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Stigma and Help-Seeking Differences: Mental Health in the US and the UK

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Abstract

The cultures and healthcare systems in the United States and the United Kingdom are very different from each other, though citizens in both of these countries are exposed to stigma surrounding mental health and help-seeking. Examining the differences in stigma predictors and help-seeking behaviors between the two countries offers valuable insight into what cultural and structural factors play a role in whether or not a person in need seeks help. This study involved an online survey that asked college students in both countries to answer questions about their personal experience regarding mental health stigma and help-seeking. Multiple regressions were used to analyze the predictors of stigma, help-seeking behaviors, and the differences between the two countries. It was found that participants from the UK had significantly lower scores in help-seeking attitudes and perceived university support, and that men reported lower help-seeking attitudes and higher stigma than women. Several correlations are explored, including the significant positive correlation in the full sample between self-reliance and stigma as well as between help-seeking attitudes and mental health literacy and university support. Hierarchical multiple regressions predicting help-seeking were conducted separately for each country, revealing a similar role for self-stigma but some variation in relationships with other predictors. These results have important implications for how both countries can improve to better support their students, and could be used by universities in both nations.

Keywords: stigma, help-seeking, predictors

Stigma and Help-Seeking Differences: Mental Health in the US and the UK

Despite the fact that 22% of the US population suffers from a mental illness, only half of these people with mental illnesses receive treatment from mental health services (National Institute of Mental Health, 2024; Substance Abuse and Mental Health Services Administration, 2022). Meanwhile, it is estimated that merely 25% of people with mental illnesses in England get the treatment they need (Davies, 2014). With so many mentally ill people in both countries not receiving the help that they need, it is crucial to understand the reasons for this and whether or not these countries differ in the underlying reasons. There is a multitude of research that examines stigma and mental health help-seeking behaviors in both countries, but there is little research that compares the two. Learning more about the predictors of stigma and mental health help-seeking behaviors in both countries provides insight into how the differences in the two countries' environments and approaches to mental healthcare affect their citizens' ability to get treatment. In turn, this new knowledge (the comparison of factors that lead to specific mental health related outcomes in both nations) will open up possibilities for improved treatments and better care for students in both countries. This study focused on college students between the ages of 18-27, given that research has demonstrated age to have an impact on mental health stigma and help seeking (Mackenzie et al., 2019; Substance Abuse and Mental Health Services Administration, 2023). The purpose of the current study was to examine (a) the predictors of mental health stigma and mental health help-seeking behaviors in both the United States and the United Kingdom and (b) the differences in the predictors, stigma, and help-seeking behaviors between these two nations.

Stigma and Help-Seeking in the United States

A multitude of studies have investigated the presence of mental health stigma and the prevalence of help-seeking behaviors in the US (Brecht et al., 2017; Dunley & Papadopoulos, 2019; Lee et al., 2023; Pederson & Vogel, 2007; Wester et al., 2010). As previously mentioned, many in the US who need mental health help do not receive it. A large portion of mentally ill people in the US do not seek help, and despite clear support for the effectiveness of psychotherapy, Brecht et al., (2017) note that rates of use have shown a decline in recent years; research suggests this trend may be associated with personal preferences and help-seeking stigma. Notably, psychiatric medication use has increased, suggesting that more intensive contact with mental healthcare providers may deter some from seeking help. It is also worth noting that since the COVID-19 pandemic in 2020, the overall mental health service usage increased as telehealth use offset the loss of in-person mental health services (McBain et al., 2023). This is promising, but it remains true that even with professional help becoming more accessible, many still struggle to seek it.

The literature points to various reasons why many people do not seek the help that they need. In their review of 24 research studies, Dunley and Papadopoulos (2019) explored the barriers to mental health help-seeking that college students face in the US and Canada. These barriers were categorized as institutional, sociocultural, and personal barriers. Institutional barriers included issues related to university access to mental healthcare (with one issue being discoordination between services at the university, such as counseling and disability services), as well as access to insurance. Personal barriers included lack of awareness regarding mental health access or mental illness, as well as hesitation to seek help based on fears of being judged, not having time, or not being comfortable. In terms of sociocultural barriers, gender, sexual orientation, race and ethnicity can all play a role in whether or not a person is likely to seek help.

For instance, women, White individuals, and LGBTQ+ individuals are most likely to seek mental health help. The barriers to mental health help-seeking in the US are complex and intertwined.

Other studies have explored the idea that men are less likely to seek help than women due to the masculine norms ingrained into US society that associate help-seeking with weakness (Lee et al., 2023; Pederson & Vogel, 2007; Wester et al., 2010). In fact, Terlizzi and Zablotsky (2020) outlined that 24.7% of women in the US received any mental health treatment within the given year, while the same could only be said for 13.4% of men. Pederson & Vogel (2007) found that men who face more gender role conflict in their lives (meaning that they are more negatively affected by the societal expectations of gender roles) have more negative attitudes towards help-seeking and less willingness to find or attend counseling. Specifically, this study found that the link between gender roles and help-seeking was mediated by (a) self-stigma connected to help-seeking, (b) disinclination to share distressing information, and (c) attitudes regarding looking for or attending counseling. These links illustrate the damage that masculine norms do in terms of help-seeking and stigma related to mental health. Further supporting this pattern, Lee et al. (2023) found that the framing of messages about mental health can impact men's perceptions of help-seeking stigma. When ad campaigns framed mental health care as the key to a fresh start in life, men viewed the ads more positively and were less likely to think that seeking help was weak. Stigma is pervasive in US society through these gendered norms, and this study is crucial in understanding how its damage can be undone.

Stigma and Help-Seeking in the UK

Just as has been recorded in the US, stigma and mental health help-seeking are prominent issues and topics of research in the UK. In a review of five electronic databases spanning

1980-2011, stigma was found to be the fourth highest hindrance to mental-health help-seeking, with concerns about disclosure being the highest hindrance related to stigma in the UK (Clement et al., 2015). Stigma appears highly prevalent in the UK, and it affects adults and children alike. For instance, ADHD is often stigmatized in the UK, with both parents and children being vulnerable to stigma due to deficiencies in schools and mental health services. ADHD is often viewed as an anger problem rather than a learning disability, with many being more concerned about children's conduct than the treatment of the disorder (Singh, 2018).

Despite the fact that ⅓ of the UK population will experience trouble with their mental health during their lifetime (Putman 2008), misunderstanding and lack of awareness are major issues in the UK. Given the prominence of misinformation and negative attitudes surrounding mental health, Putman (2008) reviewed published research about mental health attitudes to assist in developing learning resources for workers at the NHS Direct call centre. The review identified several key themes regarding barriers faced by mentally ill people in the UK, including issues related to violence (both having violence directed towards them and being seen as violent), media portrayal of mentally ill people, problems in employment, lack of understanding, discrimination, and personal issues. Based on these findings, the author's recommendations for mental health workers emphasized that educating the public is crucial in reducing stigma. Thus, mental health literacy appears key in promoting positive attitudes surrounding mental health in the UK.

