MENTAL HEALTH IN A CAMPUS CONTEXT: A MIXED METHODS APPROACH TO STIGMA AND MENTAL HEALTH KNOWLEDGE

A Dissertation by
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Submitted to the Department of Psychology and the faculty of the Graduate School of Wichita State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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STIGMA AND MENTAL HEALTH KNOWLEDGE

The following faculty have examined the final copy of this dissertation for form and content, and
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DEDICATION

First and foremost, I dedicate this dissertation to my parents, who despite all of the challenges life has presented me with, have never given up on me. To know that you have a support system that is unconditionally by your side in both the good and bad times is invaluable and I would not have had the courage or confidence to pursue my dreams without their love and encouragement. To my brothers, who have always been there to provide a word of advice, challenge me to think in different ways, and put a smile on my face when I need it – thank you for always being there for me. It means more than I can express. To my grandparents, who always believed in me and taught me to go after my dreams (while making sure to have fun along the way). To my fur family, Ralph and Millie, who were a calming presence in the unpredictability of graduate school life and never passed judgment, even in my most stressful moments. At least not verbally. And lastly, I dedicate this to any students on campus currently living with mental illness – you are valued and contribute so much to making this campus special.
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ABSTRACT

The Jed Campus Framework presents a multi-faceted approach to how colleges and universities can provide quality mental health services to their students and enhance the support of the campus community. However, research has suggested that a significant barrier to students seeking help and utilizing on-campus resources is the fear of stigma associated with mental illness. One mitigating factor to stigma is knowledge about mental health-related issues or having personal contact with individuals who have diagnoses. The current study was interested in the levels of perceived public stigma, personal stigma, and mental health knowledge present on campus, which were measured by a survey to students, faculty, and staff to better understand the relationship between these factors. Additionally, focus groups were conducted with students with mental health diagnoses to get a sense of their experiences on campus relating to stigma and how policies and resources could better address their needs. The survey findings suggested that the more mental health knowledge individuals had, the lower their levels of personal stigma. Student focus groups echoed these findings and provided valuable insights for how campus can improve its approach to supporting student mental health.
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Mental Health on College Campuses

The transition from high school to college can be difficult for any student; it is a time filled with newfound independence, responsibility, self-discipline, and uncertainty. In the best of circumstances, students gain the tools to become successful in both their academic and personal lives, but for many young adults, college brings a host of challenges, including new stressors that exacerbate symptoms of mental health issues and lead to negative health outcomes (Kwan, Arbour-Nicitopoulos, Duku & Faulkner, 2016). It also impacts many areas of student life, including their academic success, productivity, coping skills, social relationships, and substance use (Hunt & Eisenberg, 2010).

In recent years, several highly-publicized incidents regarding gun violence or student suicides, including the mass shooting at Virginia Tech and the string of suicides at Cornell University in the mid-2000s have garnered national attention. While these cases highlight the most extreme examples, they serve to bring attention to an issue that does not have the level of awareness it deserves. Beyond the stories in the media, there are many college students that struggle in silence with serious consequences related to untreated mental health issues (Kelly, Jorm, & Wright, 2007). In a 2006 literature review, Mowbray and her colleagues make the case that while the increased media coverage is certainly preferable to none at all, it still has not had the desired effect of creating a more intensive plan for dealing with the issue. Although many campuses have resources for students to utilize, there seems to be a disconnect that is holding
students back from both coming forward with their challenges and using the services they have at their disposal as well as universities taking responsibility for their role in the solution.

Mental health has always existed as a significant issue on college campuses, but it has only been within the past twenty years that colleges and universities have begun to take proper measures to address it (Hunt & Eisenberg, 2010; Eisenberg, Hunt, & Speer, 2012). Studies in recent years have shown that college students are experiencing substantial increases in the symptoms relating to several mental health disorders, including depression (Eisenberg, Hunt, & Speer, 2013). Approximately 75% of all mental illnesses are identified and diagnosed by the age of 24, which suggests that many students may begin to see changes in their mental health during their college years (Kessler et al., 2005; Hunt & Eisenberg, 2010; Eisenberg et al, 2012; D’Amico, Mechling, Kemppainen, Ahern, & Lee, 2016). Another study suggested that 51% of students with mental illness experience the onset of their disorders prior to attending post-secondary institutions, so it is clear that many students are dealing with symptom management concurrently as they adjust to college life (Storrie, Ahern, & Tuckett, 2010).

Additionally, it has been estimated that over 90% of university counseling centers in the United States have reported increases in the number of students seeking out their services (Gallagher, 2009; Czyz, Horwitz, Eisenberg, Kramer, & King, 2013) and that on average there are 1,500 students for every counselor at a university (Wood, 2012). Counselors also face a variety of student issues, including cultural and ethnic considerations, gender, sexual orientation, and stress, in addition to the typical psychological symptoms (Kitzrow, 2003; Mowbray, 2010). Only 60% of post-secondary institutions have psychiatrists on staff, which often puts the responsibility on therapists to refer clients to outside psychiatrists or risk students not receiving additional services they may need, especially medication (Roy & Braider, 2016). It is
encouraging to note that more students are seeking out services, but research has also found that 45% of students that stopped attending college or university due to mental health related reasons had never sought treatment (National Alliance on Mental Illness, 2013). Many universities are orienting themselves to provide care to students who are facing mental health issues, but there are a lack of resources to make this possible for all students wishing to seek out professional help.

While there are several important factors to consider when addressing the topic of mental health, stigma is cited as a substantial barrier to help seeking behavior among college-aged students (Kitzrow, 2003; Eisenberg et al., 2009; Corrigan & Shapiro, 2010; Eisenberg et al., 2012; Lipson et al., 2015). The present study seeks to measure general knowledge of mental illness by students, faculty, and staff and compare the results with measures assessing levels of stigma. Because stigma often becomes a deterrent to students seeking out treatment, it is important to have a deeper understanding of the level and type of stigma currently present.

**Prevalence of the Issue**

Per the National Center for Education Statistics (2016), there are currently 20.5 million students attending college in the United States, of which approximately 25% will live with a mental illness in a given year (NAMI, 2013). In a 2010 study conducted by Hunt and Eisenberg that examined 26,000 students from 70 different colleges and universities, it was found that approximately 44% of undergraduate students and 49% of graduate students used services for their mental health at some point in their lifetime (Drum, Brownson, Burton Denmark, & Smith, 2009). That number drops when they are in college, with only 19% of undergraduates and 21% of graduates seeking out on-campus services. However, a 2006 American College Health Association National College Health Assessment of 95,000 students reported the rates for the
following diagnoses as: 13.4% anxiety disorders, 18.4% depression, 4% anorexia/bulimia, and 4% for substance abuse problems (2007). Compared to their non-college peers, students were more likely to have alcohol use disorders, which is commonly an issue that is comorbid with mental health issues.

When this research is applied to the current Wichita State University campus of 14,500 students, approximately 25% or 3,624 students will be living with a mental illness in any given year. This is not including the number of students who are experiencing mental health-related issues on a less severe scale. Therefore, when upwards of 25% of the population is likely to be diagnosable, it becomes especially pertinent for the issue to be adequately addressed and researched.
The Jed Foundation Campus Program, a nationwide initiative to help colleges and universities better address factors relating to mental health and student success, has developed a Jed Campus Framework as a guide for campuses to utilize. This framework is described by the foundation as “promoting mental health, preventing suicide, and limiting substance use” and cites a number of recommendations for the basis of their various components. The nine separate factors targeted by the framework include: policy, systems, and strategic planning, develop life skills, connectedness, academic performance, student wellness, identify students at risk, increase help-seeking behavior, provide mental health & substance use disorder services, connectedness, and means restriction & environmental safety.
help-seeking behavior, provide mental health and substance use disorder services, and means restrictions and environmental safety.

Policy, Systems, and Strategic Planning

Policy, systems, and strategic planning have a primary concern with how well a campus is equipped to address student needs surrounding mental health, including current university policies, allocation of financial resources to support services for these students, and ensuring that these issues are recognized and addressed campus wide. Many campuses around the country have rules and protections in place to help their students succeed, but have not reviewed and modified them to accommodate the current needs of students. However, it is in their best interest to do so, as mental health funding has been shown to be associated with student retention which ensures tuition money for the universities and higher graduation rates (Kitzrow, 2003; Mowbray et al., 2006). Even if universities do not view mental health as an important issue, there is still a financial incentive for institutions to have adequate campus resources.

Another recommendation for ensuring policies are reflective of the needs of students is to foster communication between students and departments on campus that directly work with issues related to student health (Kitzrow, 2003). An example of this implemented on a broad scale is the state of California, in which the California State universities, University of California campuses, and the California community colleges all worked together to create a system aimed to improve student mental health. With the input of students, a comprehensive effort was conducted to examine the prevalence of mental disorders, what types of services students access most frequently, and how students described their campuses response to mental health-related issues (Sontag-Padilla et al., 2016). Through this effort, students were not only to be a part of the
decision-making process, but could see their input directly being applied to new university and system-wide policies.

In response to many college and university students experiencing both an increase in mental health symptoms and psychiatric episodes (which require immediate medical attention), a Behavioral Health College Partnership was created as a collaboration between 45 colleges and universities and their campus counseling centers on the East Coast. Those working in the psychiatric units at the surrounding hospitals recognized that many students were coming in experiencing suicidal ideations or intensity of symptoms but were often overwhelmed by the adults in the unit with serious mental illness and feelings of isolation increased. By working closely together to focus on the needs of the students, the hospitals and universities were able to establish young adult inpatient units as well as outpatient services, which allowed for college students to have a safe, supportive network of peers who were experiencing the same issues (Roy & Braider, 2016). Beyond the intake unit itself, the partnership helps to provide support for students as they transition back to school and creates individualized treatment plans for them based upon their specific needs. While this a special example that would not be feasible in all college settings, it presents the widespread impact that can be found by implementing a broader, systemic plan to address mental health.

Develop Life Skills

A second component to the Jed Campus Framework focuses on how college students grow into individuals outside of the classroom. The transition from high school to college presents many unique opportunities and challenges to young adults as they attempt to navigate through the new responsibilities and expectations that college life presents to them. While mental health is an issue in both the general population and the college subset, there are different things
to consider with students. Many of the issues that present themselves during this period are the results of “situational crises” that arise as a result of the academic and social environment of college (Mowbray et al., 2006). College is a place for young adults to experience new things and explore areas of interest they have not previously had exposure to. Although this growth is an important part of the university experience, it does not mean this newfound independence will not present challenges for some students as they attempt to navigate their new lifestyle. While some have learned how to find the support they need to make this transition, including professional help, too many eventually find going to college a “risk factor.” These students with major disruption of their lives do not have the totality of their previous support system and resources they did at home and too often do not seek out campus based services.

In a recent study examining the unique impact of stress on the millennial population, it was found that although there are a lot of positive attributes to the younger generation that prepare them well for secondary education, they are at risk for higher academic pressures, overburdened schedules, and lower self-esteem due to the high levels of stress they experience (Bland, Melton, Welle, & Bigham, 2012). The authors cite both smaller family sizes and more highly educated parents equating to their children being more heavily monitored (also called “helicopter parenting”) and experiencing more strict structure to their schedules, which has led to a lack of problem solving and patience skills in millennials, which are both identified as being related to poorer mental health (Bland et al, 2012). In another study, students cited relationships, homesickness, sexual assault, and spiritual concerns as areas that caused them significant levels of distress (Yorgason, Linville, & Zitzman, 2008). There are a variety of life skills that students are learning and balancing during their college years that may be difficult to address if they are struggling with their mental health.
In addition to resources that target aspects of skill building relating to living independently, the Bland et al. study (2012) also discussed the implications that technology and social media have had on the current generation. Researchers believe that overexposure to event negative information and news stories has resulted in trauma inducing experiences for millennials (Bland et al, 2012). Additionally, the high frequency use of websites such as Facebook have been found to contribute to depressive symptoms in users that log several hours (O’Keefe & Clarke-Pearson, 2011). These are important factors for schools to consider, because the current generation has demonstrated their ability to make it through difficult and uncertain times. Particularly in the current political climate and with social media being more commonly incorporated into daily life – even the classroom in some instances – it is important to be able to utilize it as a tool that will positively impact students’ lives, rather than a burden that creates more stress than necessary.

Connectedness

When adjusting to a different lifestyle, newfound independence, and heavier academic workload, social support becomes especially crucial to college students – particularly during their first year when several changes are happening all at once. This area of the framework highlights how social isolation is a significant risk factor for students to develop mental health issues and universities should create a supportive and open environment for all students to have a space where they feel they are part of a community. Many students identify new areas of interest during their time at college or university, so it becomes an opportunity for exploration and exposure to new people. However, when they are dealing with an onset of mental health symptoms and higher levels of stress, socializing with new people becomes more difficult to do. This is critical, because studies suggest that greater increases in social support help to mediate
the impact of stress (Brisette, Scheier, & Carver, 2002). It has been found that during the transition process, many students deal with feelings of isolation and loneliness as they work to adjust to college life. If these issues are not adequately dealt with, students are higher risk for dropping out (Kitzrow, 2003).

One study analyzing student mental health utilization and treatment across 72 different institutions found that when students were required to live in on-campus housing it helped to boost their overall wellbeing by increasing their social interaction with other students and fostering an environment of community and inclusion (Lipson, Gaddis, Heinze, Beck & Eisenberg, 2015). Particularly at larger institutions (defined in this study as those with more than 10,000 students), it was found that on-campus housing helped students feel less intimidated by the size of campus and as though it was more manageable. Additionally, for students living on campus, it was thought to help aid retention rates and increase academic performance because they were more likely to utilize resources on campus and be in an academic environment with other students, especially if the institution had learning communities connected with their student housing (Lipson et al., 2015).

Although not all schools will not have the same access to on-campus housing options for students to utilize, particularly if they are commuter campuses or community colleges, it is still important for them to emphasize feelings of inclusiveness and community. By creating opportunities for study groups and other activities to happen outside of regular class time, this can help build friendships and support networks for students who may do better meeting people beyond the classroom. This becomes especially important when considering students with developing or existing mental health issues, because it can be easy to isolate oneself when struggling with worsening symptoms. However, when students have friends or individuals close
to them who also have mental health-related issues, they are more likely to seek out help and feel support (Eisenberg et al., 2012). Not only do these people help them know they are not alone in their struggles through their shared experiences, but also provide a source of support during tough times.

Another common outlet for students to feel connected to others is through the use of social media. A study of 200 Facebook profiles of sophomore and junior undergraduates found that 25% of statuses contained information consistent with depressive symptoms (Moreno et al., 2011). This study also found that when students engaged in these personal statuses their peers were more likely to post supportive messages and give the statuses more attention. This could be a reinforcer for students to use this type of outlet to share difficulties or negative symptoms they are experiencing, rather than seeking out help from more traditional methods.

**Academic Performance**

Academic performance is another factor students deal with that becomes more difficult as they experience worsening mental health symptoms and newly developed disorders. This includes how students manage their school and class workloads, which can become major sources of stress when they are unable to effectively cope with changes in their mental health. This is not a burden that should lie solely on the students, but is also the responsibility of universities to ensure that instructors, advisors, and administrators are trained to help students work through these issues and provide adequate support. If students are struggling to attend classes and begin to experience academic consequences, this can impact their academic standing, scholarships, and may ultimately cause them to be removed from school because of poor performance. Students who experience significant issues with their emotional health are more likely to have it result in lower grade point averages and increases their likelihood to drop out
(Storrie et al., 2010). They are also at risk for greater levels of test anxiety, lower perceptions of self-efficacy related to their academics, and difficulties with time management (Kitzrow, 2003). Managing stress and fatigue are crucial for academic success, as well as ensuring that they are combating negative coping strategies and instead focus on regular physical activity and sleep schedule (Kwan et al., 2016). When traditional college-aged students are experiencing their first time of independent living away from home and are attempting to balance the demands of school, work, and social commitments, exercise and sleep are two things that will likely be sacrificed.

