiencing something that is outside of the norm, they must be defective, they must be damaged.

Another participant, Kurt, explained that he didn't want to be seen as different by his peers and therefore did not use special-education services in high school. He stated, "I just don't

like being treated differently … I just like didn't want to be looked at differently by my school, by my friends. Just like ... I don't know, lesser or different."

Anastasia described her own experiences with stigma as "Losing friends, losing not individual friends and not best friends, but losing groups of friends. Just losing the allure that I once had. I guess, it's hard to become popular when you've got a weird thing going on with you."

Joshua shared that he had had a mixed reaction when others knew he had mental-health struggles:

> Some people, usually if they got to know me before I admitted it, they're like, "Oh, yeah. You're fine." It's been kind of a neutral response. That information has not really changed their relationship to me. Others have treated me like I'm a ticking time bomb, and some try and make light of it, but you can still tell that something has changed. Not necessarily that they're bothered, but they look at you slightly differently. That's not always in a negative way. It's very hard to articulate exactly what I mean, but that information changes their perception of you in some slight way.

Others examples varied. Kurt noted that if he chose to share information relating to his mental-health issues more frequently, he knew he would experience more stigma. Anastasia shared a common example of someone being left off an invitation list to a party because others thought she was weird because of her mental-health issues. She explained how that situation made her uncomfortable. Relating her experiences of being seen as different, Marie noted, "Every single time I've told someone something, they've always, not judge me, but I feel like they feel differently towards me, or they're scared to say something because they think I'll be depressed, or sad, or something."

Heather observed that she believed stigma impacts everyone to some extent: "I think it [stigma] impacts everyone because ... Like I said earlier, "You worry about getting that perfect image, and you worry about what other people think…"

Subtheme 2: Experiencing negative talk. Negative talk about individuals with mental-health struggles emerged from the interviews as an additional aspect of the theme of social distance and being seen as "other." Several participants described experiences in which peers discussed other people with mental-health struggles in a negative light. Participants explained the impact these interactions had on them and how they reinforced stigma, leaving them more hesitant to share their own mental-health information, and to be in more fear about the social consequences if the information were to be known.

Esme described a situation in which her roommates were talking about another roommate who was open about having bipolar disorder. The roommates made negative comments about the roommate because of her diagnosis. She explained the things they would say and her reaction to it:

> "They would say things like "I wonder when she's going to freak out. You can't just really trust her because you'll never know when she's going to flip"; and it just wasn't accurate because she was being medicated too. She was always very even-keeled, and if anything, she was one of the nicer people that I was living with.

Esme also noted that she stopped taking her medication while living in that situation because she didn't want her roommates to find out about her mental-health struggles.

> I just generally didn't really trust them very much because I live at … and it's weirdly just like a high-school zone. There is, like it's very gossipy. I'm already pretty introverted. People, I mean notably… I was already like a weirdo. I don't want there to be more things for people to fall into.

Anastasia experienced situations in which peers were talking negatively about someone with mental-health struggles:

> People getting called *psycho,* people laughing at other people. I hate when they do that with me. It makes me feel they're going to do that about me. It makes me think less of them and it makes me feel sorry for the ... I think they're victims. For the victims, that makes me want to go help the victim. I mean, this is a huge problem, and I think it's just a huge shame. I never know whether to tell the person who has been made fun of… That these people are cruel behind their backs.

Finally, Anastasia explained her strong feelings about talking about other people and stigma:

> I just don't think it's anyone's place to call anyone else sick or ... You just can't really ever speak for another person on what's going on with them, and you could always ... That was one person talking to another person, and it's usually people that don't even know each other very well. They could be talking to someone who's dealing with their own inside issues, and little do they know that's going to make it harder for that person now to reveal themselves.

Subtheme 3: Being treated as fragile. Participants also discussed being treated as fragile by others once those individuals had knowledge of their mental-health struggles; this treatment can also contribute to social distance and being treated as an "other." Joshua described "being treated overly gently because of a condition." Esme mentioned how, once her friends knew about her struggles, they didn't joke and tease her anymore:

> …making fun of each other and stuff like just about little things in a very loving way, but they totally stopped doing that to me. It made me feel really abnormal because the one thing I felt like I really have left was the amount of normalcy that was going on between me and my friends... They try to adjust when really they should have just kept … I'm still me.

Marie shared a similar experience:

> After I've been friends with someone and I tell them [about my challenges], I feel like they're afraid to joke with me and they get a little more touchy. It's nice but I don't want to feel like I'm the gigantic bird in the room. I don't want to feel like they have to constantly step over me. I don't want to be the problem. It's something that I have to deal with. I don't want people to change their opinions of me; I'm still the same person. I'm the same person that you met before you knew that I had problems.

In addition**,** participants noted that they might not be asked to go out socially once others knew about their mental-health struggles and were worried that the participants might consume alcohol. Marie explained that a friend had had problems when he went out socially and he was no longer invited out, although she thinks it may be because of some drastic mood swing he experienced when he drank alcohol.

One of my friends has some type of bipolar disorder, and they don't want him to drink. Because I guess apparently something happened and he got really angry, and then immediately really sad, and one of his friends had to talk to him. So now they don't invite him to drink anymore. We were actually talking about that, how people… they stop asking you to hang out if something happens; and that's what I've noticed about mental illnesses in college.

Subtheme 4: Recognizing differences between high school and college. Participants discussed high school as being the hardest time in regard to stigma, while they generally saw college as better. Several participants described experiencing intense bullying and ridicule because of their mental-health struggles while they were in high school. Joshua shared his experiences with being targeted by peers at that time:

When I was in high school, that's where the "Oh, because you have this mental-health condition, you should be locked up," that kind of shit happened. When people found out I had depression, they would jokingly suggest I commit suicide. I think some of them weren't joking. It made me very sad, because I'm like, "These people are basically bullying me and picking on me for something that already sucks anyway." I was basically bummed about it. Sometimes I'm like, "Oh, I wish you struggled to get out of bed every morning, so I wouldn't have to see you." Sometimes I would wish my problems on other people.

Marie explained her experience in high school and shared some of the painful peer interactions: "…there was a couple times where people would say really mean things like, 'You should kill yourself,' or 'kill yourself,' or 'You're so depressed,' and stuff like that. It would really get to me."

Commenting on high-school students compared to college students, Marie continued,

They're just meaner, less accepting. When you come to college, you try and change yourself. You realize you have a past, and so that's why people are more open with you and they're more down to listen to your story. Sometimes they'll judge you and sometimes they won't. With high school, it's like "You have a problem, stay away from me; we don't want to joke with you; we're going to make fun of you behind your back. We're going to post tweets about you," stuff like that. It's just like bullying, I guess; they're just mean. In high school, people are just way meaner than in college.

Marie also related that people are often more open in college:

I feel like a lot of people in college, they've either been with someone who has a problem, or seen someone who has a problem, or has [*sic*] a family member who has a problem, so they've experienced more. Rather, in high school, everyone's young, and all ignorant, and stupid. In college, we're more accepting, I guess I'd say, a little bit more accepting….

I feel like it's different [in college], because I don't know everyone that I go to school with…When you talk to someone they're not going to immediately judge me.

Depression is really serious, but when you feel like an outcast completely it makes you just feel like a complete looser rather than just, "I'm a person with depression and depression is not me." That's how it feels in high school. In college I feel like more people are open, they're not just going to judge you completely. Even though they may not invite you to parties…

Kurt stated that, in spite of needing them, he chose not to use academic accommodations on tests in high school because he didn't want to have to explain his doing so to peers:

…For example, the extended time on test[s]. You take the test in a different room and you're the only student in the class that gets up and leaves and gets to take the test outside. The other students wonder why you are taking the test outside, but you can't really say anything, and they ask you. You don't really want to say anything because there's this general idea of that.

Finally, for Esme, there had been a number of tragedies in her community during her high-school years. She noted that students did not talk much about their struggles in order to avoid drawing attention to themselves.

I mean, like I said, there are [*sic*] so many things happening in my community at that time that I'm sure everybody was struggling on this a little bit, which is also why it was really dumb that everyone was being so private about their feelings. I guess I was pretty scandalous. I guess you have to be private about your feelings about stuff like that, as to not perk anybody.

Theme 2: Social Connection

The second theme that emerged in connection with research question 1 was social connection. Individuals discussed how they decided whether to disclose mental-health struggles, and also the support they had found after sharing. These findings were revealed in the subthemes of (a) making decisions to disclose and (b) finding support through self-disclosure.

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Subtheme 1: Making decisions to disclose. Participants were likely to acknowledge

their mental-health struggles if the other person had shared her own. Similarly, participants

explained that they might disclose their mental-health struggles if they knew a person well and

trusted her. Participants generally found that it was difficult to decide whether to disclose. Other

times, they noted that symptoms could appear that drew attention to their behavior and they

might need to explain the cause.

Joshua explained what it was like to get to know someone well first, and then share his

struggles. "They get to know you and get comfortable with you, and then they find out you have

bipolar, or depression issues, or whatever; their opinion doesn't really change because they've

already formed their opinion of you."