Specific Populations

Research focusing on specific, often vulnerable, populations demonstrates the pervasiveness of stigma and related barriers to mental health help-seeking. For instance, Holt et al. (2023) specifically studied sexual and gender minority survivors of near-fatal suicide attempts

and their help-seeking behaviors and experiences with mental healthcare. Their thematic analysis highlighted important commonalities among the respondents, including issues with structural barriers (lack of access to mental healthcare), previous negative experiences, social support problems, and incompatibility with hospitalization. Meanwhile, Cogan et al. (2023) studied the mental health help-seeking experiences of Asian international students in the UK, finding one of the three main themes regarding their barriers to help-seeking as "negative beliefs, stigma, and fear of judgment" (p.1), as well as difficulties with adaptation and communication. Both of these studies provide valuable insight as to why vulnerable populations may not get the help that they would benefit from, and allow researchers to further understand various sociocultural factors that may factor into a person's likelihood of help-seeking.

Interestingly, age groups may differ in their help-seeking behaviors based on stigma. Despite the common perception that younger people may face less stigma than older generations, there is research to suggest otherwise. In fact, Mackenzie et al. (2019) found that, "older participants had the lowest levels of stigma and the most positive help-seeking attitudes" (p. 2259). The study by Mackenzie et al. (2019) supports previous literature that also found positive correlations between age and help-seeking attitudes, suggesting that older people may have more positive mental-health attitudes than younger people (Mojtabai, 2007). Moreover, young adults' greater mental health stigma and resistance to seeking treatment coincides with markedly higher levels of psychological distress. The results from the 2022 National Survey on Drug Use and Health (NSDUH) add to this idea, finding that 23.1% of adults 18 and older in the United States had a mental illness, with the highest percentage of these adults (36.2%) being between the ages of 18 and 25 (Substance Abuse and Mental Health Services Administration, 2023). Given the

elevated rates of mental illness in younger adults, the current study focused on college students in this age range.

Predictors of Stigma and Help-Seeking Behaviors

With the plethora of mental health research in both the US and the UK, many variables have been identified as being possible predictors of stigma and help-seeking behaviors. For instance, one study from the southern US states identified self-reliance as a predictor of stigma, finding that higher self-reliance had direct associations with higher self-stigma, public stigma, and mental health self-reliance (Keller & Owens, 2022). Because self-reliance discourages dependence on others for support, it leads to reduced mental health help-seeking. Evidently, self-reliance is intertwined with the masculine norms embedded in US society that prevent many men from seeking help, and its prevalence in the UK should be examined as well.

In addition, as shown in Putman's (2008) review and elsewhere (Dunley & Papadopoulos, 2019), lack of understanding and awareness regarding mental health have been cited as factors in the perpetuation of stigma and barriers in help-seeking. Gorczynski et al. (2020) explored whether or not there was a relationship between mental health literacy and help-seeking behaviors among college students in the UK. Interestingly, this study did not find a significant relationship, despite previous research suggesting otherwise. Thus, mental health literacy as a predictor of stigma and barrier to help-seeking merits further exploration.

Lastly, university support and structure have been found to significantly predict positive help-seeking behaviors, highlighting the importance of access to services for college students' well-being (Clements & Paramova, 2023). For various reasons, many mentally ill college students do not receive the support they need even when these services exist, whether it is because they are unaware of their existence (which overlaps with mental health literacy as a

predictor), unsure about insurance coverage, skeptical about how effective the treatment will be, etc. Initiatives to make these university services more accessible to students may be crucial in promoting mental health help (Eisenberg et al., 2007). By examining predictors such as self-reliance, mental health literacy, and university support and structure, this study aims to increase not only the understanding of the origins of stigma and help-seeking barriers, but also the understanding of the roots of any differences between students in the US and the UK.

Present Study Overview

The current study examined the predictors of mental health stigma and help-seeking behaviors in college students in the United States and the United Kingdom. College students specifically were examined for a multitude of reasons. Firstly, high rates of mental illness have been reported in people between the ages of 18-25 (Substance Abuse and Mental Health Services Administration, 2023). In addition, this is a population that often has some access to mental health treatment through college counseling centers, allowing us to more clearly investigate how knowledge of available treatment and perceptions of its usefulness relate to help-seeking in both countries. The study looked at the ways in which the predictors differ between the two countries, as well as the relationship of the predictors to mental health stigma and help-seeking behaviors in both countries. While there is an abundance of research regarding these variables in each of these two countries, there is little research that compares the two. Given that the two systems of mental health care differ in important ways, it is valuable to see how students in the two countries differ in relation to seeking treatment and attendant barriers.

Before the study was conducted, it was hypothesized that higher reported levels of self-reliance would be associated with higher levels of stigma and lower levels of help-seeking behavior for both countries (Keller & Owens, 2022). It was also predicted that men, due to the

masculine norms of society in the US and the UK, would report higher self-reliance and lower levels of help-seeking (Lee et al., 2023; Pederson & Vogel, 2007; Wester et al., 2010). It was also expected that lower reported levels of mental health literacy and university support and structure would be associated with higher levels of stigma and lower levels of help-seeking behavior for both countries (Clements & Paramova, 2023; Dunley & Papadopoulos, 2019; Eisenberg et al., 2007; Holt et al., 2023; Putman, 2008). Lastly, though the literature has not compared the two countries, it was predicted that stigma may be more prevalent in the UK than the US, and that UK students may have more negative attitudes towards seeking help. This prediction is based on the low percentage of people receiving the help that they need, the research on stigma surrounding various mental health issues, and the extent to which stigma and related barriers prevent help-seeking in the UK compared to the US (Brecht et al., 2017; Clement et al., 2015; Davies, 2014; Singh, 2018; Substance Abuse and Mental Health Services Administration, 2022).

Method

Participants

The study consisted of 200 participants (101 from the UK and 99 from the US) who completed an online survey through Prolific that asked them questions about their personal experiences regarding mental health. Participants were paid $1.50 for completing the survey. In order to be eligible, participants had to be current college students, aged 18-27, currently residing in the United States or United Kingdom. Prescreening occurred through Prolific whereby only eligible participants were invited to complete the study. Upon reaching the end of the survey, participants were redirected to Prolific's website for payment through their system. In addition to the 200 participants in the final sample, 21 potential participants began the study but did not reach the end of the survey. Ten potential participants were excluded because they provided

answers that did not match their responses to prescreening questions or they elected to discontinue before completion and return their survey to Prolific. 11 participants did not finish within the 44 minute time limit and were timed out. Consistent with Prolific's guidelines, these 21 individuals did not receive payment and their data was not used. Demographics for the participants in both countries are described in Table 8.