While students are responsible for balancing their schedules and academic demands, there are additional outside factors that can contribute to difficulties related to their schoolwork. A comprehensive literature review about the topic of mental health on college campuses by Mowbray et al (2006) found that many university faculty members have increasing demands to generate publications and funding, which may take away focus from their students and decrease the amount of support they provide. The review also suggested that increasing class sizes and the hiring of adjunct faculty members further removes the connection between student and faculty members. If students felt more comfortable approaching their professors, it may be easier for them to ask for help, particularly when they are struggling with mental health symptoms. Instead, there appears to be a growing disconnect on many college campuses between students and their instructors. Furthermore, it has been found that in the university setting, psychological disorders are more likely to be viewed as behavioral issues and a lack of engagement with school and classes (Storrie et al., 2010), which highlights the need for faculty and staff to be educated about how to properly address and approach mental health issues students may be experiencing.
Student Wellness

The foundation has identified student wellness as another important factor in their campus framework, which emphasizes the necessity for students to exercise regularly and practice positive health behaviors. By engaging in these protective factors, students are utilizing coping skills that will help aid them when their level of stress raises and help lessen the impact that symptoms of mental health issues may bring about. When students are taught by their universities how to engage in positive health behaviors, it will likely influence their future health and help them to practice various ways to incorporate these tools into their everyday life (Kwan et al., 2016).

The time after high school graduation brings about a number of negative changes in health behaviors by young adults, including increases in tobacco, recreational drug, and alcohol use. It was found that engaging in multiple health risk behaviors such as these puts individuals at higher likelihood for poorer mental health. During this time there is also a decrease in proactive health-related activities, including exercise and healthy eating (Kwan et al., 2016). Young adults who are transitioning to college are often undergoing their first experiences being away from home and having the independence to make their own choices about a number of things, including behaviors impacting their overall health. While some have learned the tools to make the transition more easily, for others, their heightened stress will contribute to depressive symptoms and higher levels of psychological distress.

Identify Students at Risk

Identifying students at risk is another issue highlighted by the Jed Foundation Framework. Many students who are experiencing symptoms from developing mental health
issues are reluctant to come forward or may not even recognize that they should be seeking out campus resources. Under this category, the framework emphasizes the necessity for all those working in college and university settings to be trained to recognize students who may be at-risk for developing psychological disorders. This goes beyond just those involved in the classroom and includes all employees who directly interact with students as part of their jobs. These include individuals who work in the dorms, counselors, academic advisors, and even fellow students who are in positions to help identify those who are struggling.

Women are two times more likely to have depression than men, which is important because the majority of college students (57%) are women (D’Amico et al., 2016; Hunt & Eisenberg, 2010). One study identified additional risk factors which included low socioeconomic status, relationship stress, lack of social support, certain personality traits, minority status, and genetic predispositions for disorders (Hunt & Eisenberg, 2010). This study also found that one in three students were so depressed that it was difficult to function at least once in the previous year and that 10% of students reported that they contemplated suicide.

In addition to demographic indicators, there are certain behavior changes to be mindful of that may be present in students with worsening symptoms or higher rates of emotional or psychological distress. These include things such as poor or failing grades, decreased sociability or social isolation, and decreased emotional or behavioral skills (Kisch, Leino, & Silverman, 2005; Storrie et al., 2010). Beyond educators or school employees, it is also important for individuals to be aware of the warning signs and symptoms of deteriorating mental health. This includes those with a potential diagnosis and their friends, who can help by identifying mood or behavior changes in their friends.
In addition to preparing faculty and staff on campus to help recognize students at-risk, another goal of the JED Campus Framework is to make resources more accessible and visible for students to utilize on their own. This includes providing detailed information about the different treatment options available for students, helping to combat stigma and normalizing the experience of mental illness, and providing information and support to those who may not be in a financial position to get the help they want. By creating a campus atmosphere that is not only supportive and inclusive of students with mental health issues, but provides a variety of resources, educational information, and programs for students to access, colleges and universities are increasing the likelihood for students to take steps to get the help and information they need.

There are several reasons to help understand why students are not utilizing resources available to them on their campuses. For some individuals, the fear of being stigmatized for their mental health issue is enough to prevent them from exploring their options. For others, they are simply unaware of the types of services their individual campus may have to offer them. Past research has found that up to 60% of students on campuses are not able to identify potential mental health services (Yorgason et al., 2008). However, in many cases, students often have to take the first step toward seeking out resources on their campus. For many students, this is not viewed as a simple or straightforward process and there are a number of reasons why this may be the case. While research has suggested that more students have begun to utilize the mental health resources on their campuses with 41% of students surveyed in a 2002 National Comorbidity Survey Replication, and this is a positive statistic, it may also be reflective of the fact that students in recent years are more willing to get help for their symptoms (Hunt & Eisenberg, 2010).
Women, in general, have a higher literacy of mental health-related topics and have been found to be more prepared to explore potential treatment options (Cotton, Wright, Harris, Jorm, & McGorry, 2006; Kelly, Jorm, & Wright, 2007). Females are also more likely to have a positive view about seeking treatment than males, which increases the likelihood that they will take the first steps toward getting the help that they need (Möller-Leimkühler, 2002). This is important to note, because women have been found to be twice as likely as men to be diagnosed with depression, particularly citing feels of worthlessness and anxiety, compared to the aggression and substance use reported by men with the same diagnosis (D’Amico et al., 2016).

Beyond gender, stigma can also play a role in students’ decisions not to seek help. One generalization of mental illness is that it is a sign of personal weakness, which may dissuade students from utilizing mental health services, particularly if it is located in a more visible campus setting (Eisenberg et al., 2009; Kisch et al., 2005; Storrie et al., 2010). Symptoms such as hopelessness and lack of energy may also prevent students from seeking help (Storrie et al., 2010). There are a number of contributing factors that can help explain why students do not seek help, which suggests that to change this, a comprehensive approach would be most likely to meet students’ needs.

_Produce Mental Health & Substance Use Disorder Services_

It is no revelation that arguably the most important component to any campus mental health framework is for the university to ensure that it is providing students with high quality and readily accessible and available services and resources. These include ones that are flexible to meet the wide range of potential issues that students deal with beyond mood and anxiety disorders – such as eating disorders, sexual abuse, issues relating to traumas, LGBTQA, and racial and ethnic minority concerns (Kay & Schwartz, 2010). In addition to being prepared to
meet broad needs, counseling services must have adequate staff to ensure that students are receiving satisfactory services in a timely manner. While these centers often do a good job of providing treatments and counseling for some students, they often do not have professionals trained in dealing with serious mental illness. One major issue that many college counseling centers are facing is the lack of psychiatrists on their staff. As mentioned previously, 40% of all counseling centers do not have a psychiatrist employed in their center, so students must go off campus to receive recommendations for medications (Roy & Braider, 2016). In a broad survey of counseling centers, staff were asked to rate their psychiatric services for students and 32% rated them as “inadequate/non-existent” and 41% rated them as “insufficient” (Kay & Schwartz, 2010). This is a clear indication that universities are not pleased with the services that they are giving to their students and recognize there is a need for change to occur.

In addition to a lack of psychiatrists on staff, those who are employed will often see 2-3 students per hour due to the large demand for their services. Some universities, to help meet these high demands, are employing nurse practitioners to step in and act as psychiatrists (Kay & Schwartz, 2010). It is a crucial piece of mental health services to have a staff member who can recommend treatment and prescribe medications to students who are in need and it is an especially key component to overall treatment to have the collaboration between psychiatrists and therapists. Often, they can work together to identify what treatment approach may be best for an individual and can paint a more in-depth picture of an individual’s symptoms, strengths, and areas to focus on.

Counseling centers must also be make sure that their clinics are flexible in terms of the way they choose to operate their services. Many students attend classes during the day time hours, which does not always leave them with extra time to spare for appointments if the clinics
on campus are only open from typical 9-5 hours. Additionally, many non-traditional students who are more likely to take night classes may have to work during the day. Therefore, counseling centers must reach out to their students to figure out which hours may be most beneficial for them to ensure that students who need treatments are receiving them. Beyond operational concerns, counseling centers must also make sure that they are being flexible with the types of treatments and services they are providing. While it may be difficult for some centers to employ staff that have expertise in different types of therapy, there is such a broad range in the types of issues and therefore adaptability of treatment must be an important goal for on-campus centers. This includes a good relationship and frequent communication between the counseling center and the general student health services on campus. If the centers are not capable of providing the types of services that a student may need, then the campus needs to have a good relationship with several different off-campus resources in the community – while keeping in mind that they must be adequate, appropriate, and affordable for students.

For handling students who have substance use disorders, the JED Campus Framework stresses that students should have access to both assessment and treatment options for any alcohol or drug related issues they may be facing. College is a time where many students are experiencing their first doses of independence and this also means greater access to a variety of substances that they may not have tried before or not had such ease accessing them. According to Kay & Schwartz (2010), an estimated 44% of students engaged in binge drinking in a two-week period, which was associated with several negative outcomes, including missing class and subsequently falling behind in classwork, less time studying, and lower overall grades. It was also estimated that 60% of college binge drinkers meet the criteria for alcohol abuse and 20% met the criteria for alcohol dependence (Kay & Schwartz, 2010). These statistics highlight how
serious of an issue alcohol use can become for college students, particularly because this age group is less likely to seek treatment for their issues, in part because this type of behavior is viewed as “normal” within university culture. For students who are experiencing an increase in negative symptoms associated with a mental health issue, they may turn to alcohol or substances to cope. In a College Alcohol Study that was conducted for three years in the 1990s, it was found that students with poorer mental health met more of the criteria for alcohol abuse (Weitzman, 2004).

One way that college campuses have been dealing with related to their mental health services is an adjustment in their funding models to provide ‘brief therapy’ to their students. By shifting the diagnoses from students from a more “serious” disorder that would require in-depth attention and more regularly scheduled visits and incorporating this new model, schools are attempting to make up for the shortage of psychiatrists on staff by recommending less strenuous and time intensive treatments (Storrie et al., 2010). While counseling center staff may believe they are doing a service to students by getting them treatment, this method is clearly overlooking the seriousness of many students’ diagnoses and may end up worsening symptoms and negatively impacting students’ overall wellness in the long run.

*MMeans Restriction & Environmental Safety*

The ninth and final component of the JED Campus Framework refers to the broader campus community and highlights the necessity for removal of or limited access to means of self-harm for all university students. Research suggests that doing this can result in fewer suicides or accidental deaths related to psychological issues. The framework categorizes things such as weapons, poisonous chemicals, windows, and high buildings all as potential threats to campus safety. Due to the potential prevalence of these materials or environments, it is
recommended that campuses do a thorough environmental scan to ensure that they are making sure proper safety precautions are being met for all students, particularly those at-risk. Considering the new campus carry laws being proposed on college campuses around the U.S., it is important to keep the potential environmental impact of more guns being present, particularly what it may mean for students who are experiencing suicidal ideation.

Suicide is a significant issue for colleges and universities, with a study by Czyz et al. (2013) finding 6% of college students reporting that they had seriously contemplated suicide in the past year, with 1% actually making an attempt. It was also reported that over half of students who reported having suicidal thoughts never sought any sort of treatment, with the National Survey of College Counseling Center directors stating only one-fifth of students with those thoughts were seen by providers at their university (Czyz et al., 2013). Previous research has also supported this notion that individuals with suicidal thoughts are less likely to seek out professional help, often citing “help-negation” as a reason for this. This has been defined as the behavior of refusing or avoidance of seeking out help for suicidal thoughts, often due to the state of helplessness or hopelessness those who are severely depressed may reach when experiencing severe symptoms. These people are believed to often be those who are at the greatest likelihood for suicidal ideation and have more negative outlooks for the future. What appears to be the most important factor for young people to take the next step for seeking help when having suicidal thoughts is for them to recognize that they, in fact, have a mental health disorder that requires treatment (Wilson & Dean, 2010).

The JED Framework and Stigma

The JED Foundation Framework addresses several important issues and considerations relating to a whole person approach toward mental health and suggests various ways these can be
addressed on college campuses. While they all are crucial factors to students’ overall success, it is also important to recognize another major topic relating to mental health – stigma. For colleges and universities to ensure their efforts to promote positive mental health will be well received on campus, there needs to be an understanding of the attitudes and beliefs of students, faculty members, and staff members regarding the issue of mental health (Song-Padilla et al., 2016). If it becomes clear that stigma is prominent, addressing stigma early will better prepare the university community for campus-wide changes (Wahl, 1999).

Stigma

A theoretical framework established by Link and Phelan (2001) was created in response to previous theorizations of stigma that focused solely on how people develop their concepts about various groups of people that have undesirable or unusual characteristics. These initial frameworks included things such as perceived responsibility for one’s mental health condition, the extent to which interpersonal relationships become strained once a condition becomes common knowledge, and if an individual’s condition can be reversed over time (Jones et al., 1984). There was less focus on how these reactions and conceptualizations by the general population impact the individuals who were living with the stereotyped conditions.

In Link and Phelan’s (2001) framework, they lay out common, interrelated instances in which stigma becomes present. They describe people making the connection or beginning to recognize another individual is different from them and therefore label them in a negative fashion. One way this identification happens is through the dominant cultural beliefs and values that are present in a society, which link these labeled individuals to negative characteristics or stereotypes. When this happens, people are inclined to put labeled individuals into a separate category, creating a barrier between the two groups. The main point is to ensure that it is clear
they themselves are not part of the “undesirable” group. From this clear and distinct separation that occurs, those in the out-group begin to experience loss of power and status, which can be in the form of financial, social, and political loss (Link & Phelan, 2001). This labeling or stereotyping of individuals has many negative consequences for those in the stigmatized groups, often based off of inaccurate or fictional information.

Stigma is a word commonly associated with mental illness, but there is no universal consensus about the extent to which it can impact a given individual. For something that is frequently cited as being an important consideration of mental health treatment and help seeking behaviors, it is crucial to understand the various ways stigma can impact mental health consumers. While the word is used as a standalone, there are different types of stigma that are important to consider.

Public Stigma

Public stigma has been defined as general negative stereotypes and prejudices about mental illness (Eisenberg et al., 2009; Livingston & Bord, 2010). A population survey in England examined the concepts related to stigma and found that 55% believed individuals with mental illness could not be held responsible for their own actions, while 63% believed that less than 10% of the population would ever experience mental illness over the course of their lifetime (Angermeyer & Matschinger, 2003). A U.S. literature review that examined stigma and mental health found that individuals in 2006 were 2.3 times more likely to describe someone with mental illness as dangerous as they would in 1950 (Parcesepe & Cabassa, 2013). Another survey of U.S. and UK citizens found that they believed persons with mental illness were unstable, unable to take care of themselves, and irresponsible with their actions (Corrigon & Watson,
2002). Clearly these misconceptions are not only vastly incorrect, but also widely held across Western populations.

In a study conducted on stigma and mental health seeking among the college population, it was found that perceived public stigma was substantially higher than one’s own personal stigma, which suggested that individuals believe the public views mental illness in a more negative light than they personally do (Eisenberg et al., 2009). Universities should be directing their attention toward changing public perceptions as part of their educational mission and to better serve the mental health needs of their students.