Anastasia described how she decided whom to tell about her mental-health struggles:

> If people have shared before me, then I'll share with them. That's like a no-brainer. If
> they're going to be in my life for a long time, I'll share it with them. Besides that, if they
> really care and they really want to know, and if I think that they could help, I totally share
> it. I don't just offer it out to people.

There were also times when participants indicated it was hard to know whether they

wanted to share. Whether it was at a work meeting or with roommates, some participants noted

that deciding was a challenge. Anastasia explained that knowing how to handle mental-health

information at work was difficult because she wanted to be perceived as a professional. Kurt

noted that, although he currently shared information about his mental-health struggles only with

his close friends, he would like to know how to make the choice for other situations.

> I just like to know when is a good time to share it … where it would be beneficial for me
> to share that information and where it wouldn't benefit me. Not necessarily hurt, but just
> not be very, like, that productive.

> Actually, I never really felt like the need to share it until recently, like the beginning of
> this year. I don't know why, but I just felt like I would like to be more open on that.

The struggle of not knowing whom to tell can also be draining. Anastasia explained:

It has made me weary about who[m] I should be talking to. It's when we feel sometimes like, "I can't get help" because when there's a stigma, it feels like, the whole world thinks, is thinking one way. It's made it hard for me to like, trust who[m] I'm talking to because I feel like, they're just being two-faced and all, like, act like they understand when really, like they are not advocates and they think another way.

Several participants also discussed times when they experienced symptoms of their mental-health struggles, which manifested in noticeable ways. In these situations with a teacher or peer, they might decide to disclose their struggles to explain their behavior. For example, Joshua explained,

I've told some folks after I get to know them pretty well; or if I do something that's uncharacteristic, I use that to explain it. "Oh, I was acting so weird and tweaky, because I'm bipolar, and I was having a manic episode. You didn't do anything to offend me, and I was not on a bunch of drugs."

A final point about a bit of difference between participants relates to their outlook regarding sharing mental-health information. Some participants expressed a desire for greater sharing of mental-health experiences, seemingly as a way to decrease stigma, while others disagreed. As Heather noted,

I think that if people come out and they tell their story and things like that, that will pass on to other person[s], and then it will just keep bouncing. Everyone['s] story has an impact on someone else, so I think that's what someone ... That's what I wish that I had known when I was younger.

Kurt, in contrast, appeared to express a different view, stating, "I feel like I haven't experience stigma as much, but I feel like if I shared it more I would."

Subtheme 2: Finding support through self-disclosure. Participants talked about how they had found social support from communities and individuals who were accepting. Often support came from others with mental-health or other issues, but it also came from trusted friends. Participants expressed that this support was helpful.

Several participants mentioned the support they received from accepting communities, including an online community, a 12-step program, and sports teams. For example, Marie shared her experience with teammates on her high-school water-polo team:

> We had a huge water-polo tournament and the bus ride was an hour long, and they sat down and said, "Hey, Marie, tell us about stuff; we want to know about you, and we want to help you and stuff." They did, and we sat down and everyone cried. It was really nice. I finally felt I had people who finally understood me and wanted to be my friends, and didn't think I was weird.

Joshua described being understood and welcomed in his online community: "When I have brought it up, they're usually like, 'Oh, we understand,' or 'Oh, yeah, I have the same issue. I deal with this anxiety disorder, so I know how you feel.'" He also described support and some alliance from social groups at school.

> There was support. It was kind of like "Yeah. I don't know exactly what you're going through, but I know that makes you sad. I hope you feel better." Actually the most understanding group at my high school at least were the goths and punks, and then some of the art students were pretty nice because they had their own issues. I kept their secrets, because ... I found out some of them suffered from depression, but I did not let anyone else know because I didn't want them to get the same shit that I was getting.

Anastasia talked about feeling welcomed and understood at her 12-step program and with her social group:

> If I would go to Emotions Anonymous or support groups specifically for mental illness, obviously, I'm totally welcomed and it's great … I won't go out with friends at nighttime. I'll invite my more intimate friends, and we'll have an art party and paint at my house or something like that. I gravitate to the people who[m] I feel comfortable around and who get it and who are like me.

Support from individuals was also important to the participants. Heather offered an example of how her friends reacted positively to her sharing her struggles:

> She was really happy because it just made us closer, and she realized that I trusted her enough to talk about things like that; the same with my other guy friend that I talk to. He was happy that I was able to talk to him about that. Knowing someone trust[s] you feels good.

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Kurt also explained how helpful it can be to talk to a friend who understands your struggles:

> I shared my whole life story with one of my friends from back home. A lot of the things that I was worried…, like I was the only one having these issues she also had, just more relating to ... Instead of talking to someone and like going into a therapy session is different than talking to someone who also has the similar things going on. Now, we call each other: "Hey, I'm feeling anxious."

Theme 3: Social Misunderstandings

The third theme that emerged through the analysis of participant responses was social misunderstandings about mental health. Identified subthemes included (a) being seen as dangerous, (b) experiencing gender and diagnosis stigma, and (c) recognizing a stigma hierarchy.

Subtheme 1: Being seen as dangerous. The participants pointed out that, although they are inaccurate and misleading, characterizations often link mental illnesses and violence rather than presenting more realistic symptoms such as crying or emotional pain. Anastasia explained,

> I feel like they portray mental illness as like something to fear, that the characters that are assigned roles of, like, bipolars, schizophrenic, or often seen with, like, guns or having, like having serious psychotic episodes where they are dangerous and need to be, like, isolated them, locked up like that. They don't really portray people with just crying or like with emotional pain. Just dangerous people.

Media portrayals of individuals with mental-health struggles as dangerous or violent can deter some people from admitting they might need help. Participants provided examples of individuals with mental-health struggles being portrayed as dangerous in several shows, including *Law and Order,* and in other movies. In reference to the character called the Joker, Joshua explained that hearing the characterization that the Joker was *manic* (another term for bipolar) made Joshua not want to admit he might be bipolar.

> People described him as manic, and one of the phrases to describe bipolar is *manic depressive.* I was like, "I'm not like the Joker." Not only was it a limited understanding, but it was also the stigma related to it that I would deny that I had this condition, and

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some of it was because of the stigma. Also some of it is because of ignorance, which ignorance helps keep stigmas alive.

In addition, participants pointed out that when a crime has occurred media seem to link the behavior to a mental-health issue. Anastasia stated,

> …if there is ever a shooting or something like that, they always relate it back [to] mental illness. I think that they just over-traumatize and [are] trying to create a story and blame it on mental, mental illness. As "the guy who beats me"—that's really dangerous.

Some participants pointed out that most times there is no way to determine based on appearances whether someone has a mental-health struggle. Heather explained,

> Mental health, like people that are depressed, I guess that are portrayed in the media usually are very ... They wear dark clothes, they have their hoods on, stuff like that. Really in reality people like me, for instance, you wouldn't think, "Wow, she was depressed." I don't dress really muggy or dark. I have some friends that I know too, I would have never guessed that they were depressed. I think that's when the media portrays it wrong. Because there are so many people that are depressed that don't physically show it, but really struggle internally.

In addition, Joshua emphasized that he believes people are always assessing their risk and danger, and this often occurs once a mental-health struggle is known or disclosed about someone.

> I think people are constantly assessing risk, and I think if they found out that someone has a mental-health disorder, they automatically think crazy, and crazy equals dangerous. I think part of it is a risk assessment like that person is dangerous. Therefore, "I should distance myself from them, or I consider them lesser so I have no problem with them being eliminated." Deviation from norms and overactive risk assessment. They're dangerous.

Subtheme 2: Experiencing gender and diagnosis stigma. Participants discussed gender and disorder-related expectations or stereotypes. They described expectations for males and females regarding expressing emotion and dealing with problems. Additionally, they articulated stereotypes and differences in the levels of stigma attached to different mental-health diagnoses.

For males, participants described that the societal expectation is to be strong and not show emotions. Joshua noted, "…there's this thing that men have to be strong; men can't show feelings. If you show feelings, then you're weak, you're a sissy, you're less of a man." He further explained,

> They're protectors, they're breadwinners, and to be strong and to sacrifice themselves at the drop of a hat for the good of society or the good of the family ... This disposability… but then their frailties are ignored. That also kept me from ... "Oh, I have to be strong, not show these emotions, not admit I had feelings, don't cry, don't be sad, don't get too happy about something, don't let people see how you feel," because there is this perception that, first off, I wasn't supposed to, and second, if people saw how I feel, they would hurt me because of it.

Joshua explained how this impacted him personally:

> Because I was a male, I was not supposed to show these feelings. I think we've gotten better about that, but there are still some people who are in denial that men have feelings more complicated than being drunk and horny the whole time.

> The media and some people almost won't entertain that there is something deeper to men and that there is actually emotional issues.

> Also, there's the perception that I have to be tough and I should be tough and try and go without help.

For females, several participants discussed a stereotype of being "crazy," "crazy bitches," or "bipolar." Anastasia explained how the term *bipolar* is used inappropriately:

> Because there's a thinking of some, "Psycho ex-girlfriend who acted crazy on them," and thinking that that's bipolar. When, really, bipolar is an internal, emotional mess and sometimes people don't know … If someone were to call me *bipolar,* I would always think that they were calling me *psycho.* It's not a term of endearment.