Measures

Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherod, 2000). This 5-item scale was developed to investigate people's perceptions of public stigma regarding seeking mental health help. Participants respond to each item using a scale with options 0 (strongly disagree) to 3 (strongly agree), with higher scores indicating that the participant perceives higher levels of stigma. An example of an item on the scale is "People will see a person in a less favorable way if they come to know that he/she has seen a psychologist." See Appendix for the other items in the scale. This scale has been demonstrated to positively correlate with self stigma, and negatively correlate with help-seeking. Mackenzie et al. (2019) found the internal consistency of the scale to be 0.86, with college and community samples having internal consistencies between 0.72 and 0.82. Internal consistency in the current sample was 0.774.

Self-Stigma of Seeking Help (SSOSH) (Vogel et al., 2006). This 10-item scale measures self-stigma in regards to mental health help-seeking. Participants respond using a scale from 1 (strongly disagree) to 5 (strongly agree). A higher score indicates greater self-stigma when it comes to help-seeking, with some items requiring reverse-scoring. An example item is "I would feel inadequate if I went to a therapist for psychological help." See Appendix for the remainder of the items. The SSOSH has been shown to be negatively correlated with help-seeking behavior

and positive attitudes toward mental health support (Vogel et al., 2006), and the scale was found to have an internal consistency of 0.91. Internal consistency in the current sample was 0.882.

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Farina, 1995). This 10-item scale measures participants' attitudes toward mental health help-seeking, including beliefs about the benefits of mental health treatment and anticipated desire for such help. Sample items include, "A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help," and "I would want to get psychological help if I were worried or upset for a long period of time." See Appendix for the other items in the measure. They respond using a scale from 0 (disagree) to 3 (agree), with some of the items requiring reverse coding. A higher score indicates more positive attitudes towards seeking professional help for mental health issues. The ATSPPHS has been shown to be positively correlated with actual use of support services (Fischer & Farina, 1995). The scores from this abbreviated scale correlated 0.87 with the original scale, and its internal consistency (Cronbach's alpha) was found to be 0.84. Internal consistency in the current sample was 0.86.

Self-Reliance Scale (Mahalik et al., 2003). This 5-item subscale is part of a larger scale, the Conformity to Masculine Norms Inventory (CMNI), created by Mahalik et al. (2003) and reexamined and abbreviated (to become the CMNI-46) by Parent and Moradi (2009). The Self-Reliance scale measures the extent to which participants rely on themselves rather than others for support, using items such as "I hate asking for help." See Appendix for the other items in the measure. They respond using a scale from 1 (Strongly disagree) to 4 (Strongly agree). Higher scores on the CMNI indicate higher levels of conformity to masculine norms, and thus higher scores in the Self-Reliance subscale would indicate more self-reliance. The internal

consistency score (Cronbach's alpha) for this subscale was found to be 0.87 (Hammer et al., 2018). Internal consistency in the current sample was 0.835.

Mental Health Literacy Scale (MHLS) (O'Connor and Casey, 2015). This 35-item scale investigates the mental health literacy of participants by presenting items that assess the attributes of mental health literacy, including the ability to recognize various mental health conditions, attitudes that encourage awareness and help-seeking, and awareness of risk factors/causes, self-treatment, and the information and professional help that is available. An example item is "To what extent do you think it is likely that Dysthymia is a disorder." See appendix for the remainder of the items. Although the MHLS assesses multiple facets of mental health literacy, the authors found a unidimensional structure best fit their data. However, the scale includes items assessing help-seeking attitudes, which overlap with the help-seeking measure used in the current study (ATSPPHS, Fischer & Farina, 1995). Therefore, only a subset of MHLS items was used in these analyses. Twelve items assessing attitudes concerning individuals with mental health disorders were combined to form a measure of Mental Health Literacy (MHL) Attitudes. These items were rated on a 5-point scale, and the mean was taken after reverse-scoring negatively worded items; higher scores on the resulting measure indicate more positive mental health attitudes. Similarly, 15 items assessing knowledge about mental health topics were combined to form a measure of Mental Health Literacy (MHL) Knowledge. These items were rated on a 4-point scale, and the mean of the 15 items produced a knowledge index with higher scores indicating greater mental health knowledge. Internal consistency in the current sample was acceptable for both MHL-Attitudes (alpha = 0.917) and MHL-Knowledge (alpha = 0.727).

University support and structure (SPUSS) (Wintre et al., 2009). This 21-item scale measures college student participants' perception of how supportive and structured their university is, in terms of both informal and formal resources. It measured perceptions of support with items such as "If a student needed help for an emotional problem, it would be easy to find a service on campus to help them," and perceptions of structure with items such as "There are lots of confusing rules that make registration and course selection difficult." See Appendix for other items. Participants respond on a scale ranging from 1 (very strongly disagree) to 9 (very strongly agree), with higher scores representing perceptions of the university being supportive and structured. The scale was found to have Cronbach alphas of 0.87 and 0.89 for internal consistency and 0.86 and 0.88 for split-half reliability (Wintre et al., 2009). Internal consistency in the current sample was 0.896.

Demographics: In addition, participants' self-reported race, ethnicity, gender, sexual orientation, perceived socioeconomic status, and age were measured.

Procedure

Firstly, this study was approved by the Human Subjects Review Board (HSRB) at Roger Williams University. After approval, the study was conducted with participants obtained through Prolific. Participants on Prolific are all over the age of 18, and are able to participate in most OECD countries (except Turkey, Lithuania, Colombia, and Costa Rica), though the website is UK based. They are generally recruited by word of mouth or through social media, and they are all vetted and verified. On Prolific, participants make an account where they are then alerted via email whenever there is an available study that they qualify for based on the demographic information they gave to prolific through the prescreening questions. These participants can also view available studies they qualify for on their studies dashboard. Informed consent was

provided to all participants at the beginning of the Qualtrics survey, as they were all required to read the informed consent form and click a button indicating agreement. Participants were then asked to complete an online questionnaire consisting of the measures described above. The survey took participants an average of 10 minutes and 32 seconds to complete, and at the end of the survey, they were thanked for their participation and debriefed regarding the purpose of the study. Participants were paid $1.50 for full completion of the survey via Paypal.

Data Analysis

In order to examine factors associated with mental health stigma and help-seeking attitudes, the data was analyzed using correlational analysis and multiple regressions. Pearson's correlation coefficient was calculated separately for the US and UK samples, assessing relationships among self-reliance, mental health attitudes, mental health knowledge, university support, public stigma, self stigma, and help-seeking attitudes. To further examine help-seeking attitudes, separate regression equations were then conducted for the U.S. and U.K. samples, predicting help-seeking attitudes from the set of predictor variables (self-reliance, mental health attitudes, mental health knowledge, university support, public stigma, self stigma) and demographic variables. Hierarchical multiple regression analysis was used to predict help-seeking from demographics (age, gender, and social status) in step 1, adding self-reliance, mental health attitudes, mental health knowledge, university support, public stigma in step 2, and self stigma in step 3. Although a full mediational analysis was not conducted, this strategy allowed for examination of the prediction of help-seeking attitudes before and after accounting for self-stigma, as well as the unique contribution of self stigma. Both public stigma and self stigma were included in the analysis, but self stigma was entered alone in step 3 since it involves expectations of self-directed stigma in the context of help-seeking; this may make it a more

proximate predictor of help-seeking attitudes than perceptions of public stigma and other attitudinal predictors. U.S. and U.K. students were also compared on the predictors and outcomes using independent samples t-tests. In addition, gender comparisons were conducted using t-tests for each predictor variable. Exploratory analyses examined the gender X self-reliance interaction on self stigma and help-seeking attitudes using Factorial ANOVA's, but as no significant interactions emerged (nor any 3-way interactions involving nationality), these analyses are not presented here.