Stigma is often discussed in terms of how the public or specific populations view individuals with mental illness, but there has not been as much research done from the perspective of the mental health consumers themselves. In a national study conducted by Wahl in 1999, 1300 consumers participated in a survey, and a subset of 100 completed more detailed interviews, focusing on their experiences of stigma and discrimination related to their mental illness. A primary goal of the researchers was to have the exercise be an empowering experience for those with lived experience to have an opportunity to share their stories. The survey and interviews found that approximately 80% of individuals had heard people making offensive comments toward those with mental illness, with over half reporting it happening ‘often or very often’, while 70% reported being treated as less competent once their illness was known.

Furthermore, 60% stated they had experienced being avoided by others who were aware of their mental health status. Given these figures, an unsurprising 74% stated that they often or very often avoided telling people outside their immediate families about their mental illnesses. Another interesting result was when asked about the main source of stigma, 46% stated “the community”, which was the highest by over 7% (Wahl, 1999). This study highlighted the reality
of stigma experienced by mental health consumers and provides evidence for why many may be reluctant to take the first step toward receiving treatment by disclosing their experiences and risk strangers or colleagues in the community finding out. When asked about potential coping strategies, including recommendations for combating stigma, consumers rated public education (66%), advocacy (44%), and more understanding from the public (39%) as the most effective (Wahl, 1999). Clearly the ideal strategy is involving all members of community and when a given population is as multi-faceted as a college campus, it becomes even more important for success.

Personal Stigma

Stigma can be a major barrier to students’ help-seeking behaviors, but in many cases, particularly among the college-aged, it is even more related to an individual’s own personal stigma against their mental health issues rather than public stigma (Eisenberg, Downs, Golberstein, & Zivin, 2009). Personal stigma is an individual’s own opinions and prejudices against those with mental illness. Higher personal stigma has been found to be positively associated with lower help seeking in both adults and adolescents, which highlights how powerful the perception of mental health can be on a person’s willingness to seek help (Eisenberg et al., 2009; Czyz et al., 2013). It is also related to lower levels of hope, empowerment, self-esteem, and social support (Livingston & Boyd, 2010). Stigma is any form has powerful consequences for the individuals experiencing it, whether it is personal stigma or stigma held at a public level.

Eisenberg et al (2009) found that students with a higher personal stigma were found to be less likely to perceive a need for help, using medications, or using therapy/counseling. These students were also less likely to say they made the initial decision to get help and less likely to
talk with those in academic positions about their mental health. Students who had higher levels of personal stigma were also more likely to be male, more religious and from a lower socioeconomic status. The study also found that students who had high personal stigma were also more likely to have high perceived stigma around the issue, which suggested that their understanding of how the public in general views the issue of mental health was likely to have influenced their personal beliefs (Eisenberg et al., 2009). The researchers suggested that once mental health becomes more widely accepted as a normal issue, the more likely students living with mental illness will be to change their personal stigma and therefore increase their help-seeking behaviors.

A 2010 literature review conducted by Storrie et al. found that many students are afraid to disclose information about their disorders to university services because they were “concerned that their emotional problems might not be understood… and they will be stigmatized by being in emotional distress.” It is a common theme among individuals with psychological disorders to perceive their symptoms or struggles as a sign of personal weakness. The study also found that some of the potential impacts on students from severe emotional stressors include poor academic performance, decrease in the ability to handle emotional and behavioral difficulties, and withdrawal from others. Taking this into consideration, along with a lack of discussion around the issue at many colleges and universities, it creates the impression that mental health is not a topic that is openly shared or commonly acknowledged, which can exacerbate the effects of existing stigma and worsen the symptoms experienced by students.

Further supporting this idea, in an online survey of almost 34,000 students across 39 college campuses in California, it was found that students who viewed their campus culture as supportive of mental health related issues were more likely to use mental health services, both on
and off campus (Song-Padilla et al., 2016). A key component to addressing mental health at universities is ensuring that the issue is openly discussed and students feel encouraged to disclose and share their own personal experiences, not only with their friends, but their campus community as well.

The same literature review also found that individual characteristics are another common contributor to a lack of help-seeking behavior in college students. Students who are under high levels of distress due to their psychological symptoms are less likely to perceive their experiences as unusual or as something requiring additional attention. This is supported by a 2016 study (Kwan et al.), that found that young adults as a whole experience higher levels of stress and psychological symptoms than they did in the past and college students in particular report heightened levels of distress related to their mental health.

**Mental Health Knowledge**

Beyond stigma, another important issue relating to people’s understanding of mental illness is a concept called “mental health literacy.” As defined in a study by Jorm et al. (1997), mental health literacy refers to “knowledge and beliefs about mental disorders which aid their recognition, management, or prevention” (p. 182). This includes facets such as knowledge of how to prevent mental health disorders, recognition of when one is developing, awareness and knowledge of potential treatment options, utilization of self-help strategies for less severe issues, and first aid skills to assist others who may be experiencing a mental health crisis (Jorm, 2012). The higher one’s mental health literacy, the better able they are to understand how to recognize symptoms and seek appropriate help for mental health related issues. People tend to resort to general beliefs or stereotypes to guide decision making and subsequent behavior when they are
confronted with topics of which they are not familiar. It is important that mental health literacy increases.

Research based on Star’s theory (Star, 1957) regarding public perceptions and knowledge of mental illness found that while people struggled to identify mental illness when presented scenarios of someone experiencing symptoms, 9 in 10 people could correctly identify an individual with schizophrenia, while only 3 in 10 could correctly identify someone with depression (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). Participants were also asked about their beliefs regarding the causes of 6 presented mental health conditions, with 90% suggesting that stress was the main cause, apart from alcohol dependence, in which how someone was raised, and drug abuse, was based in a person’s own bad character. This is supported by another study, which found that the public tends to believe that environmental issues are more likely to be significant causes of mental illness than biological ones (Jorm, 2000). This study also found that beyond their own experiences and interactions with mental illness, people’s beliefs tend to stem from media accounts, anecdotes, or more formal sources of information (Jorm, 2000).

The Link et al. study (1999) asked respondents to rate their willingness to interact with individuals who 5 different mental health conditions, including major depressive disorder, schizophrenia, and alcohol dependence. Even major depressive disorder, which had the highest rating of willingness to interact, had 47% unwilling. However, Jorm (2012) found in his study that people do not always refer to depression by its name and sometimes label it as “stress” or a “life problem”, which is consistent with the public’s beliefs about what causes mental disorders. This labeling difference could potentially impact how a person is treated by others, particularly when there are likely preconceived notions surrounding a label of “depression”. This same study
suggested that when an individual is part of a social network that has a higher mental health literacy, they are more likely to facilitate and encourage help-seeking behaviors (Jorm, 2012). Link’s (1999) study also found that 63% of respondents were unwilling to interact with someone diagnosed with schizophrenia and 70% were unwilling to interact with someone who was diagnosed with alcohol dependence, suggesting that people would rather stay away from people with mental health related issues. While mental health knowledge and literacy has certainly improved, there are still many misgivings that contribute to stigma (Link, 1999).

Stigma and Mental Health Knowledge

In the 1999 Surgeon General’s Report on Mental Health, it was determined that one major reinforcer of negative stereotypes about mental health is selective media reporting, which essentially teaches people to stay away with those with mental health related issues (U.S. Department of Health and Human Services). The report also stated that stigma is heightened in rural areas, which makes sense given the smaller, tighter knit nature of those types of communities. Stigma was also found to negatively impact the public’s willingness to pay for mental health treatment (U.S. Department of Health and Human Services, 1999). In the current political climate and with several cuts being made to government funded programs regarding mental health, this makes addressing stigma increasingly important to the wellbeing of millions of Americans.

A 2008 study conducted by Wang & Lai that focused on personal stigma and mental illness found that those who had a familiarity with the issue, whether it was them personally or a family member or close friend, experienced less of a desire for social distance than those who did not have much familiarity. The same study also found that even with participants who had direct personal experience, over 40% rated persons with mental illness as unpredictable, over
20% rated persons with mental illness as dangerous, and 10% believed it was a sign of personal weakness (Wang & Lai, 2008). Despite some level of mental health awareness, it did not totally erase stigmatizing viewpoints. In a similar vein, a study conducted by Link and colleagues in 1999 found that when rating the risk of violence in individuals with various mental health conditions, 33% of respondents rated persons with major depression as being a potential risk for violence, with that number increasing in relation to schizophrenia (61%) and alcohol dependence (71%). While is it encouraging that individuals with personal experience of mental health experience lower stigma, most people do not have this personal experience.

**Current Study**

Mental health is a substantial issue facing many students on college campus, with 25-50% likely to experience a mental health disorder over the course of their college career. The JED Campus Framework sets up a well-rounded model addressing multiple aspects of the issue. However, one significant barrier is stigma. Stigma has a substantial impact on an individual’s decision to be open about their lived experience of mental illness and may also impede their choice to seek help or further treatment for their symptoms. This study will focus on two main components: an assessment of the level of stigma – both perceived public stigma and personal stigma – related mental illness currently present on campus, and general knowledge of mental health.

The goal of the current research is to better understand the level of mental health stigma present on campus at Wichita State among students, faculty, and staff members. The following questions will attempt to be answered by the survey:

1. What is the level of perceived public stigma of mental health on campus?
2. What is the level of personal stigma of mental health on campus?

3. What is the level of mental health knowledge on campus?

4. What is the relationship between:
   a. perceived public stigma and personal stigma?
   b. perceived public stigma and overall mental health knowledge?
   c. personal stigma and overall mental health knowledge?

5. Are there differences between:
   a. perceived public stigma between students, faculty, and staff members?
   b. personal stigma between students, faculty, and staff members?
   c. overall mental health knowledge between students, faculty, and staff members?
CHAPTER II

METHODS

A mixed methodology approach was used to obtain in-depth information about the perceptions and lived experiences of students on campus with mental illness diagnoses. Data collection methods included surveying current students, faculty, and staff and conducting focus groups with current undergraduate students.

Quantitative

Procedure

To determine the level of stigma present on campus, an electronic survey was created and distributed to current students, faculty, and staff. Data was collected from members of these groups, regardless of their status as an individual with lived experience of mental illness. In addition to researching different types of stigma, a knowledge measure was included that assessed how informed each of the respondents were about the topic of mental health and its associated stereotypes. IRB approval was obtained and the informed consent indicated the study was about mental health on campus. Faculty and staff members were contacted via their Wichita State University email addresses, which are available to the public, and sent a link via Qualtrics to the 57-item survey, which included the Discrimination-Devaluation Scale, the Self-Stigma of Mental Illness Scale, the Empowerment Scale, and the Knowledge Test. A sample of students was also recruited via the SONA Experiment Management System. These included those who were currently enrolled in Psychology courses at the university, which was only a small sample of the student population, but still included several hundred potential participants.
Participants

Students

The student sample consisted of WSU students who were currently enrolled in the university at the time of the study. At the time of this study, there were 14,495 undergraduate and graduate students on campus. The only inclusion criteria for students was that they were over 18 years of age. Students received Qualtrics survey links through their university email accounts.

Faculty

The faculty member sample consisted of those in teaching positions, including professors, lecturers, instructors, educational coordinators, and department chairs. At the time of the study, there were 657 faculty members on campus. Faculty members received Qualtrics survey links through their university email accounts.

Staff

The staff sample included those associated with college athletics, the police department, IT, administrative positions, academic advisors, maintenance crew, and campus services, among other positions. At the time of the study, there were 2,198 staff members on campus. Staff members received Qualtrics survey links through their university email accounts.

Survey Instruments

Stigma

Beliefs and perceptions related to stigma of mental illness were measured using validated surveys and items that were modified to reflect a college campus population rather than a broad general population.
Perceived Public Stigma

*Discrimination-Devaluation Scale*

The first instrument used was a 12-item adaption of the Discrimination-Devaluation scale that was originally developed to measure perceptions regarding “mental patients” (Link, 1987; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989).

In the adapted version for this research, the wording was changed to reflect an individual receiving mental health treatment, instead of the “mental patient” that was originally used. For the purposes of the current study, rather than asking respondents to rate the extent to which they thought most people would agree or disagree with the statements in the survey, wording was changed to “At Wichita State, most members of the campus community” in order to reflect the specific population being researched. In addition, certain items were removed from the assessments that used dated or extreme language (i.e. “Most persons with mental illness are disgusting”) and were not deemed relevant to the current population being studied. The same scale used in the original instrument was used in the current study, which was a 6 point Likert scale: *strongly agree, agree, slightly agree, slightly disagree, disagree, strongly disagree*.

*Self-Stigma of Mental Illness Scale*

A second instrument was added to measure perceived public stigma, the Self-Stigma of Mental Illness Scale from the Toolkit for Evaluating Programs Meant to Erase the Stigma of Mental Illness from Illinois Institute of Technology (Corrigan & Shapiro, 2010). The survey is divided into four total sections – stereotype awareness, stereotype agreement, self-concurrence, and self-esteem decrement.
For the purposes of the study, only the first two sections were used, because they reflected the concepts of perceived public stigma (stereotype awareness) and personal stigma (stereotype agreement). The questions from the perceived public stigma section were changed to reflect the format of the Discrimination-Devaluation instrument used. To accomplish this, wording of the 10-item survey was changed from “I think the public believes…” to “At Wichita State, most members of the campus community believe…” The original scale for this assessment was a 9-point Likert scale, so that was changed to reflect the 6-point Likert scale from the Discrimination-Devaluation survey.

**Personal Stigma**

Three assessments were used to measure participant level of personal stigma as it relates to mental illness. There were a total of 26-items on the survey relating to personal stigma.

*Self-Stigma of Mental Illness Scale*

To measure individual’s levels of personal stigma associated with mental illness, the second portion of the Self-Stigma of Mental Illness Scale was used. This was a 10-item survey that reflected the same statements used in the perceived public stigma section, but instead the language had been changed to “I believe…” followed by the ten statements regarding mental illness. Instead of the “I believe” heading, the statements were changed into complete sentences and intermixed with the items from two additional scales measuring personal views of mental illness.

*The Recovery Scale*

The second questionnaire used to measure personal stigma was the Recovery Scale, which was adaptation from the Recovery Assessment Scale. The original scale was 27 items, but
the adapted Recovery Scale is a 13-item assessment of the highest loading factors of the original. This scale was designed to measure perceptions related to mental illness that revolve mainly around the idea of recovery of serious mental illness. These include topics such as goal setting, life beyond an illness, and hope for the future.

**Empowerment Scale**

The third questionnaire examining personal stigma was the Empowerment Scale, also from the Illinois Institute of Technology’s toolkit, consisting of 3 questions. This scale was designed to gain knowledge about “one’s perspective on life and having to make decisions” (Corrigan & Shapiro, 2010). A 9 point Likert scale had originally been used and was changed to reflect the 6 point Likert scale used for the previous instruments.

**Mental Health Knowledge**

Mental health knowledge was measured using the 13-item Knowledge Test designed to assess individual knowledge and attitudes relating to mental health. The measure was initially designed as a true/false assessment intended to measure the effectiveness of a school curriculum unit regarding mental illness and was administered as both pre- and post-tests, but can also be used as a one-time measure of knowledge (Watson et al., 2004). For the purposes of consistency, the current study changed the scale from true/false to the 6-point Likert scale (ranging from **strongly agree** to **strongly disagree**) used with the rest of the assessments.

**Demographic Information**

Participants were asked to respond to four demographic questions which asked about their current status on campus (student, faculty member, or staff member), gender (male, female, transgender male, transgender female, prefer not to answer, and other), race (African American,
Asian, White/Caucasian, Hispanic, American Indian, Mixed Race, Pacific Islander, Middle Eastern, North African or Other), and age.