Esme described how the negative stereotype impacted her as a female:

> They just call these bitches *crazy*; but, first of all, I'd never use that word, that's terrible. But I think that using ... Just in a very subtle way puts it in the back of your mind you've got to stay very level-headed and never seem like one of those girls who's going to be a psycho. There are definitely a lot of pressure[s] placed on women to be even-keeled, I think, just because we're so frequently depicted as flying off the handle at any little thing, which just in my experience it's not the case; but I think definitely in that regard ... And

then men, on the other hand, have to be strong and so showing any signs of emotion is weakness.

I think that women really frequently are interpreted as being weak, and it's hard to admit that there's actually something that you maybe are actually in sort of a vulnerable, weaker place. It feels like you're giving up on trying to fight against that notion at all, because like I said, I didn't ever want to seem like one of the psycho girls. I didn't want to seem like one of the girls who would just cry all the time, or was really emotional about anything, so I went to a very opposite extreme of just trying to more identify with my guy friends.

Gender and diagnosis expectations seem to be compounded in particular for anyone with a bipolar diagnosis. For males, in addition to their being seen as potentially dangerous, some of the symptoms may be normalized; whereas for females, the term may be used inappropriately to describe any emotional expressions. Esme explained,

I think women being bipolar versus men being bipolar is a very different thing, and that women are just ... All women are considered bipolar. "Oh, she just flipped on me like that, she's so bipolar"; and men, they just get angry about things sometimes, and that's okay because they're a man and they're just expressing themselves, they're just expressing their anger. They're tough because they punch their fist through a wall, which is ridiculous.

Subtheme 3: Recognizing a stigma hierarchy. Participants also observed that there are different levels of stigma for various diagnoses or disorders. Esme shared, for example, that attention-deficit disorder (ADD) is more acceptable than other diagnoses such as being bipolar:

I weirdly think that ADD is actually sort of a … No one in my life has ever had a problem admitting that they have that. Being bipolar, on the other hand, I would say people definitely think less of that or have some amount of fear on that; and then depression, I think that people just ... I don't know if they're thinking less of you but just don't want to hang out with you, like "just depressing to hang out with this person." Bipolar, just ... People think less of that.

Additionally, Anastasia articulated a hierarchy of stigma by diagnoses:

No. I think there's a hierarchy. I think the people who get off easy are the people with social anxiety. Then, it's the people who have depression. We're getting used to accepting that with commercials for Abilify. The people with sleep disorders are in sort of [an] acceptable category. Insomnia, no one is going to be afraid of those people; but underneath, that would be the people with suicidal depression. Worse than that, it would

be the people who have neuroses, who are afraid to go out of their house; the people with paranoia, that gets a little worse. I'm talking in terms of the stigma for it.

Worse than that, I think, it would be bipolar. People who can imagine overcoming it. People who are just then stuck with ruined minds, that's what people think. Rude personalities, just weirdos; and then underneath that, I think, the worst would be schizophrenia, and there are schizophrenics, and there are different versions of that. I'm not speaking for myself; I'm speaking for the people watching a schizophrenic ... You put a room of people together, no one is really going to talk to the schizophrenic person, no one is really going to talk to someone who is having a bipolar episode. They're just kind of left alone.

Findings From Responses to Research Questions

In this section, I provide discussion and analysis regarding participants' responses to the research questions and when relevant, to various themes and subthemes identified with those responses. As noted earlier, participant responses often revealed similar experiences, while others reflected differing perspectives. In combination, the findings convey both the commonalities and the complexities of the students' experiences around stigma related to mental-health issues.

Research Question 1

To review, the findings in this study for research question 1, "How do students who self-identify with some mental-health issue experience stigma?," reflect three themes: (a) social distance, (b) social connection, and (c) social misunderstandings. In turn, these themes also revealed various subthemes.

Theme 1: Social distance. Social distance was a predominant theme as participants described the various ways in which they experienced mental-health struggles that resulted in social distance between them and others. As previously noted, the subthemes of (a) being outside of the social norm, (b) experiencing negative talk, (c) being treated as fragile, and (d)

recognizing differences between high school and college are also reflected in the comments and observations participants shared about this theme.

The participants illuminated that distance and silence were created by negative talk among others about people with mental-health struggles. Further, although peers may have been well-meaning, participants explained they were often treated as particularly fragile by others if they shared their mental-health struggles; this treatment, in turn, resulted in them feeling more separate from their peers. For these participants, high school emerged as their time of greatest struggle as a result of the stigma they experienced. They shared examples of bullying and other painful experiences during this time. They regarded college, in contrast, as better, and where people were more open and accepting.

Theme 2: Social connection. Social connection also emerged as a theme in these students' experiences of stigma, along with the subthemes related to issues of disclosure and support. Connections with others was an important support for the participants, but they sometimes struggled in deciding whom to share information with. Participants were most comfortable sharing with individuals who they knew also had mental-health struggles. They found accepting and supportive individuals and groups in diverse forms, including online communities, recovery groups, teammates, and peers.

Theme 3: Social misunderstandings. This final theme and its subthemes associated with research question 1 illuminated the ways in which others viewed participants inaccurately. First, the participants often equated having a mental-health struggle with being viewed as dangerous. Next, they expressed that gender expectations were placed on males and females; they noted that females, and especially those with bipolar disorder, were seen as erratic and "crazy," and males were limited by expectations that they should be tough all the time and not show any emotions.

Last, participants discussed a hierarchy of stigma and their views that some mental-health

diagnoses are seen as having more stigma while other diagnoses are viewed as having less.

Research Question 2

In this section, I address research question 2, "What kind of influence does stigma have

on these students' willingness to seek help?," and discuss the theme of stigma's negative

influence. In addition, I consider in detail the three subthemes that emerged for this question: (a)

navigating external pressure and internal denial, (b) experiencing an internal process in deciding

to seek help, and (c) building and maintaining strength.

Theme 1: Stigma's negative impact. Participants described both the impact stigma can

have on help-seeking behavior and the reluctance people may have to seek help because of

negative stigma. Participants explained that they didn't want others, especially peers, to know

that they were seeking professional help for a mental-health struggle.

The negative impact of stigma was so profound for these participants that they may have

internalized it in the form of denial. They related how they didn't want to believe they needed

help, and that they thought of mental-health issues and therapy as negative. All of this made it

difficult for them to admit they needed help.

Subtheme 1: Navigating external pressure and internal denial. Joshua asserted that

individuals will hide their conditions to avoid being stigmatized by others. He explained,

> "…because they don't want to be treated differently, and they don't want to be
> persecuted for something that's not their fault. A lot of times they'll just keep it secret.
> They'll not seek help. They won't talk to people."

In fact, just the idea of therapy or professional help can be overwhelming and difficult

for individuals to consider initially. Heather explained,

> I think when you hear the word *therapy* you just think, or I use to think, "They must have
> this huge mental issue." I think when people portray people going to therapy they think,

"Wow, they're kind of hesitant, or being careful with them. Because they worry that they're going to say the wrong thing to mess them up or something." That's how I use to see when I hear the word *therapy,* like, "Oh, they're going to therapy. Oh no."

My mom used to say, "Have you ever thought about therapy? There might be something really wrong with you, you should go to therapy." I used to say, "No, I don't need therapy." I realized obviously it's a big deal, but the word *therapy* isn't just for people with huge issues; it could just be for something small, and they just need to get their chest off. It's really helpful.

As another instance of denial, Esme shared that she was angry with her therapist for

suggesting that she might have depression.

I felt like someone was telling me there was something wrong with me, like I was broken; and I'd always been so proud of my ability to fix everyone else's problems, I felt like it was impossible that I had any of my own…. Even after getting help I didn't tell anyone else for about 4 more months, and then I had to go through all that broken, loss-of-control stuff again.

Joshua also described how he overcame his own denial in spite of media stereotypes.

I think some of it was ignorance. Ignorance of what actually could be done, what were the options, the exact nature of the condition, because some of it is "Oh, I'm not quite like it's depicted in the media," which is often an overblown and very dramatized type that you think, "maybe I don't." It's like denial. "I'm not quite like what's in the media so maybe I am normal or maybe I don't have that problem," so I would say ignorance.

Subtheme 2: Experiencing an internal process in deciding to seek help. Students

discussed their own processes of deciding to seek help. Heather discussed her experience of

coming to the point of seeking help this way: "The top just came off and I realized I can't hold it

in anymore. It just filled up all the way and I was ready to talk about it." She added the concepts

of hitting rock bottom and understanding that everyone has problems.

I think everyone has their struggles and it's okay to have your struggles. I think that if you do have your struggles or if you do hit rock bottom, there's always ... Once you hit rock bottom, there's only up. That's what I like to say.

When people do hit rock bottom are just struggling really hard, that they should talk about it, and they should get it off their shoulders.

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Joshua explained how he eventually let go of outside perceptions and admitted he needed

help:

> People's outside perceptions, you should try to not let them affect you too much. That is incredibly difficult to do … It took through high school to admit maybe some of this isn't normal. Maybe my dark gloomy feelings and preoccupation with death is not a normal thing. Maybe I should actually go to a psychiatrist.