Results

In order to first test for correlations between the primary variables being measured in the survey, researchers tested for Pearson's correlation coefficient (r) for all participants (Table 1) as well as for each individual country (Tables 2 and 3). For the analyses that looked at all participants, significant correlations were found between all of the variables at either the 0.01 level or 0.05 level. In this test, self-reliance demonstrated a positive correlation with both public stigma, $r(198) = .220$, $p = .002$, and self-stigma, $r(198) = .419$, $p < .001$, and a negative correlation with help seeking, $r(198) = -.379$, $p < .001$. Mental health literacy knowledge and attitudes both demonstrated positive correlations with help-seeking and negative correlations with public and self-stigma, with mental health literacy attitudes exhibiting a particularly strong correlation with both self-stigma, $r(198) = -.504$, $p < .001$, and help-seeking, $r(198) = .519$, $p < .001$. University support and structure similarly demonstrated a positive correlation with help-seeking, $r(197)= .256$, $p < .001$, and negative correlations with public stigma, $r(197) = -.206$, $p = .004$, and self-stigma, $r(197) = -.312$, $p < .001$. In addition, a particularly strong negative correlation was found between self-stigma and help-seeking, $r(198) = -.671$, $p < .001$.

Country-level Correlations

In both countries, self-reliance was expected to correlate positively with levels of stigma and negatively with help-seeking. In the US, as predicted, self-reliance significantly correlated with self-stigma, $r(97) = .447$, $p < .001$, and help-seeking, $r(97) = -.298$, $p = .003$, but contrary to predictions, self-reliance did not correlate with public stigma. In the UK, self-reliance did significantly correlate with self-stigma, $r(99) = .403$, $p < .001$, public-stigma, $r(99) = .262$, $p = .008$, and help-seeking, $r(99) = .474$, $p < .001$. In addition, lower levels of mental health literacy and university support and structure were expected to correlate with higher levels of stigma and lower levels of help-seeking. In the US, mental health literacy knowledge, mental health literacy attitudes, and university support and structure were all significantly correlated with self-stigma in the expected directions ($r(96) = -.326$, $p = .001$ for mental health literacy knowledge; $r(97) = -.624$, $p < .001$ for mental health literacy attitudes; $r(97) = -.274$, $p = .006$ for university support and structure). These variables were also significantly correlated with help-seeking ($r(96) = .496$, $p < .001$ for mental health literacy knowledge; $r(97) = .657$, $p < .001$ for mental health literacy attitudes; $r(97) = .285$, $p = .004$ for university support and structure), in the expected directions. However, no relation was found between public-stigma and these variables (except mental health literacy attitudes, $r(97) = -.336$, $p < .001$). In the UK, both mental health literacy knowledge and attitudes correlated with self-stigma ($r(99) = -.293$, $p = .003$ for mental health literacy knowledge; $r(99) = -.425$, $p < .001$ for mental health literacy attitudes), public-stigma ($r(99) = -.223$, $p = .025$ for mental health literacy knowledge; $r(99) = -.366$, $p < .001$ for mental health literacy attitudes), and help-seeking ($r(99) = .360$, $p < .001$ for mental health literacy knowledge; $r(99) = .437$, $p < .001$ for mental health literacy attitudes), as expected, but university support and structure only correlated with public stigma, $r(98) = -.237$, $p = .018$, and self stigma, $r(98) =$

-.313, $p = .002$. There was no significant correlation between help-seeking and university support and structure.

Group Differences on Study Variables

Independent samples t-tests were conducted to determine gender differences with each variable (Table 4). For the sake of this analysis, those who did not identify as either male or female were not included in the equation. Interestingly, there was no significant difference between males and females when it came to self-reliance or university support and structure. However, the results showed that men scored significantly higher on public stigma, $t(186) = 2.07$, $p = .04$, and self-stigma, $t(142.678) = 1.985$, $p = .049$, whereas women scored significantly higher on help-seeking, $t(186) = -2.923$, $p = .004$, mental health literacy knowledge, $t(185) = -3.471$, $p < .001$, and mental health literacy attitudes, $t(186) = -3.286$, $p = .001$.

Independent samples t-tests were also conducted to determine the differences between each country based on their mean scores on each subscale (Table 5). No significant differences were found in the mean scores between both countries for public stigma, self-reliance, mental health literacy knowledge or mental health literacy attitudes. However, as expected, the mean scores of the participants from the UK were significantly lower than those in the US for both help-seeking, $t(198) = 3.235$, $p = .001$, and university support and structure, $t(197) = .292$, $p = .004$. In addition, the differences in the scores for self-stigma were approaching significance, with the mean scores from the UK being higher than those from the US, $t(198) = -1.708$, $p = .089$.

Prediction of Help-seeking Attitudes

After these initial tests, the data was analyzed using hierarchical multiple regressions, with separate regression equations for the U.S. (Table 6) and U.K. samples (Table 7). For US

participants, demographics (age, gender, and socioeconomic status) alone were not significant predictors of help-seeking in step 1, $F(3, 86) = 1.575$, $p = 0.201$, with only 5.2% of the variance accounted for. However, in step 2, the model including all predictors except for self-stigma was significant, $F(5, 81) = 16.05$, $p < 0.001$, accounting for 52.4% of the variance. Specifically, public stigma was found to significantly predict help-seeking, as did mental health literacy knowledge and mental health literacy attitudes. However, self-reliance, university support and structure, and the demographic variables previously discussed did not. In step 3, the model including all predictors as well as self-stigma was significant, $F(1, 80) = 8.559$, $p = 0.004$, with 57% of the variance accounted for, suggesting that self-stigma alone accounted for almost 5% of the variance in this model. Mental health literacy knowledge and mental health literacy attitudes remained significant, in addition to self-stigma. However, public stigma was no longer found to be a significant predictor of help-seeking in this model.