**Plan of Analysis**

*Descriptive Statistics*

Descriptive statistics will be collected to report rates and frequencies of perceived public stigma, personal stigma, and mental health knowledge and examine means differences. Beyond identifying numbers of students, faculty members, and staff members, these will also identify the percentages of various genders and races included in the sample. This provides an overview of characteristics and will answer the first two research questions, which ask what the levels of perceived public stigma and personal stigma are on campus. Furthermore, this information can be divided among the three participants groups – students, faculty, and staff, which will answer the research questions regarding differences between participant group in scores of perceived public stigma, personal stigma, and overall mental health knowledge.

*Correlation Analysis*

Correlations will help to determine the direction of the relationships between each of the variables and answer three of the main research questions. These include what the relationship is between perceived public stigma and personal stigma, the relationship between perceived public stigma and overall mental health knowledge, and the relationship between personal stigma and overall mental health knowledge.

*Multiple Regression*

Beyond descriptive statistics and correlation analysis, a multiple regression will be conducted to further examine the relationship between mental health knowledge and stigma. For
the purposes of this study, mental health knowledge will be the continuous dependent variable and perceived public stigma and personal stigma will be the independent variables. Analysis will expand on the research questions seeking to understand the relationships between perceived public stigma and overall mental health knowledge and personal stigma and overall mental health knowledge.

Qualitative

Qualitative studies have been suggested to be effective means for getting a deeper understanding of mental health and stigma and get at the underlying processes that connect the two (Clement et al, 2014). Beyond mental health and stigma, focus groups can provide a more in-depth look at several aspects of mental health, including barriers to treatment and help-seeking behaviors (Gulliver, Griffiths, & Christensen, 2010). The current study aims to better understand the experiences of students on campus with lived experience of mental illness and learn what the campus community could be doing better to support them.

Procedures

Participants in the focus groups were recruited through the SONA Experiment Management System and received credits for class as a result of their participation or were found as a result of participation in student organizations focused on mental health. Availability for focus group participation was posted to the SONA Experiment Management System intended for psychology students. Additionally, students were contacted through the list serves of student organizations with an emphasis on mental health-related issues. After signing up students attended focus groups held in the main library on campus. Focus groups were designed to take 60 to 90 minutes in total. Students first read through an informed consent outlining the purpose of the study and participated only after a signature was obtained. It was made clear to
participants that at any time they did not wish to answer a prompt, they were under no requirement to do so and could discontinue participation in the focus group at any time. Each of the focus groups was audio-recorded to accurately capture the answers of the participants and the audio recordings were transcribed.

**Materials**

A focus group guide was prepared using the JED Campus Framework as a frame of reference. A total of eight areas were chosen for emphasis based upon the framework and previous literature, including: prevalence of mental illness, stigma, academic support, stress, overall health, social support, on-campus resources, and existing policies. A total of 15 questions were asked, with 6 utilized as the main questions and 9 questions intended as secondary questions designed to gain deeper insight.

**Plan of Analysis**

**Thematic Analysis**

For the coding of focus group questions, thematic analysis was utilized to create aggregated themes using inductive coding schemes through first order and second order codes. Thematic analysis focuses on analyzing data by looking for commonalities in the data set that create relationships and connections between the data set, while also recognizing the distinctions in the data (Gibson & Brown, 2009). The main focus of analysis is to focus on themes that arise naturally from the data set and compare those themes in relation to the rest of the data (Alhojailan, 2012). During the coding process, the data will first be organized into first order codes, which focus mainly on the aspects of the data that stand out the most, highlighting the most basic themes and concepts present. Second order codes are more in-depth codes, which arise after the data has been interpreted and patterns have been found (Saldana, 2015; Tracy,
During the coding process, the data will first be organized into first order codes, which focus mainly on the aspects of the data that stand out the most, highlighting the most basic themes and concepts present. Second order codes are more in-depth codes, which arise after the data has been interpreted and patterns have been found (Saldana, 2015; Tracy, 2012).
CHAPTER III
RESULTS

Quantitative

Participant Characteristics

Data collection occurred at two separate time periods utilizing different recruitment methods. The informed consent regarding the study informed the participants that they would be completing a survey related to mental health and stigma. The first round of participant recruitment received one hundred seventy-four participants. The second round of surveys were obtained through emails sent to a random sample of 2,500 current students, faculty, and staff at the university during which time the survey was live for 11 days. Five hundred and seven participants completed the survey after being sent initial survey prompts and two follow-up reminder emails for a response rate of 20.3%.
Demographic Information

Demographic information was received for all participants and divided into categories corresponding to the participants’ current occupation at the university: faculty member, student, or staff member. After initial cleaning and screening of the data, the final total of participants was 540. A detailed overview of demographic characteristics is provided in Table 1 below.

Table 1.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>452</td>
<td>84.3</td>
</tr>
<tr>
<td>Faculty</td>
<td>32</td>
<td>5.9</td>
</tr>
<tr>
<td>Staff</td>
<td>52</td>
<td>11.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>176</td>
<td>32.8</td>
</tr>
<tr>
<td>Female</td>
<td>349</td>
<td>65.1</td>
</tr>
<tr>
<td>Transgender Male</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Transgender Female</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>18</td>
<td>3.2</td>
</tr>
<tr>
<td>Asian</td>
<td>52</td>
<td>9.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>35</td>
<td>6.6</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>27</td>
<td>5.1</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Native American</td>
<td>7</td>
<td>1.3</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>380</td>
<td>71.2</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>5</td>
<td>0.9</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Faculty

For the purposes of this study, faculty members were considered those in teaching positions, including tenured, assistant, associate, and adjunct professors, lecturers, instructors, educational coordinators, and department chairs. Faculty members accounted for 5.9% of the respondents, for a total of 32 out of 540 total participants. Sixteen (50%) of the respondents were
male, 15 (46.9%) were female, and 1 (3.1%) preferred not to answer. Twenty-six faculty members (81.3%) were White/Caucasian, 2 (6.3%) were Hispanic, 1 (3.1%) was African American, 1 (3.1%) was Pacific Islander, and 1 (3.1%) selected ‘Other’. The average age of faculty respondents was 51.3 years of age.

Table 2.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>16</td>
<td>50</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>46.9</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>1</td>
<td>3.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>26</td>
<td>81.3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Students

For the purposes of this study, students were considered those currently involved in the university during the time of data collection. Students accounted for 83.7% of respondents, for a total of 452 out of 540 total participants. Three hundred (66.4%) of the respondents were female, 142 (31.4%) were male, 4 (0.9%) selected ‘other’, 3 preferred not to answer (0.7%) 2 (0.4%) were transgender female, 2 (0.4%) were transgender male. Three hundred and eleven students (69.7%) were White/Caucasian, 52 (11.5%) were Asian, 32 (7.2%) were Hispanic, 25 (4.6%) were Mixed Race, 12 (2.7%) were African American, 6 (1.3%) were Native American, 5 (1.1%) were Middle Eastern, 2 (0.4%) were Other, and 1 (0.2%) was Pacific Islander. The average age of student respondents was 24.7 years of age. The results are displayed in Table 3 below.
Table 3.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>142</td>
<td>31.4</td>
</tr>
<tr>
<td>Female</td>
<td>300</td>
<td>66.4</td>
</tr>
<tr>
<td>Transgender Male</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Transgender Female</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>12</td>
<td>2.7</td>
</tr>
<tr>
<td>Asian</td>
<td>52</td>
<td>11.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>32</td>
<td>7.2</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>25</td>
<td>4.6</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Native American</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>311</td>
<td>69.7</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>5</td>
<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Staff

For the purposes of this study, staff members included those in jobs related to college athletics, the police department, IT, administrative positions, academic advising, maintenance, and campus services, among other positions. Staff members accounted for 9.6% of respondents, for a total of 52 out of 540 total participants. Thirty-four (65.4%) of the respondents were female and 18 (34.6%) were male. Forty-three (82.6%) were White/Caucasian, 4 (7.7%) were African American, 2 (3.8%) were Mixed Race, 1 (1.9%) was Native American, 1 (1.9%) was Hispanic, and 1 (1.9%) was Other. The average age of staff respondents was 46.18 years of age.
Table 4.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
<td>34.6</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>65.4</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>43</td>
<td>82.6</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Data Analysis

Descriptive statistics of the data were collected to report rates and frequencies of perceived public stigma, personal stigma, and mental health knowledge, as well as compare mean difference between groups. Both correlation analysis and multiple regression were conducted.

Research Question #1 – What is the level of perceived public stigma of mental health on campus?

The level of perceived public stigma on campus was measured using both the Discrimination-Devaluation Scale, consisting of 9 items and one component of the Self-Stigma of Mental Illness scale, consisting of 10 items which focused on stereotype awareness. There were a total of 19 items for which participants could rate their agreement or disagreement on a 6-point Likert scale, creating a range of scores from 19 to 114 for their overall level of perceived public stigma, ($\alpha = .933$).
The level of perceived public stigma reported by respondents’ scores on the two measures \((n = 530)\) found a moderate level of perceived public stigma \((M = 65.62, SD = 7.97)\) with a Likert \(M = 3.45\). This tells us that participants were only slightly less likely to agree that members of the campus would support the stigmatizing statements, with the Likert mean suggesting more of a neutral stance than anything else. The findings also suggested a large range between scores, with 48 being the lowest reported score of perceived public stigma, which falls just at the boundary of low and moderate levels, and 87 being the highest score, which falls within the high level of perceived public stigma. This suggests that on campus, there people believe there is a moderate level of negative stereotypes and prejudices held about mental illness by members of the campus community.

**Research Question #2 – What is the level of personal stigma of mental health on campus?**

The level of personal stigma on campus was measured using the second component of the Self-Stigma of Mental Illness scale consisting of 10 items which focused on stereotype agreement. A 3 item Empowerment Scale was also used, which was designed to “gain one’s perspective” on the topic. A third measure, the Recovery Scale, measured how individuals viewed the possibility of recovery from mental health-related issues, which included questions about mental health and life beyond symptoms. There were a total of 26 items for which participants could rate their agreement or disagreement on a 6-point Likert scale, creating a range of scores from 26 to 156, \((\alpha = .816)\).

The level of personal stigma reported by respondents’ scores on the three measures \((n = 506)\) found a moderate level of personal stigma \((M = 96.16, SD = 7.21)\) with a Likert \(M = 3.69\). This suggests that participants were slightly more likely to agree personally with stigmatizing statements. The findings also suggested a large range between scores, with 75 being the lowest
score of personal stigma, which is still in the moderate range, and 127 being the highest score, which is well within the high range of personal stigma. This overall score suggests that people on campus have a moderate level of negative opinions and prejudices against those with mental illness.

**Research Question #3 – What is the level of mental health knowledge on campus?**

Total mental health knowledge was measured using the Knowledge Test, which was an educational assessment designed for school-based settings. It contained 13 items used to gain an understanding of an individual’s level of knowledge of mental illness and related topics. Participants could rate their agreement or disagreement with the statements on a 6-point Likert scale ranging from 1 to 6, creating a range of scores from 13 to 78. The assessment was originally true/false, so results were coded according to whether participants disagreed or agreed with a statement and whether or not that statement was true or false. This coding creating a possible range of scores from 13 to 26, ($\alpha = .159$).

The level of mental health knowledge reported by respondents’ scores on the knowledge assessment ($n = 347$) found a moderate level of mental health knowledge ($M = 19.62, SD = 1.34$) with a total score on the assessment at 75.5%. This finding suggests an average level of knowledge about mental health with room for improvement. The findings also suggest a broad range in the scores, with a low score of 14 and a high score of 24 for a total range of 10 out of a possible range of 13. The standard deviation was also high given the limited range of the total scale and both pieces of information give evidence to the amount of knowledge being widely varied across the sample. These findings suggest that on average, people on campus have a moderate level of knowledge about issues relating to mental health.
Research Question #4 – What is the relationship between perceived public stigma, personal stigma, and overall mental health knowledge?

Correlation Analysis

The relationships between perceived public stigma and personal stigma, perceived public stigma and overall mental health knowledge, and personal stigma and overall mental health knowledge were investigated using Pearson correlation coefficients. The results of the correlational analysis presented in Table 5 show one significant correlation. A significant correlation was found between personal stigma and mental health knowledge, $r = -.178, N = 336, p < .01$. This suggests that the higher participant scored on the mental health knowledge measure, the lower their measure of reported personal stigma. There was no significant correlation between public stigma and mental health knowledge, $r = -.067, N = 342, p = .214$ or between personal stigma and perceived public stigma, $r = .047, N = 499, p = .295$.

Table 5.

<table>
<thead>
<tr>
<th></th>
<th>Mental Health Knowledge</th>
<th>Personal Stigma</th>
<th>Perceived Public Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Knowledge</td>
<td>1</td>
<td>-.178*</td>
<td>-.067</td>
</tr>
<tr>
<td>Personal Stigma</td>
<td>-.178*</td>
<td>1</td>
<td>.047</td>
</tr>
<tr>
<td>Perceived Public Stigma</td>
<td>-.067</td>
<td>.047</td>
<td>1</td>
</tr>
</tbody>
</table>

*p < .01,*
Multiple Regression Analysis

A multiple regression analysis was conducted to further examine the relationship between mental health knowledge and stigma. Total mental health knowledge was used as the continuous dependent variable and perceived public stigma and personal were the independent variables. A significant regression equation was found $F(2,329) = 4.973, p < .007$ with an $R^2$ of .029. Participants’ predicted total mental health knowledge is equal to $23.066 - .010$ (perceived public stigma) $- .030$ (personal stigma), where both variables are measured as a sum. Participant’s total mental health knowledge decreased $- .010$ points for each unit of perceived public stigma and $- .030$ points for each unit of personal stigma. Only personal stigma was a significant predictor of total mental health knowledge, $p < .004$. Perceived public stigma was not a significant predictor of total mental health knowledge, $p = .281$.

Table 6.

<table>
<thead>
<tr>
<th>Model Summary$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Personal Stigma, Perceived Public Stigma
b. Dependent Variable: Mental Health Knowledge

ANOVA

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>16.861</td>
<td>2</td>
<td>8.431</td>
<td>4.973</td>
<td>.007$^b$</td>
</tr>
<tr>
<td>Residual</td>
<td>557.789</td>
<td>329</td>
<td>1.695</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>574.651</td>
<td>331</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: Mental Health Knowledge
b. Predictors: (Constant), Personal Stigma, Perceived Public Stigma
Table 7.

<table>
<thead>
<tr>
<th>Coefficients Variables of Multiple Regression Analysis</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>23.066</td>
<td>20.809</td>
</tr>
<tr>
<td>Perceived Public Stigma</td>
<td>-0.010</td>
<td>-0.059</td>
</tr>
<tr>
<td>Personal Stigma</td>
<td>-0.030</td>
<td>-0.158</td>
</tr>
<tr>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
</tr>
<tr>
<td>(Constant)</td>
<td>1.108</td>
<td></td>
</tr>
<tr>
<td>Perceived Public Stigma</td>
<td>0.009</td>
<td>-0.059</td>
</tr>
<tr>
<td>Personal Stigma</td>
<td>0.010</td>
<td>-0.158</td>
</tr>
</tbody>
</table>

Note. Dependent Variable: Mental Health Knowledge

Research Question #5 – Are there differences between perceived public stigma, personal stigma, and overall mental health knowledge between students, faculty, and staff members?

Descriptive Statistics

Descriptive statistics were collected to gain a better understanding of scores between groups on the three main measures: perceived public stigma, personal stigma, and overall mental health knowledge. Scores have been divided into frequencies for students, faculty, and staff.

Perceived Public Stigma

Table 8.