Esme explained that she decided to stop taking her prescribed medications as a result of

the stigmatizing attitudes of her roommates. This example illustrates that an outcome of an

internal process can be not to seek help or even to drop out of treatment. Esme explained she

didn't want her roommates to know she had a mental-health struggle, so she stopped taking her

medication.

> I just felt uncomfortable having them, I mean, not watch me, but visibly see me taking pills every morning and asking me what it was about and I just didn't … I didn't want to share that with them. It was easier to just stop and try to be inconspicuous because you can't really be inconspicuous when you're sharing a bathroom with six people.

Subtheme 3: Building and maintaining strength. Joshua described his process of

withdrawing to build up his inner strength to deal with judgments and stigma:

> You need to give yourself space to build up the shield. You can't build a fortress while you're in the battle. You need to go away and have prep time and sometimes you need to do this several times because sometimes you'll think I've got a good strong wall and then you'll get beaten down again. You need to go off and build it up again.

Joshua continued,

> … while stigma is definitely an external source, its effect on you is internal. There is something that you can do to shake it off, to shake off the effects it has on you. I know that's incredible vague, but like people saying… don't care what they have to say.

> There is some of that. You know that you're a good person and that you're not a violent psycho who's going to go out and eat all the babies. You have to shield yourself from what you perceive as the stigma from outside.

Anastasia shared her view of people with stigmatizing attitudes and her approach to

disconnecting from them:

If there are haters or people start to treat me differently or whatever ... I mean, for lack of a better word, screw them. That's just a pessimistic judgmental way of living and I feel sorry for them because it could have happen to them. It could happen to one of their kids. It could be that they were raised by someone like that and they're just afraid to admit it.

Instead, Anastasia connects with supportive people:

If I'm going through it, I just kind of stay close to the people who are also dealing with it, and I don't go out into society. and that's a choice … I won't go out with friends at nighttime. I'll invite my more intimate friends and we'll have an art party and paint at my house or something like that. I gravitate to the people who I feel comfortable around and who get it and who are like me.

These subthemes that the analysis of research question 2 uncovered delineate the impact that stigma had on the help-seeking attitudes of participants, and the process those individuals had to go through as they navigated their need for help. Participants described their process of deciding to seek help and the strategies they used for gaining and maintaining their strength. The process involved dealing with external pressure along with their own denial and reluctance to admit they might have a mental-health struggle.

Research Question 3

In response to research question 3, "How do students view others with mental-health problems in relation to stigma?," the single theme of compassion and empathy for others became evident. Students shared how they viewed others who were experiencing stigma with compassion and empathy. Students noted that they had seen others suffer because of stigma. They stated that such stigma is wrong, and they even intervened to protect a peer from negative stigma.

For example, Joshua explained how he had seen stigma impact others with mental-health struggles:

I haven't had it particularly bad. I've known people that had it worse, and they're keeping a secret that's eating away at them, and literally destroying them, and they feel

like they can't be who they want to be in the open, or they can't let people know that they're having problems, because they will be turned on.

Anastasia shared an experience she had recently where she saw someone with a mental-health struggle as vulnerable and chose to intervene and attempt to protect her:

A couple weeks ago, I went out with my best friend. He got set up on a blind date. We all went to this hookah bar and the girl who came got in my car, and as she was leaving they said, "Oh, is this like a silver house or something?" She's like, "No, this is like serenity house. This is a place for people with mental illness since I have bipolar disorder." She was super open about it, almost innocent, naive way. I felt really protective over her.

There were other guys in the car that were kind of jackasses. I just knew that and I immediately said ... I immediately spoke up for her. I was like, "Yeah, I have bipolar disorder too," in front of every ... I had to ... I said, "I have bipolar disorder too. What meds are you on?" That was me actively erasing the stigma because the other guys and friends with them, they know I'm cool so they can't ... If I'm saying it then ... Do you get what I'm saying? I was like, "What meds are you on?" She was like, when we're told, "Okay." I'm like, "Oh, me too." You just have to identify ... The more people that identify it together about it the less stigma there is going to be.

She explained that others in the car responded positively:

They came up to me afterwards and they said, "Whoa, I didn't know that about you. That's really brave that you said that. I think you made her feel a lot better." They were just ... They stayed my friends and she was ... They didn't talk about it anymore. They didn't talk about her and definitely, not in front of me.

Because they have just been told, poisoned about someone else and I just feel like if people who deal with mental illness could be protected instead of, it could just be protected and treated with compassion and saved and preserved and just held by the world, they have a lot better chance of recovering.

Anastasia went on to describe both how she had seen stigma impact others and how she felt about stigma,

I have witnessed it more towards other people than I have myself. It has made it hard for me. I think the worst part of having a mental illness is the stigma and I don't let it affect me too much. I just do something about it, which is to find my own people and I've never believed in it for a second even before I had bipolar disorder. I've never gone with it. I think it's a hate-crime thing. It hasn't made my life harder and it hasn't closed any doors that I know of. It has made me feel uncomfortable and feel insecure and kind of mad.

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In summary, students shared how they viewed others who were experiencing stigma with compassion and empathy; they stated that stigma is wrong, and they even intervened to protect a peer from negative stigma. These students also shared that they had seen others suffer because of stigma.

Research Question 4

To explore the results for question 4, "How do students view themselves in relation to stigma?," I also focus in this section on the final theme my analysis of the study revealed, the process of shedding stigma.

I explored this research question with participants by asking them if they thought less of themselves because of their mental-health struggle. Their responses reflected notable agreement and even similar phrasing. First, all participants indicated that they did think less of themselves at some point in the past, when they were younger or when they first started to struggle with mental health. Second, they indicated that they didn't feel that way now. They described a process of change over time.

For example, Marie explained,

I think there are definitely times when I did think differently about myself, and I just wanted to keep it from people; I didn't want to tell anyone. It made me feel like an outsider; I didn't want to share who I was with anyone. Because of me feeling down about myself, I didn't really have many people that I could open up with. So yeah, I would say that's definite, yes.

Now I think it's different because I've grown to accept who I am, and I have a handful of people that I can talk to now, and that I trust a lot. Whenever I am feeling down about myself like, oh, you know, I talk to them and they make me feel better. I guess yeah, it still happens but definitely not as much, definitely not as much.

Joshua shared a similar response to the question about whether he thought less of himself because of his mental-health struggles:

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I would say it used to be accurate, but I do not know if it's accurate anymore because that was certainly the perception that I got when I was younger. That I would be thought less of, that I would be thought weaker, I would be less worthy of a human and less deserving of life.

My response still stands. I don't know if that's the case anymore, but I think some people certainly would feel that way, that they would think less of someone if they found out that they had a problem.

I would say that that is not indicative of my current attitude because since I have struggled, I know what it's like. Sometimes if people have overcome mental-health issues, I think more of them because this is a mountain that most people have not have [*sic*] to climb. The fact that they are managing it means that they have put a lot of effort into actually managing it.

Anastasia responded that initially she, too, used to think less of herself because of her

mental-health struggle.

It's a struggle, and so until you really overcome it and you're on the other side, it makes life harder; it gets in the way of doing what you want to do. You start to see yourself as like a different person. When you look in the mirror, you're just like disappointed and ashamed and so, yeah, all that adds up to feeling less than what you felt like before you are diagnosed.

When asked if she felt that way now, Anastasia responded,

No. Because I have really, like, worked through my issues and overcome them. I at least learned to manage them. I think that's how I overcome it. I've been doing this for 10 years, and so before that I was really, it was really hard on me, and I was really ashamed and I did feel really, really bad about myself. I didn't want to tell anybody. I don't want anyone to know because I didn't ... I was afraid that they would think less of me; and then finally when it got out, it just, it wasn't even the worst thing in the world having people think less of me or, I mean, the worst is what we do to ourselves.

I don't even know if they truly did think less of me. I just know that it separated me from a lot of people. If they did, I was like, well, I don't really have time for this. I need to heal. I need to work on myself; so I just stopped thinking about the stigma.

All the participants indicated in some form that they used to think less of themselves, but

that now they experienced some level of acceptance, even pride, that they had worked hard and

overcome struggles. Esme responded this way to the question about whether she thought less of

herself because of her mental-health struggle:

I did in the beginning, but I don't any more. I'm kind of proud of myself for overcoming the amount of ... How forever tell me [*sic*] how much I didn't want to admit that that was happening, and then eventually being able to admit it. It's definitely something that I'm very like ... I still am not that open with other people about it; so I think maybe there's like a little still residual, shame maybe, or maybe it's just discomfort because I don't really like sharing personal details of my life with people in the first place. Mostly I feel like I was brave, and it definitely made me feel like I could face challenges, like I can overcome stuff, because I do things that ultimately I overcame.

To recap, participants reflected on their views and generally explained that they used to think less of themselves because of their mental-health issues. Typically, this perspective was before they sought professional help, or when they first became aware of their mental-health struggles. However, they all now said that they didn't think less, but in fact may think more of themselves. Despite diversity in the types of disorders and the levels of treatment, there was very little variance among the participants as they used similar language to reflect on their past and share the present views of themselves.