For UK participants, in contrast to the US, demographics alone were found to be significant predictors of help-seeking attitudes/behaviors in step 1, $F(3, 92) = 6.053$, $p < 0.001$, with 16.5% of the variance accounted for. Specifically, gender and age were significant predictors, with older participants and females reporting more positive help-seeking attitudes. In step 2, the model combining all predictors except for self-stigma was also found to be significant, $F(5,87) = 8.401$, $p < 0.001$, with 43.7% of the variance accounted for. Gender and age remained significant predictors of help-seeking attitudes/behaviors, in addition to self-reliance and mental health literacy attitudes. Lastly, in step 3, the model combining all predictors including self-stigma was significant, $F(1, 86) = 51.301$, $p < 0.001$, with 64.7% of the variance accounted for. In this third step, gender, age, and self-reliance remained significant, alongside self-stigma. Notably, public stigma became significant when taking self-stigma into

consideration, while mental health literacy attitudes in this model were only approaching significance.

Discussion

Based on previous research, multiple hypotheses were formulated. It was first hypothesized that higher levels of self-reliance would be associated with higher levels of stigma and lower levels of help-seeking attitudes in both countries (Keller & Owens, 2022). This hypothesis was supported by the data. The correlations calculated for all participants demonstrated a significant positive association between self-reliance and public stigma, as well as self-reliance and self-stigma, and a significant negative association between self-reliance and help-seeking behaviors/attitudes. The same pattern was reflected for each individual country, with the exception of the relationship between self-reliance and public stigma being non-significant in the US. Interestingly though, in the UK, self-reliance proved to be a significant predictor of help-seeking while it did not in the US.

Secondly, it was hypothesized that men would report higher self-reliance and lower levels of help-seeking (Lee et al., 2023; Pederson & Vogel, 2007; Wester et al., 2010). This hypothesis was only partially supported. No significant difference in self-reliance was found between males and females. However, males did score significantly lower on help-seeking attitudes than females.

Next, it was hypothesized that lower levels of mental health literacy and university support and structure would be associated with higher levels of stigma and lower levels of help-seeking for each country (Clements & Paramova, 2023; Dunley & Papadopoulos, 2019; Eisenberg et al., 2007; Holt et al., 2023; Putman, 2008). This hypothesis was largely supported in the analysis. The correlations calculated for all participants showed significant negative

associations between mental health literacy knowledge/attitudes and both public and self-stigma, as well as between university support and structure and both public and self-stigma. Both mental health literacy and university support and structure also showed significant positive associations with help-seeking. The correlation tests conducted for each individual country demonstrated the same pattern, with just a few exceptions. For the US, the relationships between public stigma and both university support and structure and mental health literacy knowledge were non-significant. For the UK, the relationship between university support and structure and help-seeking was non-significant.

Lastly, it was predicted that participants from the UK would overall demonstrate higher levels of stigma and lower levels of help-seeking than the US (Brecht et al., 2017; Clement et al., 2015; Davies, 2014; Singh, 2018; Substance Abuse and Mental Health Services Administration, 2022). This hypothesis was partially supported. There was in fact a difference between the two countries regarding help-seeking, with participants from the UK reporting lower levels of help-seeking than the US. The difference between the US and the UK regarding self-stigma was approaching significance, suggesting higher levels of self-stigma in the UK, but more research is needed before conclusions may be drawn. The expected difference regarding public stigma, however, was not found. The hierarchical multiple regressions also showed that in the UK, public stigma only played a significant role in predicting help-seeking when combined with self-stigma, which was the opposite in the US.

The relationships found in this study also have wider implications for not only these two countries, but also society in general, and they could be researched in future studies to examine whether or not the same patterns are found elsewhere. For instance, the strong negative association that this study found between self-stigma and help-seeking provides important

evidence to suggest that future projects, especially in universities, should focus on ways to lower levels of self-stigma in order to encourage students to utilize professional mental health help. One association that stands out in particular is the strong positive relationship between mental health literacy (specifically attitudes) and help-seeking, as well as the strong negative relationship between mental health literacy and self-stigma. Previous literature regarding mental health literacy had mixed results regarding whether or not mental health literacy was associated with help-seeking behaviors, and thus this study supports and brings attention to the importance of educating the public. Additionally, this study offers some valuable insight regarding the relationship between mental health literacy and help-seeking. Though they were correlated at the bivariate level, mental health literacy knowledge in the UK did not predict help-seeking when controlling for other attitudes and beliefs relevant to help-seeking, while it did in the US. This could indicate that those in the UK with more knowledge regarding mental health topics (specifically with more positive attitudes towards those with mental health issues and concerns) may be more likely to seek help, but it may not necessarily be a deciding factor in whether or not they choose to do so. Possibly, factors that enhance understanding of mental health and dispel myths, such as education in mental health literacy, also produce more positive attitudes toward help-seeking. Further research is needed to develop a more in-depth understanding of the relationship between these variables, but these findings do provide support for the importance of mental health education.

The differences in the health care systems between the two countries, as well as in university experiences, understandably create differences in how students address and feel about mental health. Citizens of the UK have access to free, universal health care through the National Health System (NHS) paid for primarily through taxes. In fact, only 10.6% of the UK population

bought private insurance in 2020 (OECD, 2023). While the NHS provides a great amount of accessible care for the citizens of the UK, there are some disadvantages to seeking mental health help using only the resources from the NHS. Access through the NHS can take 4-18+ weeks, and unless one pays for private therapy/insurance, they likely won't have the ability to choose their therapist, control over the type of therapy they receive, or the ability to see someone for a long period of time (UK Council for Psychotherapy, 2023). Therefore, even though access to free healthcare should increase help-seeking, it is possible that these disadvantages play a role in the more negative help-seeking attitudes displayed in the UK in this study. Future research could specifically examine citizens' views of the NHS and whether or not these advantages and disadvantages play a role in help-seeking in the UK.

Meanwhile, the US does not offer universal free healthcare. Only 7.9% of the US population is uninsured, meaning that around 92.1% of the population pays for private insurance or receives coverage through a public plan, such as Medicaid and Medicare (Peter G. Peterson Foundation, 2023). While private therapy in the US is expensive as well, insurance often covers therapy, as long as the client meets certain criteria, such as having a mental health diagnosis. With insurance, the co-pay for therapy in the US can cost much less, though it varies heavily based on the therapist and insurance coverage. For this reason, insurance plays a major role in whether or not citizens of the US receive the help that they need. In fact, Walker et al. (2015) found in their study of over 36,000 adults from the US that having health insurance strongly correlated with use of mental health treatment. In addition, health insurance lowered the likelihood of feeling as though mental health needs were unmet, and of those who had perceived unmet needs, 72% reported at least one structural barrier. The prominence of health insurance in matters of mental health in the US may have played a role in the results of this study; for

instance, the more positive help-seeking attitudes and perceptions of support in the US may be connected to university students likely having access to their parents insurance or higher quality care. Future research could examine the role of health insurance in the US vs the UK (and the differences between specific healthcare plans) on the quality and perception of care. Evidently, all of the different factors stemming from the contrast between the two health care systems may account for some significant differences this study found between the two countries.