<table>
<thead>
<tr>
<th>Perceived Public Stigma</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>443</td>
<td>48</td>
<td>87</td>
<td>65.89</td>
<td>8.16</td>
</tr>
<tr>
<td>Faculty</td>
<td>32</td>
<td>48</td>
<td>79</td>
<td>64.59</td>
<td>7.13</td>
</tr>
<tr>
<td>Staff</td>
<td>51</td>
<td>51</td>
<td>79</td>
<td>64.08</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Comparisons of participant scores on measure of perceived public stigma were determined. Student scores for perceived public stigma on campus were the highest ($M = 65.89$, $SD = 8.16$) with a Likert $M = 3.46$, faculty scores were second highest ($M = 64.59$, $SD = 7.13$).
with a Likert $M = 3.39$, and staff scores were the lowest ($M = 64.08$, $SD = 6.7$) with a Likert $M = 3.37$. Each of the scores fell within the moderate range for total perceived public stigma, which suggests that each group measured believes that the campus holds some negative stereotypes and perceptions around the topic of mental health. Although the ranges between scores were relatively consistent, students saw the greatest difference, with participant scores as low as 48 and as high as 87 for a difference of 39 points. Faculty members had the next largest range, with participant scores as low as 48 and as high as 79 for a difference of 31. Staff responses had a range of 28, with scores from 51 to 79. Table 9 outlines the divisions of scores for perceived public stigma, which were determined by the standard deviations on either side of the mean.

Table 9.

<table>
<thead>
<tr>
<th>Perceived Public Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
</tr>
</tbody>
</table>

**Personal Stigma**

Table 10.

<table>
<thead>
<tr>
<th>Personal Stigma</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>429</td>
<td>75</td>
<td>127</td>
<td>96.72</td>
<td>7.16</td>
</tr>
<tr>
<td>Faculty</td>
<td>28</td>
<td>81</td>
<td>107</td>
<td>94.43</td>
<td>5.8</td>
</tr>
<tr>
<td>Staff</td>
<td>49</td>
<td>77</td>
<td>111</td>
<td>92.24</td>
<td>7.17</td>
</tr>
</tbody>
</table>

Comparisons of participant scores on the measure of personal stigma were determined. Student scores for personal stigma on campus were the highest ($M = 96.72$, $SD = 7.16$) with a
Likert $M = 3.72$, faculty scores were second highest ($M = 94.43$, $SD = 5.80$) with a Likert $M = 3.63$, and staff scores were the lowest ($M = 92.24$, $SD = 7.17$) with a Likert $M = 3.55$. Each of the scores fell within the moderate range for total personal stigma scores, which suggests that on average most members of the campus community hold some negative stereotypes and perceptions around the topic of mental health. Another noticeable outcome from the results was the large range in scores between each of the groups. Student responses had the greatest difference between their lowest and highest scores, which ranged from 75 to 127 for a total difference of 52 points. Staff member responses had the next largest range, with a low score of 77 and a high score of 111 for a total difference of 34. Faculty member responses had a range of 26, with scores from 81 to 107. Table 11 outlines the division of scores for personal stigma, which were determined by the standard deviations on either side of the mean.

Table 11.

<table>
<thead>
<tr>
<th>Personal Stigma</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Below 89</td>
<td>89-103</td>
</tr>
</tbody>
</table>

**Mental Health Knowledge**

Table 12.

<table>
<thead>
<tr>
<th>Mental Health Knowledge</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>267</td>
<td>14</td>
<td>24</td>
<td>19.55</td>
<td>1.42</td>
</tr>
<tr>
<td>Faculty</td>
<td>30</td>
<td>18</td>
<td>22</td>
<td>19.73</td>
<td>1.11</td>
</tr>
<tr>
<td>Staff</td>
<td>50</td>
<td>18</td>
<td>23</td>
<td>19.90</td>
<td>.953</td>
</tr>
</tbody>
</table>
Comparisons of participant scores on the measure of mental health knowledge were determined. Staff scores for mental health knowledge on campus were the highest ($M = 19.90$, $SD = .953$) with 76.5% on the assessment, faculty scores were second highest ($M = 19.73$, $SD = 1.11$) with 75.9% correct on the assessment, and student scores were the lowest ($M = 19.55$, $SD = 1.42$) with 75.1% correct on the assessment. Each of the scores fell within the same general range for total mental health knowledge as the overall sample, which suggests that most members of the campus community have a similar amount of mental health knowledge. There was a large range between scores for students, with a low score of 14 and a high score of 24, creating a range of 10. The range for faculty was much smaller, with a low score of 18 and a high score of 22, creating a range of 4. Staff also had a smaller range, with 18 being the lowest score and 23 being the highest score, creating a range of 5. There was a smaller total scale for this measure, so the minimum score fell within the low mental health knowledge range and the high score was a near perfect score on the measure. Table 13 outlines the division of scores for mental health knowledge, which were determined by the standard deviations on either side of the mean.

Table 13.

<table>
<thead>
<tr>
<th>Mental Health Knowledge</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Below 18</td>
</tr>
<tr>
<td>Moderate</td>
<td>18-21</td>
</tr>
<tr>
<td>High</td>
<td>Above 21</td>
</tr>
</tbody>
</table>

Discriminant Analysis

A discriminant analysis was run to conduct a multivariate analysis of variance test using three variables as predictors of membership in three groups. Predictors were perceived public
stigma, personal stigma, and mental health knowledge. The groups were students, faculty, and staff members.

The eigenvalues, shown in Table 14, show a moderate correlation (.249) between the three measures and the group membership of the participants. The first discriminant function accounted for 98.3% of the explained variance, suggesting that almost all the between-group variance occurred in that function, while the second discriminant function accounted for only 1.7% of the explained variance. The overall chi-square test was significant (Wilks λ = .937, Chi-square = 21.310, df = 6, p < .005). The Box’s M was significant (.046), but not enough to impact the results.

Table 14.

<table>
<thead>
<tr>
<th>Function</th>
<th>Eigenvalue</th>
<th>% of Variance</th>
<th>Cumulative %</th>
<th>Canonical Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.066a</td>
<td>98.3</td>
<td>98.3</td>
<td>0.249</td>
</tr>
<tr>
<td>2</td>
<td>.001a</td>
<td>1.7</td>
<td>100.0</td>
<td>0.034</td>
</tr>
</tbody>
</table>

a. First 2 canonical discriminant functions were used in the analysis.

<table>
<thead>
<tr>
<th>Test of Function(s)</th>
<th>Wilks' Lambda</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 2</td>
<td>0.937</td>
<td>21.310</td>
<td>6</td>
<td>0.002</td>
</tr>
<tr>
<td>2</td>
<td>0.999</td>
<td>0.378</td>
<td>2</td>
<td>0.828</td>
</tr>
</tbody>
</table>

The structure (loading) matrix of correlations between predictors and discriminant functions, as seen in Table 15 suggests that the best predictors for distinguishing between
students, faculty, and staff are personal stigma (.850) and mental health knowledge (-.562) on the first function and perceived public stigma (.873) on the second function).

Table 15.

<table>
<thead>
<tr>
<th></th>
<th>Function 1</th>
<th>Function 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Stigma</td>
<td>.850*</td>
<td>-0.439</td>
</tr>
<tr>
<td>Mental Health Knowledge</td>
<td>-.562*</td>
<td>-0.116</td>
</tr>
<tr>
<td>Perceived Public Stigma</td>
<td>0.400</td>
<td>.873*</td>
</tr>
</tbody>
</table>

Pooled within-groups correlations between discriminating variables and standardized canonical discriminant functions
Variables ordered by absolute size of correlation within function.
* Largest absolute correlation between each variable and any discriminant function

The results suggest that any variance the moves the total scores higher will be associated with students, as shown in Table 16 which examines the discriminant function scores by group (student, faculty, and staff) for each function calculated. For the first function, students have the highest scores (0.135), followed by faculty (-.301), and staff (-.551). This suggests that the higher scores on this function can be associated with students and the lower scores would likely belong to a faculty or staff member. Because the first function makes up the majority of the explained variance (98.3%), this would likely apply to each of the predictor variables (perceived public stigma, personal stigma, and mental health knowledge). For the second function, staff members have the highest score (.038), followed by students (.004), and faculty (-.106).
Table 16.

Functions at Group Centroids

<table>
<thead>
<tr>
<th></th>
<th>Function</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td></td>
<td>0.135</td>
<td>0.004</td>
</tr>
<tr>
<td>Faculty</td>
<td></td>
<td>-0.301</td>
<td>-0.106</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td>-0.551</td>
<td>0.038</td>
</tr>
</tbody>
</table>

Unstandardized canonical discriminant functions evaluated at group means

Gender Differences

A discriminant analysis was conducted to compare scores on the measures of perceived public stigma, personal stigma, and mental health knowledge between males and females.

Table 17.

Wilks’ Lambda

<table>
<thead>
<tr>
<th>Test of Function(s)</th>
<th>Wilks' Lambda</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.994</td>
<td>1.951</td>
<td>3</td>
<td>0.583</td>
</tr>
</tbody>
</table>

The overall chi-square test was not significant (Wilks $\lambda = .991$, Chi-square = 2.917, df = 3, p = .405), as shown in Table 17. The Box’s M was not significant (.357).
Qualitative

Participant Characteristics

Participants were recruited through the SONA Experiment Management System, where eligibility for participation included those over 18 years of age and those who have a diagnosis of mental illness. Participants were also recruited through the email list serves of on-campus student-run organizations that specifically dealt with the topic of mental health.

Demographic Information

Table 18.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>79</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freshman</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Sophomore</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Junior</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Senior</td>
<td>3</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>10</td>
<td>71</td>
</tr>
</tbody>
</table>

Fourteen undergraduate students participated across three groups, with 79% (n = 11) female participants and 21% (n = 3) male participants. A total of 21% (n = 3) participants were freshman, 15% (n = 2) were sophomores, 43% (n = 6) were juniors, and 21% (n = 3) were seniors. Overall, 71% (n = 10) were White/Caucasian, 21% were African American (n = 3) and 8% (n = 1) was Hispanic. The first focus group consisted of 5 females, the second focus group had 1 male and 5 females, and the last focus group had 2 males and 1 female.
Procedure

Participants were given informed consent outlining the purposes of the study. The researcher was one of two facilitators for two of the focus groups and helped take notes for the third focus group. All facilitators were graduate students with trained research and facilitation experience and had personal experience with mental health-related issues in order to make it a safe environment for students to share their own experiences.

Data Analysis

Thematic analysis was conducted to focus on the major themes from the data using first order and second order coding principles. Each of the three main facilitators of the focus groups were responsible for transcribing and coding of the data rather than relying on computer programs to do so. Due to these processes and that three researchers were involved in the analysis, it ensured inter-rater reliability and allowed for more definitive themes to emerge. Upon closer analysis, secondary themes and more in-depth understanding of the baseline themes were recorded (second order coding) and nine main themes in total were identified from the data. The major themes found were: 1) stigma, 2) coping strategies, 3) policy on campus, 4) symptomology 5) disclosure, 6) social support, 7) treatment, 8) trauma, and 9) prevalence. The frequency of each theme was also recorded to have a better understanding of how often participants mentioned them and how central they were overall.
### Major Themes

![Diagram showing relationships between themes]

#### Table 18.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>65</td>
<td>microaggressions, misconceptions, cognitive dissonance, self-burden</td>
</tr>
<tr>
<td>Coping</td>
<td>50</td>
<td>self-awareness, deliberate alone time, keeping self busy, self-destructive behaviors</td>
</tr>
<tr>
<td>Policy</td>
<td>34</td>
<td>&quot;culture of support&quot;, student transition training, academic-related accommodations</td>
</tr>
<tr>
<td>Symptoms</td>
<td>30</td>
<td>sleep, cyclical, stress, eating habits, impact on routine</td>
</tr>
<tr>
<td>Disclosure</td>
<td>29</td>
<td>self-selection, fear, openness, depends on professor</td>
</tr>
<tr>
<td>Social Support</td>
<td>19</td>
<td>peer support, family support, sense of community</td>
</tr>
<tr>
<td>Treatment</td>
<td>19</td>
<td>medication, Counseling and Testing Center, lack of help-seeking behaviors</td>
</tr>
<tr>
<td>Trauma</td>
<td>8</td>
<td>family relationships, abuse, guilt-based, triggers</td>
</tr>
<tr>
<td>Prevalence</td>
<td>7</td>
<td>common issue, &quot;majority&quot; has experienced something, even if not openly discussed</td>
</tr>
</tbody>
</table>
The most prevalent theme in the data was stigma, with 65 associated mentions throughout the focus groups. It also was the theme that a lot of the subsequent themes stemmed from and were closely associated to, as shown in the figure above. Although stigma was its own separate theme, it was still mentioned or connected to each of the other eight themes in some capacity, which is why it is shown in the middle of the figure. Additionally, the number of connections to stigma made by each of the other themes was counted, to highlight the significance of it as the major theme from the data.

Several points were made throughout the focus groups about the ways in which students felt stigma impacted them. One of these include microaggressions that students felt others often made about the topic of mental illness, whether intentionally or not. Students reported hearing phrases such as “We all feel like that sometimes” or “Oh, I’m so OCD about stuff” which often not only invalidated the experiences of students, but downplayed those who have diagnoses and deal with the associated symptoms. Even if there are not direct comments from others, students also reported the fear of being viewed as “weak” and “lazy” if they fell behind in class or as though they were “attention seeking” if they were to bring up the struggles they were experiencing.

Two additional aspects of stigma that came up, beyond microaggressions and misconceptions or mislabeling by peers, were the cognitive dissonance experienced by students with lived experience and the self-burden that this sometimes created for them. Many students described themselves as high achievers, who often tried to either pretend they did not have any problems or would overcompensate by trying to distract themselves through schoolwork or commitments outside of the classroom. They also cited doubt in needing to seek out
accommodations and figured that they could handle any symptoms or stressors they were experiencing. As one student put it, “I’m not a baby” and many echoed the sentiment that they often heard to “Pull yourself up by your bootstraps”, whether by their peers, family members, or their professors. For students who are used to over-achieving, they said it was sometimes hard not to get caught up in that line of thinking, when they know they are capable of high quality work.

Overall, it was clear that stigma impacted students in a variety of ways, whether it was through the hurtful, throwaway comments they heard on campus about mental illness, the misconceptions of what it was like to live with a mental illness, and the struggle for them to separate stigma from the way they conceptualized and dealt with their own diagnoses. In the subsequent themes, the topic of stigma is still salient and relevant, which further highlights its impact on students and the campus culture in general.

**Coping**

The theme with the second highest frequency ($n = 50$) was concerned with coping mechanisms and the ways in which students talked about managing their symptoms. Many students discussed the importance of having a certain level of self-awareness about when their symptoms were getting worse and practicing “conscious decision-making” to ensure that they took the necessary time to focus on their mental health. In some cases, this meant setting boundaries and not getting over involved in commitments or making sure to get one task done per day. This sense of structure helped them stay focused and feeling good.

Additionally, several students cited alone time as a helpful mechanism to do this, whether that was staying at home, isolating, journaling, sleeping, prayer, exercise, or driving as solo activities that helped them feel better. A few students took the opposite approach and believed
that constantly keeping themselves distracted and busy was the best way to handle symptoms, whether that meant being social with friends, school commitments, work, or volunteering.