Summary of Research Findings

To explore the overarching question, "What are the lived experiences regarding stigma of community-college students who self-identify with a mental-health issue?," I in turn explored the four research subquestions, six themes, and nine subthemes. Overall, the findings from the current study might best be described as confirming that stigma has a significant negative impact on college students that manifests in social distance and painful separations from peers. Navigating the hesitations around admitting the need for help, identifying whom people with mental-health struggles can safely share their struggles with, and dealing with the public's projections that people with mental-health challenges are dangerous or "crazy" all place additional strain on individuals already struggling. As one participant stated, "Stigma is the worst part of having a mental-health issue." Fortunately, based on the evidence from this study, these students feel compassion and empathy for and find support from connecting with others

with similar struggles; and all the participants involved had been able to transform their views of themselves to acknowledge their strengths and reject the stigma.

CHAPTER 5: DISCUSSION

In this study regarding stigma, I focused on the lived experiences of community-college students who self-identified with a mental-health issue. To better understand their experiences and to inquire into other aspects of stigma, I asked the following research questions:

- Question 1: How do students who self-identify with some mental-health issue experience stigma?

- Question 2: What kind of influence does stigma have on these students' willingness to seek help?

- Question 3: How do these students view others who a have mental-health problem in relation to stigma?

- Question 4: How do these students view themselves in relation to stigma?

Each question corresponded to a need for research on the topic of mental-health stigma in the college-student population. In this chapter, I briefly review the findings of my study, address the findings in relation to the current literature, and suggest topics for future research.

Overview of Findings

The interpretative phenomenological analysis (IPA) process is concerned with the lived experiences of research participants and the meaning those participants make from that lived experience (Smith, et al., 2009). For the first research question, "How do students who self-identify with some mental-health issue experience stigma?," three themes emerged from analysis of the participants' responses: social distance, social connection, and social misunderstandings; several subthemes developed within each theme (see Table 1). In brief, being outside the social norm was marked by participants' understanding that they would be seen as different and judged

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negatively if others knew about their mental-health struggles. Participants shared how other

people used negative talk about individuals with mental-health issues, and treated those

individuals as more fragile if they knew of their mental-health struggles. The high-school years

embodied the most difficult, stigma-related experiences for participants, with harsh and painful

peer interactions and experiences. Participants seriously considered whom to trust with their

mental-health information, and often chose to confide in others with similar struggles, or in

people who knew them well. Misunderstanding, ignorance, and information based on

stereotypes contributed to participants' struggles with stigma. Participants shared how

individuals with mental-health struggles, particularly males, are viewed as dangerous and

violent, whereas females dealing with bipolar disorder are seen as "crazy." In addition, they

found that some diagnoses are more stigmatizing than others.

Based on participant responses, we can apply the theme of the negative impact of stigma

to the second research question, "What kind of influence does stigma have on these students'

willingness to seek help?" Several subthemes developed under this theme (see Table 1). In

summary, participants were hesitant to seek help because of the negative images, stereotypes,

and judgments of others. This external pressure was compounded by or may have contributed to

the participants' internal denial that they needed mental-health support. However, some

participants indicated that the internal process of admitting to themselves that they had a problem

gave them the push to seek treatment. This was a difficult process and often involved their

coming to some kind of "breaking point," realizing they could not go on any longer without help.

The study results answer the third research question, "How do these students view others

who a have mental-health problem in relation to stigma?," within the theme of compassion and

empathy for others. Participants expressed empathy and compassion for others with mental-

health struggles, and one participant took action to protect someone struggling with a mental-health issue.

The theme of shedding stigma best summarizes participant responses to the fourth research question, "How do these students view themselves in relation to stigma?" All participants indicated that initially, when they realized they had a mental-health struggle, they did think less of themselves. They felt ashamed or thought of themselves as weak because of that challenge. However, their ideas of themselves in the present were different. Despite having different mental-health diagnoses and treatment histories, students in the current study were proud of themselves for overcoming the challenge of having a mental-health struggle, and they also expressed a more normalized view, that everyone has problems to overcome.

<h3 style="text-align:center">Findings in Relation to Literature</h3>

In this section, I outline my research findings in relation to the literature on the topic of help-seeking behavior and stigma for the college-student population. I further delineate the topic of stigma into perceived stigma and self-stigma, and strategies for decreasing stigma.

Help-Seeking Attitudes and Behavior

Previous research on the help-seeking behavior of college students has focused on increasing our understanding of attitudes about and barriers to treatment (Czyz et al., 2013; Eisenberg, Speer, et al., 2012). Czyz et al. found that, although respondents were at risk for suicide, a majority indicated they didn't think treatment was needed; a smaller proportion preferred to manage problems on their own and mentioned stigma as a reason for not seeking care. In addition, the Eisenberg, Speer, et al. results revealed that a majority of students with untreated depression, anxiety, and suicidal ideation reported low stigma and positive beliefs about effectiveness of treatment; this group included almost half of the students who perceived a

need for help and almost a quarter who did not. Students in the Eisenberg, Speer, et al. study questioned the seriousness of their issues, preferred to handle the issues themselves, believed that their distress was a normal part of the college experience, or reported not having time for mental-health services. In their analysis of the findings, the researchers stated, "Although few students endorse stigmatizing attitudes, a greater number of students may implicitly agree with these attitudes" (Eisenberg, Hunt, et al., 2012, p. 226). Quinn et al. (2009) conducted a mixed-methods study utilizing focus groups and interviews to better understand factors that influence students' disclosure of mental-health difficulties and decisions to seek help, to determine student experiences of support within the university, and to identify implications for improving services to students who are experiencing mental-health problems. A theme of the Quinn et al. findings was that often students expressed a reluctance to seek help for their problems, saying it was hard to admit to themselves and others that they needed help, and that they didn't want to bother other people with their problems.

Finding of the current study confirm that students may have a need for help, but they may be hesitant to utilize professional psychological support. Participants in this study described waiting until their problems and struggles got to a critical point before they sought care, stopping medication out of fear of roommates finding out about their mental-health issues, and not utilizing special-education services in order to avoid being judged negatively by peers. Participants shared that, before they sought help, they felt ashamed and as if they would be looked down on if they did so. Thus, current findings are consistent with existing research. In addition, these findings strengthen the assertion that students may "implicitly agree" with stigmatizing attitudes, at least before they have sought any professional help.

Additional studies have examined the attitudes of students already in treatment. Previous findings by Downs and Eisenberg (2012), in a study that examined help-seeking attitudes of students with a history of suicidal thoughts, indicated that treatment use correlated with perceived need, belief that treatment is effective, contact with service users, lower personal stigma, and higher perceived stigma. Nam et al. (2013) conducted a meta-analysis and found that self-stigma, anticipated benefits, and self-disclosure had the largest effect size on help-seeking attitudes. Self-stigma, defined as a person's own stigmatizing attitudes, was negatively correlated with help seeking and had the largest effect size compared to the other nine variables Nam et al. examined.

The participants in the current study had already sought some kind of professional support and thus represent a demographic similar to that in the Downs and Eisenberg (2012) and Nam et al. (2013) studies. Findings from the current study support previous findings, but also suggest that individuals' attitudes about help seeking and stigma may change in connection with their decision to seek help. Participants in the current study noted they realized they needed professional help, similar to the results Downs and Eisenberg (2012) and Nam et al. (2013) reported. Current participants also explained that at an earlier time they might have held beliefs consistent with self-stigma, but that they had effectively shed those beliefs. In fact, at the time of the study, participants described feeling positive about having sought help and having faced their struggles. They explained that they actually thought "more of themselves (rather than less)," felt proud rather than ashamed, and realized "everyone has problems." One participant stated, "I accept who I am now." The results of the current study support previous findings and also raise the question about how and when student attitudes about help seeking may change. In summary,

the findings of the current study confirm the negative impact of self -stigma, but also suggest that an individual's attitudes may change in connection with seeking help.

Informal help seeking has been examined in earlier research and also emerged in connection with current findings. In the Healthy Minds Study, a majority of student respondents with mental-health problems indicated they received support or counseling from a nonprofessional, from a friend, and from family members (Eisenberg, Hunt, et al., 2013). Drum et al. (2009) also found that, of those students who had seriously considered suicide in the preceding 12 months, a small majority who had confided in other people about their suicidal thoughts reported that telling that first person was helpful or very helpful. Of those who shared their thoughts, the majority were advised to seek professional help by the first person they told. In a study that examined Facebook, Moreno et al. (2011) found that a fourth of the profiles displayed depressive symptoms, and a small portion of these met criteria for major depressive disorder. In addition, profile owners were more likely to reference depression if they averaged at least one online response from their friends to a status update that disclosed depressive symptoms, or if they used Facebook more frequently.

The current study confirms these previous findings regarding help seeking (Drum et al., 2009; Eisenberg, Hunt, et al., 2013; Moreno et al., 2011) and highlights the importance of informal social support. Current participants discussed their connections with individuals and communities that were accepting, including friends, teammates, online communities, and recovery groups. While previous research noted that sharing suicidal thoughts with peers was not always met with a referral to professional help, participants in this study didn't necessarily indicate that they were seeking that type of support from friends and peers. Rather, they discussed how meaningful and helpful it was to feel understood and supported. And they often

experienced positive connections from individuals who were also having mental-health struggles.