It is also worth noting that the university experience is very different between the US and the UK. Firstly, the cost varies greatly, which may play a role in the significant difference between the two countries that was found regarding perceived university support. In the US, the average in-state college student spends around $26,000 per academic year for four years; not only this, but for out-of-state students, tuition alone costs around $27,000 per year on average. Considering these prices and interest on loans, receiving a bachelor's degree in the US can eventually cost $500,000 or more (Hanson, 2023). Meanwhile, according to Murphy et al. (2017), universities in England charge an average of £9,250 ($11,380) per year for three years instead of four, and before 1998, college for domestic students was completely free. While university students in the UK do graduate with a lot of student loan debt, reform in 2012 made it so this debt goes away after 30 years if they are not paid off by that point. Though it is true that the amount that students in each country pay for university varies greatly based on household income, government loans, etc., it remains true that generally speaking, US college students pay more to go to school. Thus, it is possible that college students in the US receive higher quality support during their educational careers.

In addition to this difference in cost, counseling in universities may differ greatly. In the UK, universities often limit the number of counseling sessions that a student can have per year,

whereas this is often not true for universities in the US. For example, many universities like University of Lincoln offer around six sessions per school year, after which point you are put on the waiting list (University of Lincoln, 2024). The University of Cambridge uses "One at a Time Therapy," wherein only one or two initial appointments can be scheduled, after which point the student must wait at least two weeks if they want a follow up appointment (University of Cambridge, 2024). This availability of only short-term therapy at universities in the UK could play a role in the lower levels of perceived university support as well as less positive help-seeking attitudes. Students may feel pressured to see quicker improvements in their mental health, or they may be discouraged from seeking a therapist with whom they don't have time to connect. This short-term support may also be connected to a wider issue of less guidance in university settings in the UK. Future research could potentially compare specific universities in both nations to examine both perceived and actual university support and their connection to seeking mental health help. However, university support was not found to significantly predict help-seeking, despite positively correlating with help-seeking in the full sample and in the US. This disconnect could possibly be due to some of the questions on the university support scale asking more about classroom settings rather than counseling settings. It is also possible that, even if availability of university support doesn't necessarily cause help-seeking, the same students that perceive less help and support at their school do not seek it. Thus, as previously mentioned, it would be important in the future to compare perceived and actual support offered. With this many factors related to both cost and counseling, there are many directions that future research could take to examine whether or not the university experience plays a role in the help-seeking differences between these countries, as well as the reason for the disconnect between the two variables.

This study yielded relevant findings that have important implications for both nations. Seeing this significant difference in help-seeking between the two countries and examining which factors most heavily influence help-seeking in each highlights the areas in which the country can begin to improve to better support its students. Knowing that the UK has significantly lower levels of help-seeking compared to the US can begin the discussion of which predictors may lead to this difference. This information could be useful to a wide variety of people who have the capability to help others or encourage them to seek help. It may be useful to policy makers, specifically at the university level, but also in other settings where considering an international perspective may be useful for helping employees, students, etc. For example, policies on a UK college campus that aim to better support students may want to focus on demographics that were shown to be significantly less likely to seek help (men and younger students), and they may use this information to focus on creating initiatives that lower unhealthy self-reliance and self-stigma. This information could also be used by faculty and RA's at universities in order to better support both local and international students. Mental health professionals could use this information as well, working to deconstruct self-stigma and unhealthy self-reliance. The findings from this study could similarly be used in the US; self-stigma was found to play a significant role just like it does in the UK, and interestingly, mental health literacy seems to play a larger role in significantly predicting help-seeking. With this in mind, those in the previously mentioned roles could focus on working to deconstruct stigma and educate people on mental health topics in order to promote help-seeking and support students in the US.

There were several limitations to this study. Firstly, a larger sample would allow for results that are more representative of each country's population. On a similar note, this study

only examined college students between the ages of 18-27. With previous literature as well as the findings from this study suggesting that age plays a role in mental health attitudes and stigma, it would be worthwhile for future research to examine other age groups. Not only this, but future research could examine other cultures within these two countries. For instance, while this study looked at gender, age, perceived socioeconomic status, etc., it did not look at groups based on religion, political affiliation, etc. These subcultures can make a big difference in how someone addresses their mental health, and would be relevant variables in future research. On a similar note, the geographic region in which participants live within their country (particularly in the US, as it is very large and cultures differ by state) may also have a significant impact on the way they address and view mental health issues. This study did not take this into account, and it would be valuable to consider and compare different geographic regions in future research. Additionally, this study did not take into account the difference between nationality and country of residence, leaving the possibility of some participants studying abroad or living in the opposite country despite their country of origin. Replicating this study in other countries would also be useful in determining how to best support people around the world. People around the world deal with varying levels of stigma, and thus would benefit from a study such as this, especially in a post-pandemic society. While this paper briefly touched upon help-seeking before and after the COVID-19 pandemic in 2020, the effects of this pandemic on mental health issues are still being discovered. Thus, future research could also dive deeper into the pandemic's effects on the predictors of help-seeking with the intent of helping people in a new era.

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Table 1

Correlations Amongst Variables for All Participants

	Mental Health Literacy Knowledge	Mental Health Literacy Attitudes	Public Stigma	Self-Stigma	Help-Seeking	Self-Reliance	University Support and Structure
Mental Health Literacy Knowledge	—-						
Mental Health Literacy Attitudes	.528**	—-					
Public Stigma	-.142*	-.349**	—-				
Self-Stigma	-.308**	-.504**	.484**	—-			
Help-Seeking	.422**	.519**	-.281**	-.671**	—-		
Self-Reliance	-.140*	-.173*	.220**	.419**	-.379**	—-	

University Support and Structure	.172*	.192**	-.206**	-.312**	.256**	-.337**	—-

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Table 2

Correlations Amongst Variables in the US

	Self-Stigma	Mental Health Literacy Knowledge	Mental Health Literacy Attitudes	Public Stigma	Help-Seeking	Self-Reliance	University Support and Structure
Self-Stigma	—-						
Mental Health Literacy Knowledge	-.326**	—-					
Mental Health Literacy Attitudes	-.624**	.527**	—-				
Public Stigma	.509**	-.065	-.336**	—-			
Help-Seeking	-.649**	.496**	.657**	-.350**	—-		
Self-Reliance	.447**	-.114	-.179	.180	-.298**	—-	

University Support and Structure	-.274**	.272**	.319**	-.179	.285**	-.312**	—

**. Correlation is significant at the 0.01 level (2-tailed).

a. Nationality = US

Table 3

Correlations Amongst Variables in the UK

	Self-Stigma	Mental Health Literacy Knowledge	Mental Health Literacy Attitudes	Public Stigma	Help-Seeking	Self-Reliance	University Support and Structure
Self-Stigma	—						
Mental Health Literacy Knowledge	-.293**	—					
Mental Health Literacy Attitudes	-.425**	.538**	—				
Public Stigma	.471**	-.223*	-.366**	—			
Help-Seeking	-.681**	.360**	.437**	-.221*	—		
Self-Reliance	.403**	-.166	-.168	.262**	-.474**	—	