Finally, the last area of coping that was brought up included more destructive means of coping. Several students said they used alcohol as a way of helping to numb the intensity of the emotions and symptoms they experienced. One student mentioned that it was a pattern in her family, “…I use substances a lot to avoid my issues. I also just kinda reassure myself that it’s okay because it runs in my family, even though I know it’s not okay. …I don’t want to be like that… It’s like breaking that cycle.” Others said they sometimes gave into their emotions and would purposely “feed” their moods with things they knew would make them feel worse or would engage in negative self-talk and be overly critical of their struggles. While the majority of the time was spent focused on more positive coping mechanisms, students all agreed that it was difficult to not engage in negative types of coping from time to time.

Policy

The third most mentioned theme \((n = 34)\) centered around policies and accommodations currently existing at the university or ones that students would like to see implemented to help them better manage their mental health. A common point that was frequently mentioned was that students would like to see a “broader culture of support” around mental illness on campus and for “tolerance policies” to be a point of emphasis. This meant including students in honest conversations about the types of resources that would most benefit them as well as using research to find best practices to adopt on campus.

Beyond involving students in the conversation, participants brought up a necessity for trainings and orientations around the topic of making the transition from high school to college. Many of them said it would be helpful for administrators to go over various resources on campus
and increase awareness about their options. Beyond trainings for students, it was also suggested that faculty and staff should become more informed about issues their students may be dealing with, because often, they are the ones students turn to in a moment of need or crisis.

Another point related to policy that builds off of faculty awareness includes changing the way mental health is addressed and dealt with in the classroom. Several students pointed out that when they have a physical illness, professors are much more willing to work with them and provide necessary accommodations. However, there is often an “unwillingness” to help students beyond putting information about the Counseling and Testing Center in syllabi. Some suggestions that were made included the removal of strict attendance policies that could negatively impact student grades, adjusting workload or making time accommodations when students were experiencing difficulties with their mental health, and being more aware of instances when students need help.

**Symptoms**

The next most prevalent theme found in the focus groups was symptoms ($n = 30$), which contained a lot of specific difficulties students were dealing with as well as how being a student impacted them. While each of the symptoms mentioned were significant for students, there were some that impacted their day-to-day routine and others that had more long-lasting effects. Some of the less severe symptoms included sleepiness or lethargy, poor eating habits, messiness, lack of concentration, inability to complete schoolwork, feelings of self-doubt, and anxiety.

Beyond disruptors of student’s daily habits, students also cited more serious issues. These included suicidal ideation, self-harm, developing ulcers from extreme stress, visiting the emergency room, panic attacks, and impact on forming relationships with others. For college
students, these types of symptoms could prove difficult to handle while also balancing the rest of their responsibilities.

Another important component of symptoms that is important to note is the cyclical nature of how the symptoms happen and the consequences that arise from them. One student noted, “the second you slip up, you’re immediately punished or in a deficit.” Another made a similar comment by describing the pattern of symptoms as “feeding” one another. Instead of experiencing the effects of one symptom, they often build on one another and can become worse over time.

Disclosure

Another major theme to emerge from the data was disclosure ($n = 29$), which dealt with how students chose to share details relating to their mental illness and who they felt comfortable opening up to. Many students described being selective about the amount they chose to open up about to people and being especially cognizant about being judged for their diagnoses. The majority of students cited their friends as being the people they were most likely to discuss their mental health with. For some, their friends had similar experiences and they chose to be more open with them, but for others, they were much more selective about which friends with whom they were completely honest. Self-selection was commonly utilized in order to maintain the status of their friendships because there was fear that they would be judged for having a mental illness.

Some students took the opposite approach and instead believed that complete openness was the best way to increase understanding. One student said, “I think it was crucial for the people I was closest to actually know what was going on… that was a necessary part of, you know, being able to deal with mental issues is having people that understood there for me.”
any disclosure, students often mentioned that they were always the first one to bring up the issues and take the initial steps to have a conversation, which was not always easy. Others recall being cautioned about how open they should be, with one participant commenting, “When I was diagnosed I was really young, so when it happened I was really excited to tell my friends about it. And my mom sat me down and said, you can’t tell people about it, which I thought was really weird. Cause she grew up in a different time and so the stigma was more there at that time.” So even if students want to be open about experiences, it may be easier said than done.

Beyond personal relationships, another consideration that came with disclosure was how to talk to professors about their symptoms. Some students found it was helpful to be proactive with professors and talk to them right away about their mental health to cover the bases in case anything happened over the course of the semester. Others were more cautious about opening up because some professors simply “shut it down” and had no interest in their students’ personal difficulties or they did not know how to appropriately share details with their instructors when they missed class due to their mental health. There were even a couple of students who did not want to share their emotions at all and did not like people knowing about their personal mental health struggles.

Social Support

Another important theme that emerged from the data was social support ($n = 19$), which was mainly concerned with how students used their social networks, including family and friends, to provide them with support during tough times related to their mental health. Several students cited the importance of peer support, or seeking out friends and confidants that had a shared experience of mental illness. This helped them “find empowerment in shared experiences” and know that they were speaking to people who understood where they were
coming from. One student discussed having a friend group exclusively of individuals with
diagnoses and how they have developed their own sense of community by knowing they can be
completely open without any worry of judgment. As one student explained, “I’m just in this new
wave of empowerment in my life, so I’m just talking to people and my friends and asking – are
you taking your meds and stuff? So, talking to people with similar issues has really helped me a
lot.”

Beyond confiding in peers who also have lived experience of mental illness, students
discussed the importance of relying on their friends, romantic partners, and family members to
help them work through difficult experiences. One reason this is especially helpful is because
these supportive individuals can help identify and recognize impending symptoms or patterns of
behavior, sometimes before they can themselves. A few students mentioned that they have often
have a parent or significant other come to their appointments so that they are clued in to coping
techniques or medication side effects and have all the necessary information to be a good source
of support.

Treatment

One theme that naturally arose over the course of the focus groups was that of treatment
\( n = 19 \) because it was often intertwined with many other aspects of student’s lives. A large
portion of this theme was centered around medications and the positives and negatives that go
along with them. Several students cite medications as helping them be able to effectively deal
with their symptoms, but they also had negative aspects. Some students experienced adverse side
effects, such as weight gain or a flattening of mood and one student said it lessened her
enjoyment for creating art, which she had long used as a method for coping. Others talked about
difficulty keeping a consistent schedule with theirs, either building up resistance or a tendency to
stop taking them once they started feel better until they crashed and had to start the process over again.

When discussing where they sought treatment, several students utilized on-campus resources visited both the student health center on campus as well as the Counseling and Testing Center. They had unanimous success with student health and said that they experienced good support and it was affordable for getting the treatment they needed. There was more of a mixed view of the Counseling and Testing Center, but students overall like its affordability and the variety of services they offered. One of the biggest barriers that students experienced to seeking treatment was simply not utilizing services, even though they were aware of them.

Trauma

One of the more underlying themes that was present in the data was trauma ($n = 8$), which dealt with topics such as negative family relationships, abuse, feelings of guilt, or triggers that led to negative feelings or behaviors. Some students discussed the difficulty in talking to family members about their mental health because their issues either stemmed from treatment by someone in the family or because they did not know how to bring it up and were afraid their families would not be accepting of them. Even after discussing their mental health with family members, many students said it affected the dynamics of the relationships and that family was a large source of stress for them. Students also experienced a large amount of guilt around their trauma or abuse, which made it even more difficult when they had trouble talking about it or confiding in others.
Prevalence

The last theme to arise from the transcripts was prevalence \((n = 7)\), where the majority of the discussion revolved around how big of an issue on campus students perceived mental illness to be and whether or not they believed other students dealt with it. One student observed about mental illnesses, “I think they’re really prevalent, it’s not really talked about as much.” Most students agreed and said they believed that there was a high prevalence and that most students have experienced some sort of mental health-related issue. The most common mental health issues students thought people on campus dealt with were anxiety and depression and that “a lot” of people struggle with symptoms related to them. As to why they believe more students do not speak up or reach out for them, one said “I think that the main reason it’s not talked about much is that people who are experiencing it don’t want to open up and are scared of how people will react.” While the issue was unanimously viewed as common by the participants, it was clear that many students on campus were not being open about their experiences.
CHAPTER IV

DISCUSSION

Mental illness is a prevalent issue across populations, but presents a unique challenge when discussed in the context of college and universities. The purpose of this study was to examine the relationship between mental health and stigma in a college campus community. Two main types of stigma were studied – both perceived public stigma and personal stigma – along with a measurement of overall mental health knowledge. While stigma is associated with mental health regardless of environment, college-aged students have been shown to have the lowest rates of help seeking behaviors, which has been suggested to be related to the stigmatization of the issue (Mowbray et al, 2006).

The current study was intended to gather a full picture of the issue of stigma and mental health as all members of the campus community understand it. This included current students, faculty members, and staff members, who hold a variety of different positions within the university. The information obtained from this study can be used to better inform the administration about what perceptions are held by campus community members about mental health and use this to address gaps in current resources and create policies to better support students with lived experience. Additionally, the focus groups conducted with current students will help to supplement the findings about stigma and mental health knowledge to better understand what the unique experiences are of students with mental health diagnoses.
The theoretical framework for the current study was the JED Campus Framework, which was developed as a national initiative to aid universities and colleges in supporting students with mental health-related issues by approaching the issue from a comprehensive whole-health perspective. Nine total factors were included in the framework, including policy, systems, and strategic planning, develop life skills, connectedness, academic performance, student wellness, identify students at-risk, increase help-seeking behavior, provide mental health and substance use disorder services, and means restriction and environmental safety. While not all nine factors
were specifically addressed in this study, there were still several important findings from this study that touch on many of the items in the framework.

**Policy, Systems, and Strategic Planning**

One major component of the JED Campus Framework that this study provides useful information for is policy, systems, and strategic planning. The emphasis of this area is on existing university policies focusing on support for students with mental illness and ensuring the issue is addressed campus-wide. Not only did this study find moderate levels of both perceived public stigma and personal stigma present among students, faculty, and staff, but it was also evident that this effect was mediated when the individual was more knowledgeable about mental health-related topics. This suggests that if there are policies in place that require training for all members of the campus community about mental health, the level of stigma will go down. Several students in the focus groups echoed the ideas of trainings, with one stating, “I’m pretty sure they had a mental health training [on campus] over the weekend. I went to it with some friends because I think it’s an awesome thing to have those kind of trainings.” This will likely have several positive effects, not only on the campus level, but for students with mental illness feeling safer and more supported.

Additionally, in circumstances where leadership made dealing with student mental health a priority on campus, students experienced increased social improvements and academic performance (Warwick et al, 2008). Students in the focus groups frequently brought up the idea of a “culture of support” on campus, with one students stating that “empathy and understanding” was the most important thing for the university to do to better serve their students. Students made clear the value in being heard and listened to, which is a good place for universities and
campuses to start when they begin to address mental health and how best to serve the needs of their campus community.

*Increase Help-Seeking Behaviors*

Beyond policy change, the JED Campus Framework highlights the importance of getting students to seek out treatment options for any symptoms they may be experiencing. To accomplish this, the model suggests making treatment options visible and accessible to students, educating campuses about mental illness to help combat stigma, and providing financial support and information to students who may not be able to get the care they need. This study found perceived public stigma and personal stigma were moderate in all groups, but highest in students. The study also found that that more knowledge an individual had about mental health, the lower their reported levels of stigma. This suggests that when people are better informed about mental health, they are less likely to apply judgments or stereotypes to individuals who have a mental illness. Previous research has found that students are less likely to seek out treatment and resources if they believe others hold stigmatizing views against mental illness (Wright et al, 2006, D’Amico et al, 2016).

This dangerous labeling of individuals has many consequences for those in the stigmatized groups, because often inaccurate or fictional information is the basis for people’s stereotypes. Therefore, if the higher a campus community rates perceived public stigma, more likely students with mental health-related issues are going to feel as though they are being judged if they seek out treatment. This is especially true for men, who are far less likely than women to report psychological issues than women are, in part because of the stigma not only of mental health, but gender-related norms (Möller-Leimkühler, 2002). Studies have found that once people learn individuals have previously utilized services for mental illness, they become more
likely to rate them more negatively than if they were seeking services for physical illnesses (Vogel, Schetman, & Wade, 2010). Clearly, if there is a general belief that mental illness is negative, especially in a context such as a college campus, it is likely to hinder students from seeking the treatment they might otherwise need. Even perceived public stigma at the moderate level, like was found in this study, is enough to prevent individuals from feeling comfortable taking that initial step to get help.

**Identifying Students at Risk**

Another aspect of the JED Campus Framework related to this study is identifying students who are most at risk for developing mental health-related issues. This portion of the framework emphasized the need for faculty, staff members, and administrators who directly interact with students to be able to recognize warning signs and symptoms for students who may be struggling to cope with worsening symptoms. Fellow students are another important resource for identifying students at risk early, as they will likely have the most face time with those at risk. The findings from this study suggest that those most knowledgeable about mental health also have lower rates of stigma, which suggests that if they encounter another student who is displaying symptoms of mental illness, they will be less likely to judge them and more able to help in a constructive manner. This is easier said than done, because research has suggested that both young adults and older adults struggle with identifying mental illnesses and recognizing symptoms (Kelly et al, 2007). Students from the focus group supported this notion, with one nothing, “I feel like there is a lot of people don’t know…people will describe symptoms of mental health and but they don’t know that it is mental health, if that makes sense. A lot of times people will say, you know, I feel really tired, I’m really exhausted - for a month… and weight loss or weight gain, and things like that, and they’ll talk about it and they don’t identify it as
mental health.” One major way to address this would be to ensure that information is being disseminated to students about mental health symptoms and what warning signs to look like if they experience changes in their mood or behavior or notice changes in others.

This information is also important for faculty and staff to keep in mind, as past research has suggested that both are likely to believe that students who are displaying signs of mental health-related issues are instead not taking their academics seriously and are “problem” students. However, they also expressed a desire to want to work with students in a way that is conducive to their success and the success of the broader institution (Storrie et al., 2010). This study also highlighted the difficulty in achieving this, citing that faculty and staff often overestimate how helpful on-campus resources are for students and often do not seek out additional services beyond that (Storrie et al, 2010). This information further highlights how critical it is to ensure that all members of the campus community are given the basic tools with how to deal with mental-health related issues in order to better serve their students and create a more supportive atmosphere on campus.

**Summary of Findings**

*Perceived Public Stigma*

The levels of perceived public stigma were measured to gain a better understanding of what people on campus believed the general perceptions were about mental illness, including stereotypes and assumptions. It was found that overall, there was a moderate level of perceived public stigma reported by respondents. There was also a broad range of scores, with some individuals reporting scores in the low range of perceived stigma and others reporting scores in the high range. When these numbers are broken down between each group – students, faculty,
and staff – it was found that all groups scored in the moderate range relative to the overall sample. Student scores for perceived public stigma were the highest (65.89), followed by faculty (64.59), and staff (64.08) rating it the lowest.

Differences between males and females were also examined, but were also not significant. Past research has suggested that men, on average, perceive higher rates of stigma than women do (Golberstein et al, 2008), which may be due to women have more direct exposure to the topic than men. This same study also found that younger individuals tend to hold higher levels of perceived public stigma. In the current sample, the average age of students was 24.7 years old, the average age of faculty members was 51.3 years old and the average age of staff members was 46.18 years old. Students also had the highest level of perceived public stigma, which was suggested to be because they are often either having their first exposure to mental illness being on a diverse college campus or they themselves are experiencing symptoms (Golberstein et al, 2008). Therefore, they may be more likely to believe the public in general has the same amount of knowledge that they do on the topic. The first onset of 75% of mental health-related issues occur before the age of 24, which is the average age of the students in this sample (Eisenberg et al, 2009). Therefore, this may help explain why students rated perceived public stigma the highest. One student believed that in order for things to change, “… the majority of people would require a perspective shift.”