Additionally, some participants expressed critical views of some posts on social media. One view participants in the currently study expressed was that, although individuals with mental-health struggles are not likely to share diagnosis-related information on social media, some people who do not have mental-health struggles post messages that include casual and inappropriate references to mental-health conditions.

The current study did not provide results specific to suicidality in connection with help seeking and social support. However, in terms of responding to a peer or friend, participants in the study expressed compassionate views of others with mental-health struggles. For instance, one participant described stigmatizing attitudes as being similar to a hate crime, and others described that they had seen others, including roommates and classmates, impacted worse than them by stigma. Overall, participants of the current study seemed to identify the need for social support and advocacy for individuals with mental-health struggles, with an emphasis on the benefits of sharing experiences and less on referrals to professional help.

On a related note, researchers have used the theory of planned behavior to explore help-seeking decisions of college students (Hess & Tracey, 2013). Specifically, Hess and Tracey examined help-seeking decisions for three different concerns: depression/anxiety, career choice, and alcohol/drug use. One aspect of their findings was that subjective norms, defined as "what others would think of me if I sought help," was the strongest negative predictor of a student's intention to seek help. Similarly, the findings of the current study provide support for the importance of social norms relative to the mental-health experiences of college students. A prominent theme in the current study was that participants thought about social norms and knew

they would be seen negatively if information about their mental-health problems was known. Specifically, they described understanding a) the existence of stigma and negative views of mental-health issues, and of being aware of these attitudes from a young age; b) that deviations from the norm would result in negative views of them; and c) that those negative views might be a reason not to disclose their struggles because the experience would be painful and likely cause others to judge or see them as "other," and to want increased social distance from them. Thus, the current findings confirm the important role of social norms for college students with mental-health struggles.

Stigma

In a study focused on stigma, Aggarwal (2012) utilized a mixed-methods approach to investigate student beliefs and attitudes toward people with health disorders, and the impact these beliefs have on students who specifically have mental-health disorders. Seventy-six students in the health sciences completed surveys, and five students with different mental-health disorders were interviewed. Survey results revealed that individuals with mental-health struggles were generally seen (by others who did not have such struggles) in a negative light and described as somewhat "weak, dependent, incompetent, unreliable, and strange" (p. 39). n the interviews, participants who had mental-health struggles expressed concern about disclosing information to others for fear they would be treated differently, discriminated against, or socially excluded.

Similarly, participant responses in the current study were quite similar to the results in the Aggarwal (2012) study regarding the impact of stigma on students with mental-health struggles. Current participants described in detail their understanding that, if others knew about their mental-health struggles, a) they would be viewed as dangerous, especially if they were male and had a bipolar diagnosis; and b) others would see them differently and desire greater social

distance from them, which might materialize in the form of their not receiving social invitations or their being treated as fragile. Additionally, participants described the impact of negative talk by peers about others with mental-health problems, which in one instance caused a participant to stop taking her medications because she didn't want her roommates to know she had a mental-health struggle. Relatedly, both Quinn et al. (2009) and Martin (2010) both examined student attitudes about seeking the help of university services. In general, the current findings were consistent with the results of those studies in regard to students being hesitant to admit to themselves that they needed help, and their awareness of others' negative views attached to anyone with a mental-health struggle.

The current findings both confirm previous findings and further illuminate the impact of stigma on college students with mental-health struggles (Aggarwal, 2012; Martin, 2010). In particular, the current study provides rich descriptions of participants' deep and painful experiences of having a mental-health struggle. One participant with a significant mental-health history, including inpatient treatment and a diagnosis many years ago, stated that stigma was the worst part of having a mental-health struggle. Another participant described stigmatizing experiences that dated back to elementary years and included never feeling normal because of her struggles and how peers saw her. Several participants described painful bullying experiences prior to college in which peers said on social media that they should kill themselves; another student had had multiple experiences of being seen as "the next school shooter" as a result of people knowing he had bipolar disorder.

Quinn et al. (2009) found that students with mental-health struggles want to able to be more open about their struggles without fear of negative stigma. The current study results strongly support that finding. Participants in the current study also wanted to be able to be more

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open about their mental-health struggles without being judged negatively, or even simply to know who was a safe person to tell and who was not. Overall, participants in the study stated they were likely to share information about their mental-health struggles when they trusted the person and believed the shared information wouldn't change others' opinion of them. Examples they gave included when they needed to explain behavior that might be related to mental-health symptoms, such as their having difficulty coming to class or experiencing a mood swing. Participants were most comfortable with and gained the most support from sharing information with someone else who also had a mental-health struggle.

Although I located no studies that addressed gender- and diagnosis-specific stigma, these areas emerged in the current study. Participants discussed gender and indicated that males and females are seen differently related to mental health, with males likely to be seen as dangerous as a result of their mental-health diagnosis, and females to be overly penalized for emotions and often to be seen as unpredictable and even "crazy.". Additionally, participants explained that males are generally expected to be strong protectors and not to have real emotions, which can make it difficult to admit the need for help. They also described varying levels of stigma attached to different mental-health diagnoses, with anxiety and ADHD having relatively low levels of stigma attached to them, and bipolar and schizophrenia having higher levels.

Perceived stigma and self-stigma. Previous studies have examined personal or self-stigma and perceived public stigma (Eisenberg et al., 2009; Golberstein et al., 2008; Nam et al., 2013). Eisenberg et al. (2009) defined perceived stigma as that which relates to negative stereotypes and prejudices about mental illness held by society, and personal stigma as the application of these stereotypes to oneself. In their meta-analysis, Nam et al. (2013) found that negative beliefs about one's self based on mental health (personal/self-stigma) was associated

with negative attitudes about seeking help; however, perceived stigma was not significantly associated with help-seeking attitudes (Nam et al., 2013). The findings of Eisenberg et al. (2009) indicated that participants generally reported substantially higher rates of perceived stigma than self-stigma. Additionally, a scatter-plot analysis of responses revealed that many students in the study reported high rates of perceived stigma and low rates of self-stigma, but nearly no students reported high levels of self-stigma and low levels of perceived stigma. A majority of participants in the Eisenberg et al. (2009) study endorsed perceived stigma by agreeing with the statement, "Most people would think less of a person who has received mental-health treatment"; but they disagreed with the personal-stigma statement, "I would think less of someone who has received mental-health treatment" (pp. 531–532). Levels of self-stigma responses varied more than those of perceived stigma responses. In addition, self-stigma was associated with a lower likelihood of each measure of help seeking, while higher levels of perceived stigma were associated with a higher likelihood of a perceived need for help, although not with actual use of help.

The findings of the current study seem to support the results of these previous studies regarding strong beliefs about perceived stigma among college students with mental-health struggles. The results of this study provide some confirmation for the notion that perceived stigma is fueling self-stigma. That is, the external societal beliefs in the form of "negative stereotypes and prejudices" appear to be strongly connected to the origin of self-stigma. Individuals in the study seem to have internalized external negative ideas about having a mental-health struggle. Further, an unexpected aspect of the current findings was that participants' perspectives about self-stigma changed. Participants were asked a) whether most people think less of someone with a mental-health struggle, and b) whether they think less of themselves because of their mental-health struggles. All six participants in the current study endorsed the

statement of thinking less of themselves, indicating self-stigma, before they sought treatment or when they initially realized they might have a mental-health issue. However, all participants also described feeling much differently about themselves at the time of the interview, expressing low levels of self-stigma, with some participants stating that they might even think more of themselves.

Strategies for decreasing stigma. Although the focus of the current study was primarily concerned with the experiences of college students with mental-health struggles and did not specifically examine strategies for decreasing stigma, some findings are relevant to the latter topic. First, the current study supports the results from Mann and Himelein (2008), who found that a diagnosis of schizophrenia may translate into higher levels of stigma. The results of the current study strongly support that a diagnosis of schizophrenia tends to have higher levels of stigma attached to it. In addition, the current study found that bipolar disorder may also be associated with a strong stigma compared to other diagnoses.

Eisenberg, Downs, et al. (2012) examined the stigma-related attitudes of randomly assigned roommates, including individuals with and without mental-health struggles. Their research results indicated higher levels of stigma for individuals whose roommates had mental-health issues. A key aspect of the Eisenberg, Downs, et al. (2012) study was that it occurred in a naturalistic setting, with little intervention and no educational components provided. The current study's findings were similar to that study, in that they provided descriptions of interactions between individuals with mental-health struggles and those without, and they offered an account of the impact of those experiences on individuals with the mental-health struggles. The data in the current study collected from individuals with mental-health struggles revealed a theme of negative talk, which was carried out by individuals who did not have mental-health struggles

about those who did have such struggles. The negative talk came in the form of individuals referring to others with mental-health issues as "crazy" and endorsing other negative stereotypes associated with mental-health issues. This negative talk served to warn and even silence participants who had not yet disclosed their struggles of how they would be viewed if their peers knew of those struggles. One participant even described that she stopped taking her medication and withdrew from mental-health treatment after she heard the negative talk from her roommates. These findings support the notion that college students in general need education and guidance regarding the issue of mental health. Like the Eisenberg, Downs, et al. (2012) study, the current study found that in a naturalistic setting students may continue to endorse stigmatizing attitudes, and those attitudes are likely to have a negative impact on individuals with mental-health struggles.