University Support and Structure	-.313**	.071	.096	-.237*	.162	-.376**	—-

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

a. Nationality = UK

Table 4

Gender Differences

	Mean Score (Male)	Mean Score (Female)	Std. Deviation (Male)	Std. Deviation (Female)	Significance (two-sided p)	t	df
Public Stigma	2.2880	2.1168	.60827	.51736	.04	2.07	186
Self-Stigma	2.5308_a	2.3027_a	$.81332_a$	$.70451_a$	$.049_a$	1.985_a	142.678_a
Help-Seeking	2.7070	2.9575	.58040	.57225	.004	-2.923	186
Self-Reliance	2.5680	2.4265	.59733	.58463	.109	1.61	186
University Support and Structure	6.4099	6.4991	1.03897	1.21469	.603	-.521	185

Mental Health Literacy Knowledge	3.1006	3.2614	.33110	.29583	<.001	-3.471	185
Mental Health Literacy Attitudes	3.9200	4.2382	.63693	.65880	.001	-3.286	186

a = equal variances not assumed

Table 5

Differences in Mean Scores US vs UK

	Mean (US)	Mean (UK)	Std. Deviation (US)	Std. Deviation (UK)	Significance (two-sided p)	t	df
Public Stigma	2.1818	2.1921	.56935	.53135	.895	-.132	198
Self-Stigma	2.3000	2.4813	.69164	.80415	.089	-1.708	198
Help-Seeking	3.0172	2.7537	.56551	.58593	.001	3.235	198
Self-Reliance	2.4869	2.4871	.58982	.59087	.998	-.003	198
University Support	6.6969	6.2132	1.13262	1.18486	.004	.292	197
Mental Health Literacy Knowledge	3.2126	3.1920	.32284	.31804	.651	.453	197
Mental Health Literacy Attitudes	4.0918	4.1774	.70605	.63319	.367	-.903	198

Table 6

Hierarchical Multiple Regressions Predicting Help-Seeking Behaviors/Attitudes: US

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	R^2 (Adjusted R^2)	R^2 Change
		B	Std. Error	Beta				
1	Gender	.164	.129	.141	1.274	.206		
	Age	.048	.026	.210	1.853	.067	.052 (.019)	.052
	Perceived Socioeconomic Status	.044	.039	.121	1.118	.266		
2	Gender	-.118	.100	-.101	-1.176	.243		
	Age	.025	.020	.109	1.268	.208		
	Perceived socioeconomic status	.027	.030	.074	.901	.370		
	Public Stigma	-.176	.081	-.182	-2.176	.032		
	Self-Reliance	-.143	.085	-.147	-1.686	.096	.524 (.477)	.472
	University Support and Structure	-.013	.043	-.028	-.312	.756		
	Mental Health Literacy Knowledge	.433	.163	.254	2.663	.009		

	Mental Health Literacy Attitudes	.357	.080	.445	4.432	<.001		
3	**Gender**	-.095	.096	-.081	-.987	.326		
	Age	.022	.019	.095	1.158	.250		
	Perceived Socioeconomic status	.033	.029	.092	1.163	.248		
	Public Stigma	-.077	.085	-.080	-.915	.363		
	Self-Reliance	-.029	.090	-.030	-.329	.743		
	University Support and Structure	.000	.042	-.001	-.012	.991	.570 (.521)	.046
	Mental Health Literacy Knowledge	.393	.156	.230	2.515	.014		
	Mental Health Literacy Attitudes	.218	.090	.272	2.407	.018		
	Self-Stigma	-.288	.098	-.346	-2.926	.004		

a. Nationality = US

b. Dependent Variable: Mean_Help_seeking

Table 7

Hierarchical Multiple Regressions Predicting Help-Seeking Behaviors/Attitudes: UK

Model		**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**	**R^2 (Adjusted R^2)**	**R^2 Change**
		B	**Std. Error**	**Beta**				
1	**Gender**	.350	.111	.302	3.159	.002		
	Age	.060	.023	.254	2.645	.010	.165 (.138)	.165
	Perceived Socioeconomic status	.060	.037	.157	1.637	.105		
2	**Gender**	.235	.099	.202	2.380	.019		
	Age	.047	.020	.196	2.361	.020		
	Perceived Socioeconomic status	.027	.034	.072	.815	.418		
	Public Stigma	.064	.097	.060	.664	.508		
	Self-Reliance	-.377	.088	-.386	-4.290	<.001		
	University Support and Structure	.015	.049	.028	.294	.769	.437 (.385)	.272
	Mental Health Literacy Knowledge	.127	.178	.068	.715	.476		

	Mental Health Literacy Attitudes	.261	.092	.282	2.841	.006		
3	**Gender**	.216	.079	.187	2.756	.007		
	Age	.040	.016	.168	2.542	.013		
	Perceived Socioeconomic status	.048	.027	.124	1.766	.081		
	Public Stigma	.243	.081	.227	3.005	.003		
	Self-Reliance	-.252	.072	-.258	-3.494	<.001		
	University Support and Structure	-.043	.040	-.083	-1.073	.286	.647 (.610)	.210
	Mental Health Literacy Knowledge	.101	.142	.055	.715	.476		
	Mental Health Literacy Attitudes	.143	.075	.154	1.904	.060		
	Self-Stigma	-.417	.058	-.586	-7.162	<.001		

a. Nationality = UK

b. Dependent Variable: Mean_Help_seeking

Table 8

Demographics: US vs UK

	US	**UK**
Mean Age in Years	21.76	21.63
Education level (Percentage Undergraduate Degree; Percentage Technical or Community College)	74.7; 25.3	97; 3
Mean Perceived Socioeconomic Status	5.09*	4.82*
Gender Percentages (Male; Female; Other)	31.3; 58.6; 10.1	41.6; 53.5; 5.0
****Race Percentages (White; Asian/Asian British; Black/Black British/African**	48.5; 33.3; 14.1; 15.2; 3.0	70.3; 17.8; 3.0; 0; 8.9

American;Latino/Hispanic; Mixed/Multiple/Other)		

*Socioeconomic Status ranked from 1 (worst) to 10 (best)

**The sum of percentages may be over 100, as participants could pick more than one response

Appendix

(Public) Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherod, 2000)

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.

Strongly disagree Disagree Agree Strongly agree

2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.

Strongly disagree Disagree Agree Strongly agree

3. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.