This is an important measure for several reasons, including the impact that it has on students with lived experience of mental illness. In Phelan and colleagues (2000) stigma framework, researchers lay out common, interrelated instances in which stigma becomes present. In one example, they describe people making the connection or beginning to recognize another individual is different from them and therefore label them in a negative fashion. One way this
identification happens is through the dominant cultural beliefs and values that are present in a society, which link these labeled individuals to negative characteristics or stereotypes. When this happens, people are inclined to put labeled individuals into a separate category from themselves, creating a sort of barrier or divide between the two groups. The main point is to ensure that it is clear they are not part of the “undesirable” group. From this clear and distinct separation that occurs, those in the out-group begin to experience loss of power and status in social circumstances (Phelan, Link, Stueve, & Pescosolido, 2000). One suggestion from the focus groups about how to combat stigma on campus was “an introduction to college course would benefit issues you might come across…to prepare you for this microcosm you’re about to immerse yourself in. Like, how to be a human 101.” If the university made it a priority to educate students and community members about real issues they may face during their time on campus, people would be better equipped with the information they need to handle difficult situations or at least where to begin the initials steps.

**Personal Stigma**

The levels of personal stigma were measured using to gain a better understanding of the negative stereotypes and assumptions that individuals on campus hold about mental health. The findings suggested that overall respondents had a moderate level of personal stigma. The scores on this measure were broken down between groups – students, faculty, and staff – and it was found that all groups scored in the moderate range relative to the overall sample. Students had the highest scores (96.72) of personal stigma of the groups, followed by faculty (94.43), and staff (92.24). Another noticeable outcome from the results was the large range in scores between each of the groups. Student responses had the greatest difference between their lowest and highest scores, staff members had the second highest member responses had the next largest range and
faculty members had the smallest range of scores. While students had the highest average level of personal stigma, they also had the lowest scores on the stigma scale, which suggests there was not a consistent level of stigma across student respondents.

There was a significant difference found between the scores which suggested that whether a respondent was a student, faculty, or staff member made a difference in the level of personal stigma they held. This is an important finding, because it has implications for how the issue is viewed and dealt with by each of these groups. Previous research has found that university faculty and staff members are likely to believe that students with mental health-related issues have ‘problems’ with behavior and are not properly engaged with their studies (Storrie et al, 2010). In the focus groups, one student commented about their experience, “I had teachers bring my grades down because of my attendance rather than like the content of my work. And I was trying to explain what was going on and they said I either needed a doctor’s note or something.”

Another study also found that there is a likelihood for staff and faculty members to label students as having behavioral issues and attributing their actions to that, rather than symptoms (Warwick, Maxwell, Statham, Aggleton, & Simon, 2008). They also have a lack of understanding of how to deal with students who exhibit symptoms, which is where their personal stigma might come in and they begin to rely on stereotypes and misconceptions to guide how they handle these situations. This was echoed by results from the focus group, with one student observing, “I’ve seen a lot of the stigma come from the professors and not necessarily the students.” While it is reasonable to assume that not every faculty or staff member will come to believe the mental health is a serious topic on campus, if the administration or leadership within
departments on campus make a point of prioritizing student mental health, there can be a shift in the way that it is dealt with.

Personal stigma has also been found to be associated with several factors relating to student outcomes and behaviors. In a study of college students, it was found that when individuals held higher level of personal stigma toward mental illness, they were less likely to perceive a need for help, less likely engage in help-seeking behaviors, and showed a decreased likelihood in use of medications prescribed by psychiatrists (Eisenberg et al, 2009). Not only does this suggest that individuals with symptoms will be less prone to seek out help, but their classmates and friends will also be less likely to show support for these issues and perceive their struggles as not needing professional help. Students experiencing mental health issues are also likely to perceive their symptoms as a sign of personal weakness and an inability to adequately cope with stressors (Storrie et al, 2010; D’Amico et al, 2010). One suggestion a student had to address these generalizations was to change the way information about mental health is presented and make sure it is understood as a medical condition. “… I think that would be a good place to start. To kind of make it, or legitimize it as a proper disease or illness or disorder or whatever. Because a lot of people think, oh, that’s just mental. Nope, it’s literally up there, the thing that controls everything else in your body. For whatever reason, people separate brain from mental [health].” These are all important things to consider, because students are often tasked with making the first step toward seeking treatment, especially because the onset of these issues occurs during their college years (Mowbray et al, 2006). If they are in an environment that does not have a positive view of mental illness, this further impedes their likelihood of seeking out help for their symptoms or even disclosing their struggles to their social network.

_Mental Health Knowledge_
The level of total mental health knowledge was measured to gain a better understanding of individual’s level of knowledge around topics relating to mental illness. The findings suggest that overall respondents had a moderate level of mental health knowledge. Similar to both of the stigma measures, there was also a large range between scores. There was a smaller total scale for this measure, so the minimum score fell within the low mental health knowledge range and the high score was a near perfect score on the measure.

The scores on this measure were broken down between groups – students, faculty, and staff – and it was found that all groups scored in the moderate range. Staff members had the highest scores (19.90) of mental health knowledge of all the groups, followed by faculty (19.73), and students (19.55). There was a significant difference found between the scores which suggests that whether a respondent was a student, faculty, or staff member made a difference in the level of mental health knowledge they had.

Although students had the lowest level of overall mental health knowledge, they also had the greatest variance between their score ranges, with participants scoring as low as 14 and as high as 24, making for a 10-point difference. Gender differences were also examined, but there were no significant differences found between the scores of male and female scores on the mental health knowledge measure. Previous research has suggested that women typically have a higher level of mental health literacy and were less prone to using stereotypes when assessing situations relating to mental health (Cotton et al, 2006, Kelly et al, 2007).

Mental health knowledge is an important consideration because previous research supports that notion that the greater one’s knowledge about mental illness, the more likely they are to recognize symptoms both in themselves and others (Jorm, 2012). People will often use stereotypes and generalizations when confronted with an issue they are unfamiliar with, but this
becomes especially detrimental on college campuses where students have less privacy about their struggles or the services and resources available for them to seek out. Students agreed with this notion about using stereotypes because of lack of knowledge, saying “but I think it’s more of people don’t exactly know, they’re not informed about mental health problems.”

One study found that when an individual is part of an environment with strong knowledge of mental health, they are more likely to support others to seek out services and help them to do so (Jorm, 2012). Another study suggested that greater mental health knowledge leads to higher rates of acceptance of others with mental illness (D’Amico et al, 2016). Students in the focus groups also cited the importance of their social support system being well informed, “I think it was crucial for the people I was closest to to actually know what was going on. And if I had a breakdown or an episode, then they wouldn’t just, you know, be kind of freaked out by what was happening, they would understand. And, it’s really helpful to know that they understand what’s happening, so they’re gonna be there if you, you know, have a breakdown. So, I think that was a necessary part of, you know, being able to deal with mental issues is having people that understood there for me.” It is encouraging that presently on campus, there appears to be a moderate level of knowledge about mental health, but with an increase in knowledge, the atmosphere could prove much more supportive for students.

**Relationship Between Variables**

Beyond examining variables individually, it was also important to examine the relationship between stigma and mental health knowledge more in-depth, as previous research has suggested an influence on one another. The results found a significant negative relationship between personal stigma and mental health knowledge, which suggested that the less knowledge an individual had about mental health, the higher their scores on the measure of personal stigma.
Previous research has suggested that the amount of knowledge an individual has about mental illness will ultimately impact how they view their issue, including the amount of stigma they hold toward it. When the public is presented with information about mental illness, they tend to rely on stereotypes to guide how they interpret this information (Corrigan, 2004). Therefore, when participants were presented with statements such as “Most people on campus view people with mental illness as untrustworthy”, they rated their agreement or disagreement with these statements based on how they believe mental illness is generally viewed by the public. Research has also provided evidence to show that it is not just stereotypes, but also a genuine lack of understanding of symptoms. A study conducted by Link et al (1999) found that only 30% of participants could correctly identify someone with depressive symptoms, but 90% could correctly identify someone with schizophrenic symptoms. So, it is not always a complete lack of knowledge, but the type of information people know about can be selective based on how they get it. The media has been found to typically only present mental illness in a negative light, which means for people who never have personal exposure to the issue, this is where their education is coming from (Byrne, 2000).

A study of almost 50,000 students, faculty, and staff from the California university systems assessed the current campus mental health climates of each of their universities. It was found that when students reported their campuses as more supportive of mental health issues, they were more likely to use the on-campus services provided to them (Song-Padilla et al, 2016). This not only suggested that the supportive environment was more aware of the issue, but also did a successful job of communicating resources and information to their students. The results from this study clearly support the notion that more knowledge reduces stigma, so a good venue to address this problem would be through the local media or campus-wide campaigns for an
educational setting such as the one used in this study. Students in the focuses groups also stated that education was an important component in changing the conversation around mental health on campus, “I think that sharing statistics will allow for students to be aware of how common it is. I think that’s something to think about. How much we don’t talk about students’ struggle.”

The study of California campuses noted that many of the universities utilized various trainings for students, faculty, and staff to learn more about mental health and the appropriate steps to take when supporting others who are dealing with symptoms (Song-Padilla et al, 2016). This interaction and engagement between students, faculty, and staff and the emphasis on training is especially important with growing class sizes and the increased use of adjunct faculty members, who often do not have the same number of opportunities to connect with their students (Mowbray et al, 2006). In addition to trainings, the use of on-campus social norms campaigns has also highlighted as a useful technique to engage conversation over the issue, while simultaneously educating people about important information (Song-Padilla, 2016; Storrie et al, 2010; Eisenberg et al, 2006; Corrigan, 2004; Weschler et al, 2003). There are a variety of effective means being utilized at different institutions, but the main cornerstone of these initiatives is the focus on educating the populations. There will not be a change in attitudes and perceptions around mental illness if people are not engaging in meaningful dialogues and learning how they can recognize and support the mental health of themselves and others. Students in the focus groups agreed, “But as far as actually how fixing a lot of this stuff goes – you can’t make everyone sit through mental health trainings, it isn’t going to change everything. All you can really do is start the conversations with people.”

There was not a significant relationship found between perceived public stigma and personal stigma and findings on the relationship between these two measures has been mixed. In
their study of stigma and help-seeking behaviors, Eisenberg et al (2009) found that people’s level of perceived public stigma was much higher than their ratings of personal stigma. They also found that it was unlikely for students to hold high personal stigma and low perceived public stigma. These findings were also echoed in a study by Pederson & Paves (2014), although they also found that personal stigma was more associated with less favorable attitudes toward treatment. In the current study, the averages were more in the moderate range for both measures, although students did have a broader range of scores than any other group, suggesting that there may have been some discrepancy between their scores on perceived public stigma and personal stigma. One difference that may be notable is that in previous studies examining perceived public stigma and personal stigma, the researchers framed public stigma as “Most people” rather than concentrating specifically on the university population. In the current study, participants were asked to rate how much they believed “Most members of the campus community at Wichita State” would agree or disagree with the statements. Therefore, respondents had a much narrower scope for where they were applying the prompts. Participants in the other studies may have been thinking much more broadly, which could have impacted their ratings.

**Implications**

There were numerous findings in this study, many of which are important considerations for college campuses to address when they make policy changes and decisions around the topic of mental illness. Although there are currently steps in place to provide support to students dealing with this issue, such as on-campus counseling centers, mental health has to be addressed at a broader, systemic level if there is any hope of combating the stigma that still exists around this issue. Many topics in the JED Campus Framework align with areas these findings could be used to direct change.
The most salient finding of the student was that there is a direct relationship between personal stigma and mental health knowledge, which suggests that the more education the university provides its population about mental illness, the less likely they will be to label or stereotype individuals with diagnoses. If policies were created that require trainings not only for faculty and staff, but provided information for students about mental health challenges they may experience during their time in college, campuses would be better equipped with the tools to make the environment more inclusive, supportive, and aware. Beyond trainings, the current policies and practices should be reviewed alongside students with lived experience of mental illness to ensure that they are relevant, up-to-date, and comprehensive enough to accommodate the needs of students with a variety of diagnoses and symptoms. Not only will this help students maintain better mental health, but they will be more engaged and successful members of the campus community. Finally, time and energy should be put into making the campus more inviting and inclusive to students with mental illness. If social norms campaigns were created to help foster an environment that celebrates mental illnesses as strengths and breaks down misconceptions and addresses how microaggressions can be harmful and invalidating to students with diagnoses.

Additional aspects of the framework focused on both increasing help seeking behaviors in students and identifying students at risk, which would be accomplished in many ways by the previous examples designed to tackle and reassess university policies on campus. By providing education and training opportunities to all members of the campus community, it is not only reinforcing that the issue itself is important, but that it is normal and okay to seek out services if one is experiencing difficulties with their mental health. There are existing student run initiatives on campus that are designed to provide safe and supportive environments for students to share
their stories and find empowerment in knowing that they are not alone in their struggles. While this is encouraging, it is also something that the university administration should recognize and provide additional support and funding towards. Not only do these groups and activities help provide a positive outlet for students, but they relieve some of the burden on the counseling and health centers by providing another means for students to receive the support and help that they need.

Limitations

The current research was conducted with a focus specifically on the college population and while the information presented was asking more generally about mental illness, it still asked participants to consider how they believed other members of the campus community would feel about the various prompts or statements in the survey. The study made an attempt to receive feedback from all relevant stakeholder of the campus community and therefore those surveyed made up a broader audience than just students, but this information may not be generalizable to the regular population because it was presented in the context of an educational setting.

Additionally, the research may have been impacted by the fact that no operational definition for the term “mental illness” was presented at the beginning of the survey for individuals to keep in mind as they answered the various prompts. This was done intentionally, because the researchers wanted respondents to be using their own concept and understanding to guide their decision-making over the course of the survey process. However, this may have accounted for people answering the prompts using vastly different ideologies about what topics and considerations constitute mental illness and therefore may have influenced some of their responses.
Demographic information was collected from each of the participants, including their gender identity, race, classification on campus, and age. However, no information was collected regarding students’ majors or the departments in which faculty and staff members worked on campus. Depending on which department or field individual respondents work or study in, they could have varying rates of exposure to topics such as mental health and stigma and therefore may be answering questions coming from different levels of knowledge around the main topics of interest. It would be reasonable to assume that an individual studying or working in the Psychology or Public Health department would likely have more of an understanding of the topics in the survey than someone in Physics or Engineering. Another consideration relating to demographic was that almost two-thirds of the respondents were female, which may be explained by previous research that suggests that women are both more likely to exhibit positive behaviors toward help-seeking as well as be diagnosed with mental health disorders (Mackenzie et al., 2006). Due to these reasons, women may have been more open to taking a survey about mental health than men were.

Additionally, there was no question on the survey that asked individuals about any personal lived experience they may have to the issue of mental health or any prior exposure they have had through a friend or family member with lived experience. Similar to choosing not to operationally define “mental illness”, not asking about an individual’s exposure to the topic was a conscious choice by the researchers. The major goal of the survey was to create a picture of what mental health and its associated stigmas looked like on campus and this campus community naturally consists of people with and without mental health diagnoses. By asking people to disclose this information, it was not giving us additional information on the measures we were looking to study, but may have provided insights to why people answered the way that they did.
Looking at the focus groups, because there were different gender, group size, and age dynamics through each of the groups, it may have impacted how students chose to answer the prompts depending on their level of comfort with the other group members. Furthermore, because the researcher was one of the facilitators, it may have impacted how students chose to answer.