Although I found no specifically related studies in the literature, another component of stigma the current study addressed is the importance of peer support by and for those who have mental-health struggles. Participants in the study gained significant support from peers who were accepting, and primarily from those who also had mental-health struggles. Knowing that other individuals also had a mental-health struggle made the participants likely to trust them and feel safe sharing their experiences. In fact, connecting with peers emerged as one of the participants' most desirable forms of informal help and seemed to reduce the negative impact stigma had on them. The support from peers appeared to be different from the type of help they received from a trained professional: Participants weren't looking for professional help from peers, just for understanding and acceptance.

Implications for Future Research

Several findings from the current study have implications for future research. The first finding is that individuals' views of themselves appear to change from their being ashamed of their mental-health struggles to being much more positive and even being proud. Future research might seek to explore further this change in attitudes related to self-stigma. Additionally, researchers might study this change in attitudes around self-stigma to expand the current understanding in the field about how and when this change occurs, and also how this process might be facilitated and supported. Possible research approaches could be to examine related attitudes when the students exit high school and during the first year of college. Students also might be interviewed to explore their attitudes and even to inquire directly of them how their attitudes about self-stigma have changed. Ultimately, understanding the relationship between this change and their help-seeking decisions could help improve professional strategies to encourage help-seeking behavior. Another possibility for future research would be to explore the developmental or temporal aspects of decreases in self-stigma. For example, research questions might include the following: How is maturity and time from the onset of a mental-health struggle related to self-stigma? What are the factors that seem to be associated with, contribute to, or encourage the attitude change?

The finding that indicates there is a hierarchy of stigma also could be a valuable topic for future research. In particular, future studies might seek to provide a basis for those in the field to better understand the nature of a hierarchy of stigma according to diagnoses. And as part of destigmatizing efforts, future studies might also explore the most effective way to challenge the hierarchy. Possible questions for such research might include these: What are the factors that seem to be contributing to stigma for some diagnoses (schizophrenia and bipolar disorder), and

What are the factors associated with diagnoses associated with less stigma (e.g., ADHD and anxiety)?

Implications for Practice

The results of this study suggest several possible implications for practice for those working in higher education. First, the finding that participants received meaningful support and acceptance from sharing their struggles with others who also had mental-health struggles would suggest the importance of facilitating these types of relationships. The study results support the value of peer programs—including mentorships, support groups, and alternative social gatherings—that seek to connect students who have mental-health struggles. In addition, the finding that at some point individuals my change their negative view of themselves seems to indicate that efforts to connect students earlier in the college years might be productive because these relationships may support the students' transition from having a negative view of themselves to having a more positive, accepting one. The specific links between peer support, changing one's negative view of oneself, and deciding to seek help are unclear, but these processes may be connected or at least may be happening during the same general timeframe of the early college years.

Similarly, the finding of a hierarchy of stigma according to diagnoses has implications for practice. The current study produced findings similar to those of Mann and Himelein (2008), which confirm that educational and destigmatizing efforts should include particular attention to the hierarchy or ranking of the diagnosis. In addition, according to this study, support for individuals with bipolar disorder and schizophrenia should be prioritized because these are among the diagnoses to which the most stigma are attached.

The finding that college-age peers engaged in negative talk about individuals with mental-health issues supports the need for broader dissemination of mental-health information and increased awareness training. This finding is consistent with the findings from past studies that examined stigma-related attitudes (Aggarwal, 2012; Eisenberg, Downs, et al., 2012). Institutions of higher education may want to consider including information about mental-health issues in orientation programs and educational campaigns. A helpful approach might be to incorporate both factual information and material that is experiential and personal. Overall, the current findings indicate that college students could benefit from more guidance and knowledge to draw on when they encounter a peer with a mental-health issue or personally experience a mental-health struggle.

An additional finding with practice implications for higher education is the identified differences participants experienced between high school and college, and the harshness of their high-school years. Practitioners in higher education working with and planning support for students can benefit from understanding the negative experiences students with mental-health struggles are likely to have had in high school, since this context typically is the precursor to college. Findings from this study suggest that students with mental-health struggles are likely to have experienced bullying and other negative reactions from peers if they shared their mental-health information. As a result, when they enter college, these students may be hesitant to disclose their mental-health struggles. This outcome would be consistent with previous studies that found that college students were hesitant to disclose mental-health information even to the university (Martin, 2010; Quinn et al., 2009). In addition, this finding strongly supports the need for students with mental-health struggles in high school to receive appropriate attention at that time through both educational and peer-support programs.

Conclusion

In this chapter, I have reviewed the findings of the current study in relation to my research questions and in relation to existing literature. The current findings regarding the experiences of students with mental-health struggles indicate that they experienced social distance marked by being judged by others and being treated as fragile, negative talk about mental health issues, and bullying during high school. Students also experienced positive support and connection from others who had mental-health struggles, although navigating self-disclosure and the personal decision to seek help were both challenging processes for them. In spite of the impact of others' misunderstandings about mental-health struggles, including negative stereotypes according to gender and diagnosis, students in the study expressed positive feelings, even compassion, for themselves and others who had mental-health struggles. And although it was an extremely difficult process, they were able to shed their own feelings of self-stigma related to the issue of mental-health issues.

Implications for practice from this study include a greater focus on peer support for college students with mental-health struggles, educational programming that provides facts about mental health, guidance for how to talk about mental health, and material that redirects possible hierarchies of stigma. The results of this study also suggest the need for research into the process of the change in attitudes about self-stigma that individuals with mental-health struggles seem to experience, from thinking less of themselves to developing a much more accepting attitude about their own struggles. Finally, future researchers may seek to understand the finding that there might be a hierarchy of stigma connected to particular mental-health diagnoses.

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APPENDIX A: VERBAL-RECRUITMENT CONSENT SCRIPT FOR COMMUNITY-

COLLEGE STUDENTS' EXPERIENCES OF MENTAL-HEALTH STIGMA: A

PHENOMENOLOGICAL STUDY

Hello, my name is Angela Andrade and I am a researcher from Colorado State University in the School of Education. We are conducting a research study on students' experiences of stigma connected to mental health. The title of our project is *Community College Students' Experiences of Mental-Health Stigma: A Phenomenological Study*. Sharon K. Anderson, in the School of Education, is the Principal Investigator and I am the Co-Principal Investigator.

In the study [we would like you to] [you as participants will be asked to] discuss experiences related to stigma in two 45-minute interviews, and to respond to three online messages. The online prompts are expected to take around ten minutes each. Participation in this study will take approximately two hours total. Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty.

We will ask you as students to choose a pseudonym at the beginning of the study to protect your identity. When we report and share the data with others, we will combine all the data from all participants. There are no known risks or direct benefits to you, but you may gain more insight into your own experiences or perhaps think more critically about stigma. In addition, we hope the results of this study will help colleges develop better antistigma strategies. As participants, you will receive a $25 gift certificate from the campus bookstore upon completion of your participation in the study in exchange for you time.

I'm handing out a letter with more information about the study. If you are interested in participating, please contact me. We can schedule a meeting according to your availability. I'm happy to work with you after finals or during the summer.

APPENDIX B: LETTER TO STUDENTS, INTRODUCTION OF STUDY

Dear Student,

My name is Angela Andrade and I am a doctoral student at Colorado State University in the Graduate School of Education distance program. I live and work in Santa Barbara, California. The title of my study is *Community College Students' Experiences of Mental-Health Stigma: A Phenomenological Study*. I am serving as the Co-Principal Investigator under the supervision of Sharon Anderson, my dissertation chair. In my study, I am seeking participants who

- are community college students;

- struggle with some aspect of mental health; and

- are willing to discuss and share their experiences related to stigma.

If you choose to participate in my study, you will be asked to

- correspond via email and provide information about yourself (5–10 minutes);

- participate in two in-person, 45-minute interviews each, approximately 2 weeks apart (1.5 hours);

- respond to three electronic messages during the week between the first and second interviews (10 minutes each, 30 minutes total); and

- review emailed interview transcripts for accuracy (30–45 minutes).

If you are interested and are selected to participate, I will provide you with a $25 gift certificate to the college bookstore at the completion of the study, in exchange for your time. If you are interested in working with me and participating in my study, or if you have any questions, please email me at angela.andrade@ucsb.edu I will email you back asking for some

information about you and provide you with additional information about my study, including a

consent form. All student names will be kept confidential.