Strongly disagree Disagree Agree Strongly agree

4. It is advisable for a person to hide from people that he/she has seen a psychologist.

Strongly disagree Disagree Agree Strongly agree

5. People tend to like less those who are receiving professional psychological help.

Strongly disagree Disagree Agree Strongly agree

Self-Stigma of Seeking Help (SSOSH) **(Vogel, Wade, & Haake, 2006)**

1. I would feel inadequate if I went to a therapist for psychological help.

Strongly disagree Disagree Neutral Agree Strongly Agree

2. My self-confidence would NOT be threatened if I sought professional help.

Strongly disagree Disagree Neutral Agree Strongly Agree

3. Seeking psychological help would make me feel less intelligent.

Strongly disagree Disagree Neutral Agree Strongly Agree

4. My self-esteem would increase if I talked to a therapist.

Strongly disagree Disagree Neutral Agree Strongly Agree

5. My view of myself would not change just because I made the choice to see a therapist.

Strongly disagree Disagree Neutral Agree Strongly Agree

6. It would make me feel inferior to ask a therapist for help.

Strongly disagree Disagree Neutral Agree Strongly Agree

7. I would feel okay about myself if I made the choice to seek professional help.

Strongly disagree Disagree Neutral Agree Strongly Agree

8. If I went to a therapist, I would be less satisfied with myself.

Strongly disagree Disagree Neutral Agree Strongly Agree

9. My self-confidence would remain the same if I sought help for a problem I could not solve.

Strongly disagree Disagree Neutral Agree Strongly Agree

10. I would feel worse about myself if I could not solve my own problems.

Strongly disagree Disagree Neutral Agree Strongly Agree

***Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)* (Fischer & Farina, 1995)**

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

Disagree Somewhat disagree Somewhat agree Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

Disagree Somewhat disagree Somewhat agree Agree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

Disagree Somewhat disagree Somewhat agree Agree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.

Disagree Somewhat disagree Somewhat agree Agree

5. I would want to get psychological help if I were worried or upset for a long period of time.

Disagree Somewhat disagree Somewhat agree Agree

6. I might want to have psychological counseling in the future.

Disagree Somewhat disagree Somewhat agree Agree

7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.

Disagree Somewhat disagree Somewhat agree Agree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

Disagree Somewhat disagree Somewhat agree Agree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

Disagree Somewhat disagree Somewhat agree Agree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

Disagree Somewhat disagree Somewhat agree Agree

Self-Reliance Scale **(Mahalik et al., 2003).**

1. I hate asking for help.

Strongly disagree Disagree Agree Strongly agree

2. I ask for help when I need it.

Strongly disagree Disagree Agree Strongly agree

3. I never ask for help.

Strongly disagree Disagree Agree Strongly agree

4. I am not ashamed to ask for help.

Strongly disagree Disagree Agree Strongly agree

5. It bothers me when I have to ask for help.

Strongly disagree Disagree Agree Strongly agree

Mental Health Literacy Scale (MHLS) **(O'Connor and Casey, 2015).**

Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Likely = I am certain that it IS very likely

1

If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**

Very unlikely Unlikely Likely Very Likely

2

If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalised Anxiety Disorder**

Very unlikely Unlikely Likely Very Likely

3

If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**

Very unlikely Unlikely Likely Very Likely

4

To what extent do you think it is likely that **Personality Disorders** are a category of mental illness

Very unlikely Unlikely Likely Very Likely

5

To what extent do you think it is likely that **Dysthymia** is a disorder

Very unlikely Unlikely Likely Very Likely

6

To what extent do you think it is likely that the diagnosis of **Agoraphobia** includes anxiety about situations where escape may be difficult or embarrassing

Very unlikely Unlikely Likely Very Likely

7

To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood

Very unlikely Unlikely Likely Very Likely

8

To what extent do you think it is likely that the diagnosis of **Drug Dependence** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)

Very unlikely Unlikely Likely Very Likely

9

To what extent do you think it is likely that in general, **women are MORE likely to experience a mental illness of any kind compared to men**

Very unlikely Unlikely Likely Very Likely

10

To what extent do you think it is likely that in general**, men are MORE likely to experience an anxiety disorder compared to women**

Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:

- Very Unhelpful = I am certain that it is NOT helpful
- Unhelpful = I think it is unhelpful but am not certain
- Helpful = I think it is helpful but am not certain
- Very Helpful = I am certain that it IS very helpful

11

To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)

Very unhelpful Unhelpful Helpful Very helpful

12

To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions

Very unhelpful Unhelpful Helpful Very Unhelpful

When choosing your response, consider that:

- Very unlikely = I am certain that it is NOT likely
- Unlikely = I think it is unlikely but am not certain
- Likely = I think it is likely but am not certain
- Very Likely = I am certain that it IS very likely

13

To what extent do you think it is likely that **Cognitive Behaviour Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviours

Very unlikely Unlikely Likely Very Likely

14

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

If you are at immediate risk of harm to yourself or others

Very unlikely Unlikely Likely Very Likely

15

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

if your problem is not life-threatening and they want to assist others to better support you

Very unlikely Unlikely Likely Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek					

information about mental illness (e.g., seeing the GP)					
19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out if it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness I would not tell anyone					
26. Seeing a mental health professional means you are not strong enough to manage your own difficulties					
27. If I had a mental illness, I would not seek help from a mental health professional					

28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socialising with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					

34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					
35. How willing would you be to employ someone if you knew they had a mental illness?					

Scoring

Total score is produced by summing all items (see reverse scored items below). Questions with a 4-point scale are rated 1- very unlikely/unhelpful, 4 – very likely/helpful and for 5-point scale 1 – strongly disagree/definitely unwilling, 5 – strongly agree/definitely willing

Reverse scored items: 10, 12, 15, 20-28

Maximum score – 160

Minimum score - 35

University support and structure: (SPUSS) **(Wintre et al., 2009).**

Student Perception of University Structure and Support Scale items

1. Students are informed during student orientation about help available to them if they are having any emotional or adjustment problems.
2. The degree and programme requirements in the university calendar are very clear.
3. It's easy to make friends.
4. Professors in classes make it clear what students are expected to do in order to get a good grade on assignments, papers and tests.
5. If a student needed help for an emotional problem, it would be easy to find a service on campus to help them.
6. Professors aren't really clear about what they expect of students.
7. A student can feel pretty anonymous in my programme.
8. There are lots of confusing rules that make registration and course selection difficult.

9. The professors don't really care about their students.
10. If students are having difficulties with their academic coursework, they can easily talk to professors or their teaching assistants.
11. Professors at this school don't really try to make you think.
12. Professors get tests and assignments back to students in good time.
13. It is hard for students to get advice in selecting courses or deciding on a programme of study.
14. Professors and teaching assistants in classes are helpful and encouraging.
15. Academic policies on cheating and copying are made clear to students.
16. Professors and teaching assistants don't give very much feedback on tests, exams or papers.
17. There's very little opportunity for students to have direct, one-to-one contact with a professor.
18. Other students in my programme are supportive and friendly.
19. Professors emphasize reasoned questions and critical appraisal of what they present in class.
20. Faculty and teaching assistants post office hours and are available when they say they will be.
21. School officials and advisers are approachable and open-minded when you have a question or problem.