Future Research

Examining this topic moving forward, there are additional components that could yield meaningful results about how the topic of mental health and stigma are conceived and understood on college campuses. One of those includes one’s personal exposure to mental illness in their own life. Individuals will likely have some sort of experience with the issue and it would be useful to understand how these prior interactions helped to inform how they feel about mental illness and whether it changed their perceptions in a positive or negative way.

Additionally, while this study expanded the scope beyond just student perceptions to get more of a campus-wide understanding of mental health, the majority of studies focus on this issue purely from the student perspective. It may be beneficial to go more in-depth with the topic of mental health from the administrator, faculty, or staff perspective to get a sense of where their beliefs and conceptions are coming from. Given the impact that perceived public stigma can have on help-seeking behaviors in students, it would be useful to know whether more could be done at the administrative level to make sure these attitudes and beliefs are not influencing the way students are being treated on campus.
Conclusion

With the number of mental health problems on campus growing substantially and many campuses being inadequately equipped to deal with them, it has become more important than ever to explore a variety of options for addressing the topic of mental illness at colleges and universities. The encouraging part of this issue is that it is receiving more attention and campuses are recognizing they have to take appropriate steps to make sure they are not only providing the necessary resources to their students, but are helping to reframe how mental health is viewed and talked about. There will never be a quick fix for an issue as complex as this, especially with stories in the media further perpetuating stereotypes about individuals with mental illness. However, an important place to begin to address it is in an educational setting, not only because students are at a high risk for developing disorders during their time in college, but because it is a learning environment designed to foster knowledge and understanding about topics such as this.

The findings from this study further support this notion for increased levels of education and resources devoted to combating the stigma of mental illness. The more knowledge all members of the campus community had about mental health-related issues, the less likely they were to hold negative views about individuals who had them. This provides evidence for the university to begin to make systemic changes about the way it thinks about and addresses mental illness and urges them to take a second look at the existing resources to ask if the campus is currently doing enough to ensure that all students can reach their full potential while at college. Not only is this important for individual success, but it also sets an important precedence about how much the university cares about the wellbeing of its students and making sure that every opportunity to achieve success is explored and provided.
REFERENCES
References


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APPENDICES
Appendix A

Wichita State University
Fairmount College of Liberal Arts and Sciences
Department of Psychology

Campus Mental Health

Start of Block: Default Question Block

Q77 Campus Mental Health Survey Informed Consent  Purpose: You are invited to participate in a research study about mental health and stigma on Wichita State University’s campus. Mental health challenges are prevalent on all college campuses and this survey aims to learn more about personal and public perceptions on our campus.

Participant selection: You were selected as a possible participant in this study because you are a student, faculty, or staff member at Wichita State University.

Explanation of procedures: Your responses will be confidential and your participation is voluntary. The survey should take no more than 15-20 minutes and you can discontinue the survey at any time. During the survey, you will be asked about the extent to which you agree or disagree with statements such as: “People with mental illness have a purpose in life.” Please take your time and give us your honest opinions, as we believe you will find this relevant and informative.

Discomfort/Risks: We believe there will be very low likelihood of risks in this survey, although participants will be asked about mental health issues, which may impact people differently depending on their experiences with the topic. If you are uncomfortable with a question, you may skip it.

Benefits: The information gained from this study may be useful in understanding perceptions and stigma around mental health on Wichita State University campus, which can better guide the resources offered to students.

Confidentiality: Every effort will be made to keep your study-related information confidential. All information discussed during the focus group is confidential to the group and participants are not to discuss what they hear with others outside of the group. All data recorded during the focus group will be stored for a minimum of 5 years in a locked filing cabinet or password protected computer and when the data is disposed of the recordings will be erased. However, in order to make sure the study is done properly and safely there may be circumstances where this information must be released. By completing this survey, you are giving the research team permission to share information about you with the following groups:
Office for Human Research Protections or other federal, state, or international regulatory agencies; · The Wichita State University Institutional Review Board; · Student Government Association · The Counseling and Testing Center The researchers may publish the results of the study. If they do, they will only discuss group results. Your name will not be used in any publication or presentation about the study. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. In some cases, this information could be used to identify you. Your data will be protected with a code to reduce the risk that other people can view the responses.

**Refusal/Withdrawal:** Participation in this study is entirely voluntary and you may withdraw from this study at any time. Your decision whether or not to participate will not affect your future relations with Wichita State University. If you agree to participate in this study, you are free to withdraw from the study at any time without penalty.

**Contact:** If you have any questions about this research, contact Greg Meissen, PhD, Wichita State University Department of Psychology, 1845 Fairmount St. Wichita, KS 67260, greg.meissen@wichita.edu, or at (316) 978-3039. If you have questions pertaining to your rights as a research subject, or about research-related injury, you can contact the Office of Research and Technology Transfer at Wichita State University, 1845 Fairmount Street, Wichita, KS 67260-0007, telephone (316) 978-3285.

You are under no obligation to participate in this study. By selecting ‘Yes’ below indicates that:

- You have read (or someone has read to you) the information provided above,
- You are aware that this is a research study,
- You have voluntarily decided to participate.

I have read the above and agree to participate in the survey.

☐ Yes (1)
☐ No (2)

Q85 Are you 18 years or older?

☐ Yes (1)
☐ No (2)
Q86 Would you like a copy of the consent form emailed to you?

- Yes (1)
- No (2)
Q83
Thank you for your participation in this survey! We will be asking your opinions regarding mental health and stigma.

In the first section, please rate the extent to which you believe these statements reflect MOST MEMBERS of Wichita State's campus community.
Q3 Please rate the extent to which you agree or disagree with the following statements.

At Wichita State, most members of the campus community...

Q1 would willingly accept someone who has received mental health treatment as a close friend.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q4 view people with mental illness as untrustworthy.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q5 believe people with mental illness are unable to take care of themselves.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q6 would be reluctant to date someone who has been hospitalized for a serious mental disorder.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q7 believe people with mental illness are unable to get or keep a regular job.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q67
Just a friendly reminder to rate how you believe these relate to most members of the campus community at Wichita State...

Q8 would say our campus treats students who have received mental health treatment just as they would treat anyone.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q9 view people with mental illness as below average in intelligence.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q10 think people with mental illness are to blame for their problems.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q11 would take another person's options less seriously once they know they have received mental health treatment.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
In your opinion, most members of the Wichita State campus community...

Q13 think employers will hire someone who has received mental health treatment if they are qualified for the job.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q14 see a person who has received mental health treatment as just as intelligent as the average person.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q15 believe a person who has fully recovered from a mental illness would be accepted as a teacher of young children in a public school.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q16 think that people with mental illness are unpredictable.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q69 One last time! At Wichita State, most members of the campus community...

Q17 believe most people wouldn't hire someone who has received mental health treatment to take care of their children, even if they had been well for some time.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q18 feel as though receiving mental health treatment is a sign of personal failure.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q19 would think less of a person who has received mental health treatment.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q20 think people with mental illness won’t recover or get better.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q21 believe potential employers would pass over the application of someone who has received mental health treatment in favor of another applicant.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q22 believe that someone who has received mental health treatment is just as trustworthy as the average person.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q81
Thank you for giving your input about how you would rate our campus community!

For these next set of questions, please rate to extent to which YOU PERSONALLY agree or disagree with the following statements.
Q23 A little reminder never hurt! Please rate the extent to which YOU agree or disagree with the following statements.

Q24 People with mental illness have goals in life they want to reach.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q26 Individuals who have a family member with a mental illness are more likely to have a mental illness themselves.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q27 People with mental illness are persons of worth, at least on an equal basis with others.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q28 Most people with mental illness are to blame for their problems.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q29 People with mental illness have people they can count on.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q89 Remember, you’re now responding the extent to which YOU personally agree or disagree with the following statements!

Q30 The brain of a healthy person works the same as that of a mentally ill person.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q31 People with depression don’t need to see a doctor - they just get over it.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q32 People with mental illness believe that they can reach their current personal goals.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q33 The majority of people with mental illness are unable to take care of themselves.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q34 Most people with mental illness can do normal things like go to school or work at a job.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q35 I would willingly accept someone who has received mental health treatment as a close friend.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q36 A person uses their brain to learn, but the heart controls a person's feelings.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q37 People with mental illness have a purpose in life.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q38 It is important for people with mental illness to have a variety of friends.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q39 I would think less of a person who has received mental health treatment.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q40 Depression is the same thing as being sad.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q42 People with mental illness are able to do things as well as other people.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q43 There are no treatments that work for most mental illnesses.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q44 Fear doesn't stop people with mental illness from living the way they want to.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q45 The symptoms people with mental illness experience interfere less and less with their life.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q46 The majority of people with mental illness will never recover or get better.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q47 Treating mental illness can change the way the brain works.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q48 People with mental illness can't be trusted.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q49 People with mental illness believe something good will eventually happen.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q50 Depression is a disease.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q51 Even when people with mental illness don't believe in themselves, other people do.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q52 Mental illness is like other diseases because a person who has it has symptoms that a doctor can diagnose.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q53 Most people with mental illness are unable to get or keep a regular job.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q54 People with mental illness are hopeful about their future.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q55 I see people with mental illness as capable people.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q56 I believe that someone who has received mental health treatment is just as trustworthy as the average person.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q87 Students and other people who have a mental illness can't learn.
- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q57 Even when people with mental illness don't care about themselves, other people do.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q58 A person who does not get treatment for depression may feel better after awhile, but there may be some long-lasting effects.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q59 People with mental illness are unpredictable.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q76 You're almost done! Thank you again for your participation.

Q60 The symptoms that a person with mental illness experience are a problem for shorter periods of time each time they occur.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q61 Coping with mental illness is not the main focus of the lives of people with mental illness.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)

Q62 Most people with mental illness are below average in intelligence.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q63 How bad a person’s mental illness is depends on many things, including genes and family environments.

- Strongly agree (1)
- Agree (2)
- Slightly agree (3)
- Slightly disagree (4)
- Disagree (5)
- Strongly disagree (6)
Q82 Just a few last questions before you go!

Q78 Are you

- Student (1)
- Faculty (2)
- Staff (3)

Q80 How would you describe your gender?

- Male (1)
- Female (2)
- Transgender Male (3)
- Transgender Female (6)
- Prefer Not to Answer (4)
- Other (5) ________________________________________________

Q79 What is your race?

- African American (1)
- Asian (2)
- Hispanic (3)
- Middle Eastern (9)
- Mixed Race (4)
- Native American (5)
- North African (10)
- Pacific Islander (6)
- White/Caucasian (7)
- Other (8) ________________________________
Q84 In what year were you born?

▼ 1999 (1) ... 1913 (87)

End of Block: Default Question Block
Appendix B

Consent Form

**Purpose:** You are invited to participate in a research study about the experiences of persons with a mental health diagnosis on Wichita State University (WSU) campus. This includes but is not limited to experiences with mental health resources, stigmatization, support, stress, and prevalence.

**Participant selection:** You were selected as a possible participant in this study because you are over 18 years of age, identify as having lived experience with mental health struggles, and are a student at Wichita State University. This study will consist of approximately 30 participants in all.

**Explanation of procedures:** After reviewing the consent form, if you wish to continue with the study, you will take part in a focus group of approximately 5 to 10 individuals. This focus group will last approximately 90 minutes and include questions regarding your experiences with various aspects of mental health at Wichita State University (i.e. What resources have you found to be the most beneficial at WSU for mental health consumers?). This study will be conducted in a reserved room in the Rhatigan Student Center in order to protect confidentiality of participants. Each session will be audio recorded for accuracy, but no identifying information will be included in the recording. All facilitators will be persons with mental health diagnoses and will provide a safe and supportive environment.

**Discomfort/Risks:** The subject matter of this focus group may cause discomfort among participants as this can be a sensitive subject. Participants may feel discomfort when listening to other participant’s perceptions and experiences with mental health that conflict with their own perceptions and experiences. If you feel uncomfortable with a question, you do not need to answer. All students will provided information regarding the Counseling and Testing Center and other on-campus mental health resources available to them.

**Benefits:** The information gained from this study may be useful in making changes and examining helpful resources for mental health on Wichita State University campus.
Confidentiality: Every effort will be made to keep your study-related information confidential. All information discussed during the focus group is confidential to the group and participants are not to discuss what they hear with others outside of the group. All data recorded during the focus group will be stored for a minimum of 5 years in a locked filing cabinet or password protected computer and when the data is disposed of the recordings will be erased. However, in order to make sure the study is done properly and safely there may be circumstances where this information must be released. By signing this form, you are giving the research team permission to share information about you with the following groups:

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- The Wichita State University Institutional Review Board;
- Student Government Association
- The Counseling and Testing Center

The researchers may publish the results of the study. If they do, they will only discuss group results. Your name will not be used in any publication or presentation about the study.

Compensation or Treatment for Research Related Injury: Wichita State University does not provide medical treatment or other forms of reimbursement to persons injured as a result of or in connection with participation in research activities conducted by Wichita State University or its faculty, staff, or students. If you believe that you have been injured as a result of participating in the research covered by this consent form, you can contact the Office of Research and Technology Transfer, Wichita State University, Wichita, KS 67260-0007, telephone (316) 978-3285.

Refusal/Withdrawal: Participation in this study is entirely voluntary and you may withdrawal from this study at any time. Your decision whether or not to participate will not affect your future relations with Wichita State University. If you agree to participate in this study, you are free to withdraw from the study at any time without penalty.

Contact: If you have any questions about this research, contact Gregory Meissen at greg.meissen@wichita.edu or 316-978-3039. If you have questions pertaining to your rights as a research subject, or about research-related injury, you can contact the Office of Research and Technology Transfer at Wichita State University, 1845 Fairmount Street, Wichita, KS 67260-0007, telephone (316) 978-3285.

You are under no obligation to participate in this study. Your signature below indicates that:

- You have read (or someone has read to you) the information provided above,
- You are aware that this is a research study,
- You have had the opportunity to ask questions and have had them answered to your satisfaction, and
- You have voluntarily decided to participate.

You are not giving up any legal rights by signing this form. You will be given a copy of this consent form to keep.
Printed Name of Subject

Signature of Subject Date

Printed Name of Witness

Witness Signature Date
Facilitator: Before we get started, we wanted to take the time to thank each of you for being here today. We are only here to ask questions and listen, not to participate. However, please feel free to talk with one another throughout your time here. If at any time you need to get up and go to the restroom or get a drink, please do so.

Let’s get started by going around and introducing yourself with your name and what your favorite part of being a student at WSU is.

We’ll start out our questions more broadly.

- On Wichita State’s campus, how prevalent do you think mental health challenges are?
  - Is it something you ever hear other students mention or discuss?
  - Do you think there is a stigma against mental health issues on our campus? Why or why not?
  - Have your challenges prevented you from getting more involved on campus?
- Would you feel comfortable approaching your professors or advisors with your challenges and experiences with your mental health? Why or why not?
  - What accommodations or resources have (or could) your professors provide you with to help with your symptoms, coursework, stress, etc.?
- What has changed for you since being diagnosed?
  - Did you tell people close to you (friends, family, etc.) about your diagnosis? Why or why not?
  - If so, what was their reaction?
- How has your mental health impacted other aspects of your health? (Ex: sleep, exercise, eating habits, etc.)
  - What are some stressors in your life? What impact does your mental health have on those?
- Do you identify as part of a marginalized/oppressed group on campus?
  - How has this impacted your mental health?
- Do you access on campus resources related to your mental health? If yes, which resources?
  - What other ways do you help cope with your symptoms? (Social support, exercise, etc.)
- What recommendations do you have for WSU in terms of how they could better serve their students with mental health diagnoses? There are no wrong answers!

Facilitator: Thank you again for your openness and honesty today. We recognize that this is not an easy topic to discuss and greatly appreciate your participation.