Sincerely,

Angela Andrade
Doctoral Candidate
School of Education
Colorado State University
805-450-1309

Sharon K. Anderson, PhD
Professor, School of Education
Colorado State University
970-491-6261

APPENDIX C: CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Colorado State University

TITLE OF STUDY: Community College Students' Experiences of Mental-Health Stigma: A Phenomenological Study

PRINCIPAL INVESTIGATOR: Sharon K. Anderson, PhD, Professor, School of Education, Colorado State University, 970-491-6261

CO-PRINCIPAL INVESTIGATOR: Angela M. Andrade, School of Education, College and University Leadership, doctoral candidate, Colorado State University, 805-450-1309, angela.andrade@ucsb.edu

WHY AM I BEING INVITED TO TAKE PART IN THIS RESEARCH? You qualify for this study because you are 18 years of age or older, are a registered community-college student, and have experienced a mental-health struggle. In addition, you qualify for this study because you are willing to share your experiences relating to mental-health stigma (i.e., experiences you have had in which you have been seen or treated differently because of your mental health).

WHO IS DOING THE STUDY? This research is being conducted by Angela M. Andrade, doctoral candidate, and is being monitored by Dr. Sharon K. Anderson, dissertation committee chair.

WHAT IS THE PURPOSE OF THIS STUDY? The purpose of this study is to explore the lived experiences of mental-health stigma (i.e., being seen or treated differently because of mental-health struggles) for college students at a medium-sized public university.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?
The study will take place in Santa Barbara, California. You will be asked to
- correspond via email and provide information about yourself (5–10 minutes);
- participate in two in-person, 45-minute interviews, approximately two weeks apart (1.5 hours total) at a time and location that is convenient for you;
- respond to three electronic messages during the week between the first and second interviews (10 minutes each, 30 minutes total); and
- review emailed interview transcripts for accuracy (30–45 minutes).

WHAT WILL I BE ASKED TO DO?
You will be asked to
- talk about mental health;
- share experiences of stigma (i.e., experiences you have had in which you have been

Page **102** of **3** Participant's initials _____ Date _____

seen or treated differently because of your mental-health struggles); and
- discuss your decisions to seek help for mental-health struggles.

ARE THERE REASONS I SHOULD NOT TAKE PART IN THIS STUDY?
If you are under the age of 18, you should not participate in the study.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
You may experience some new feelings or thoughts after discussing mental health and experiences of stigma. It is not possible to identify all potential risks in research procedures, but the researcher(s) has(have) taken reasonable safeguards to minimize any known and potential, but unknown, risks.

ARE THERE ANY BENEFITS FROM TAKING PART IN THIS STUDY?
There may be no direct benefit to you, but you may think more critically about stigma as a result of participating in the study. Overall, students with mental-health issues on college campuses may benefit from the study if professionals who administer antistigma programs become aware of the study results.

DO I HAVE TO TAKE PART IN THE STUDY?
Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.

WHO WILL SEE THE INFORMATION THAT I GIVE?
We will keep private all research records that identify you, to the extent allowed by law.

For this study, the researcher will ask you to select a pseudonym so that the only place your name will appear in our records is on the consent form and in our data spreadsheet, which links your name to a pseudonym and your data. The only exceptions to this are if we are asked to share the research files for audit purposes with the CSU Institutional Review Board ethics committee, if necessary. In addition, for funded studies, the CSU financial-management team may also request an audit of research expenditures. For financial audits, only the fact that you participated would be shared, not any research data. When we write about the study to share with other researchers, we will write about the combined information we have gathered. You will not be identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

You should know, however, that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

Your identity/record of receiving compensation (not your data) may be made available to CSU officials for financial audits.

Page **2** of **3** Participant's initials _____ Date _____

CAN MY TAKING PART IN THE STUDY END EARLY?
If you fail to show up to the two interviews and respond to three online prompts, you may be removed from the study.

WILL I RECEIVE ANY COMPENSATION FOR TAKING PART IN THIS STUDY? At the end of the study and upon completion of the two interviews and responses to the online prompts, you will be provided with a $25 gift certificate to the campus bookstore.

WHAT IF I HAVE QUESTIONS?
Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions about the study, you can contact the investigator, Angela Andrade, at 805-450-1309. If you have any questions about your rights as a volunteer in this research, contact Janell Barker, Human Research Administrator, at 970-491-1655. We will give you a copy of this consent form to take with you.

What Else Do I Need to Know?
The researchers would like to audiotape your interview to be sure that your comments are accurately recorded. Only our research team will have access to the audiotapes, and they will be destroyed when they have been transcribed.

Do you give the researchers permission to audiotape your interview? Please initial next to your choice below.

      Yes, I agree to be digitally recorded _____ [initials]

      No, do not audiotape my interview _____ [initials]

Your signature acknowledges that you have read the information stated and willingly sign this consent form. Your signature also acknowledges that you have received, on the date signed, a copy of this document containing three pages.

_____   _____
Signature of person agreeing to take part in the study   Date

_____
Printed name of person agreeing to take part in the study

_____   _____
Name of person providing information to participant   Date

_____
Signature of Research Staff

CSU#: 14-4987H
APPROVED: 4/x/2014 * EXPIRES: 5/x/2015

APPENDIX D: EMAIL THANK-YOU TO NONPARTICIPANTS

Dear _____,

Thank you for your interest in my dissertation study. Because of sampling limitations, I am not able to include you in my study at this time. I appreciate the time you took to email me. If you are interested in my findings from this study, please email me at Andrade-a@sa.ucsb.edu

Sincerely,

Angela Andrade

Doctoral Candidate

School of Education

APPENDIX E: INTERVIEW PROTOCOL/ONLINE PROMPTS: STUDENT EXPERIENCES

OF STIGMA

Interview 1: Semi-Structured Interview Questions

This goal of this project is to gain a better understanding of student experiences of stigma based on mental health. In this interview, I will be asking you a series of questions about mental health, stigma, and your experience relating to stigma.

Mental Health and Stigma

- Why did you choose to participate in this project?

- Can you talk generally about the mental health issues or struggles for which you've sought support?

- How do you define stigma? What experiences have you had when you shared with someone your struggles with mental health?

    Possible follow-up: Some people might see that as stigmatizing, does that fit for you or do you prefer another term?

    Prompt: What words come to mind to describe stigma? Do you prefer another term besides stigma? Do you call it something else?

- What images come to mind when you think about stigma?

Student Experiences of Stigma

- Can you please describe your experiences relating to stigma during your college years?

    o School:

    o Home:

o Church or community:

o Social life:

o Work setting:

- To what degree do you feel you have experienced stigma?

- Over the next 1 week to 2 weeks, you will receive three online messages asking you for a response. The first messages will ask for you any new observations or thoughts about stigma. The second message will ask about stigma in the media. The third message will inquire about the role stigma has played in your decisions to seek help for your mental-health struggles and to tell others about your struggles. The messages will be spread out over the week and will ask you to respond via Survey Monkey. When you respond, please use your pseudonym. During the second interview, we will have the chance to talk more about the online questions.

Interview 2: Semi-Structured Interview Questions

In this interview, we will focus on stigma and help seeking, and on talking about the online prompts.

Continue to explore thoughts and experiences of stigma: Follow up on online prompts.

- In your response to the first online question, you said _____ regarding stigma. Can you tell me a bit more about that?

- In your response to the second question, you said _____ regarding stigma in the media. Can you share more about that?

Explore help-seeking decisions: Follow up on online prompts.

- In the third online prompt, you said _____ regarding how has stigma

  impacted your feelings or decisions about seeking help for your struggles. You also

  said _____ about being hesitant to seek or about putting off getting help.

  Prompts: Can you say more about ways stigma has impacted your decision to seek

  help?

  - What do you think was the consequence or impact √of waiting to seek help? That

    is, did it make a difference, and what was that difference if you waited to seek

    help because of fear of stigma?

  - Were there other reasons besides stigma that you waited to seek help?

  - In what ways has being a [female/male] impacted help seeking for you?

  - In what ways has being of _____ cultural background impacted help seeking for

    you?

Explore perceived stigma and self-stigma.

- How would you respond to this statement? "Most people think less of someone who

  has a mental-health struggle."

  Follow-up question: Why did you respond in that way? What thoughts or feelings do

  you think others have about someone who has a mental-health struggle?

- How would you respond to this statement? "I think less of myself because of my

  mental-health struggle."

  Follow-up question: Why did you respond in that way? What thoughts or feelings

  come up for you when you think of yourself, who has a mental-health struggle?

Online Prompts

Prompts to be sent during weeks 2 through 4 of study, in between first and second interview.

Day 1

- Question 1: What have you noticed or thought about, if anything, regarding stigma related to mental-health struggles over the past week?

Day 4

- Question 2: What have you noticed or thought about, if anything, about stigma related to mental health in the media, including social media, TV, online, and so on?

Day 7

- Question 3: How has stigma impacted your feelings or decisions about seeking help for your struggles?

APPENDIX F: MEMBER-CHECKING EMAIL TO STUDENTS

Hi, _____,

I apologize for the slow response in sending you the transcripts of our discussions. As I mentioned when we met, you have the opportunity to review the transcripts from our meetings and make any corrections. I am attaching the transcribed files for your possible review. If you do make corrections, could you please note them in some way, either with bold, highlight, or by using the track-changes function? Also, could you let me know if you plan to review the transcripts? If you choose not to review them, that's fine. If you do want to review them, can you please let me know if you expect to send them back to me with any changes within about one week? If you need more time, just let me know.

Thank you. Again, I appreciate your time and energy as a participant in my study.

Sincerely,

Angela Andrade