THE INFLUENCE OF CULTURE AND SELF-PERCEPTION ON THE MENTAL HEALTH CARE-SEEKING INTENTIONS OF COLLEGE STUDENTS

by

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Abstract

Mental health issues are common among young adults, especially those attending colleges and universities. There has been a growing concern related to the number of unmet mental health concerns for students and the potential ramifications associated with this unmet need. Studies show that approximately 17% of college students experience a mental health concern, yet only 20% of those with a concern obtain mental health care services. One's upbringing and background are known to influence decision making and are thus likely to play a role in decisions to seek mental healthcare; however, these norms can vary across cultures. In addition, depending on how one perceives the state of their own mental health, their intentions towards service utilization may be altered. The influence of culture and self-perception on intentions to seek mental health services were examined within this study. Results showed that students were more likely to recommend formal, professional, mental health treatments for their friend rather than themselves, even if symptoms were identical, χ^2 (1, N = 861) = 96.67, $p < 0.001$. However, the study did not indicate any significant relationship between background and likelihood to recommend formal treatment options, χ^2 (1, N = 422) = .549, p = .459, nor attitudes towards seeking professional psychological care, t(832) = -0.592, p = 0.554, d = 0.091. Identification of specific barriers preventing individuals from obtaining formal treatment warrants future research and will aid in development of future direction in how to provide care-services to diverse university populations.

Influence of Culture and Self-Perception on Mental Health Care-Seeking Intentions of College Students

Obtaining effective health care is often seen as highly dependent on the health care provider; however, the importance of patient receptivity is generally overlooked. One of the biggest challenges of evaluating health is the conflicting diagnostic: the patients' own exclusive viewing of their health status- the "internal" view, versus the observations and assessment of the health care provider- the "external" view (Sen, 2002). The discord between these two views could lead to some individuals normalizing difficulties that a provider finds troubling or in need of treatment. Comparisons between the internal perception and external observations, or other objective assessments, of health have demonstrated a bias for under-reporting internal experiences. However, this bias has not been well-examined when considering aspects of mental health. If a patient, specifically a college student, feels that perhaps their anxiety, depression, or any other form of mental duress is "normal" due to their circumstances and environment, then there could be a possibility they may not acknowledge the severity of their symptoms, which could further hinder their intentions to seeking mental health services. In addition, contingent on where an individual self-identifies their origin to be, established upon country or cultural background, they may even have a different reference level of health (Jürger, 2006), and therefore, affect their level of mental health service utilization or perceived need.

A person's background lays the foundation of many ideologies a person retains for their life. Reluctance to obtain professional help for mental health related issues is one such view that can be formed. Degrees of emotional openness such as strong beliefs in individualism, stoicism, low interpersonal dependence, and reluctance to disclose inner thoughts and feelings may underlie reluctance to obtain professional help (Komiya, Good, & Sherrod, 2000). Inhibition of emotions is valued greatly in various Asian cultures. This is a value that is primarily relayed

through familial attitudes from a very young age. This later carries on throughout the children's lives, and when faced with situations where counseling is recommended, such as for mental health conditions, individuals may become very apprehensive and defensive towards a notion that goes against the values upon which they were raised (Komiya et al., 2000). Values which promote emotional inhibition can also increase the experience of self-stigma for individuals, especially college students, who may fear becoming "weak" or "inferior" if they were to seek services such as counseling (Lannin, Vogel, Brenner, Abraham, & Heath, 2015). Alexithymia is one such construct of emotional inhibition, typically a form more common in men (Berger, Levant, McMillian, Kelleher, & Seller, 2005). Alexithymia is when one has difficulty expressing, managing, and experiencing emotions. Possessing this psychological construct often results in more negative attitudes toward help seeking behaviors, thus creating avoidance for mental health care service utilization in fear it may sway from the male gender role social construct. Low emotional openness and self-stigmatizing behaviors have been found to be correlated, with low emotional openness being associated with higher self-stigmatizing behavior.

The purpose of this study was to examine factors that affect the likelihood of college students seeking mental health care services with a primary focus on the influence of culture and self-perception. It is predominantly known that one's background and upbringing often factor into aspects of daily living, yet there is limited research on the extent of this influence on seeking mental health services. Often, those coming from families that have not fully acculturated, specifically those of Asian descent, are seen to be stoic in matters related to mental health (Sen, 2002). The purpose of this study is to examine the influence of background and culture to determine the validity of the hypothesis that participants that come from a less emotionally open background and culture would be less likely to obtain and seek mental healthcare services. Furthermore, it is often seen that many people will downplay their mental health needs and

problems, thus not seek mental health services, yet it was unknown whether they would acknowledge and recommend seeking care for their friends who experience the same symptoms. It was hypothesized that participants would undermine their own need for mental health services but would recommend that their friends obtain aid if they were experiencing the same symptoms as the participants. It was also additionally hypothesized that participants from less emotionally open backgrounds and cultures would be less likely to seek mental health services and would have a less favorable attitude towards obtaining any form of aid.

The information gathered at the end of this study may provide further insight into the factors that influence college student decisions about whether or not to access mental health care as well as inform the development of future preventive interventions.

Methods

Participants

A total of 984 surveys were completed and 861 participants were included in analyses. Reasons for exclusion included incomplete data (n = 42), duplicate answers (n = 16), or likely invalid responses based on response time (fewer than 10 minutes) and validity items (participants incorrectly answering one of four validity items were excluded; n = 65).

Most participants self-identified at female (68.9%), and the average age of participants was 18.52 (range18-60) years old. Participants were all college students attending East Carolina University, enrolled in an introductory psychology course or on the university's Honors College's listserv. The sample included first-year students (84.7%), second-year students (10%), third-year students (3.4%), fourth-year students (1.4%), and other (0.5%). Participants were primarily White (77.2%), followed by African American (17.9%), Asian (4.5%), Native American (1.9%), and other (4.9%). The majority of participants (93.6%) self-reported an

emotionally open background based upon their own and parents' citizenship from world regions including North (e.g., Canada, the United States) and South America (e.g., Brazil, Mexico, Peru), Europe (e.g., United Kingdom, Netherlands, Italy), Eastern Mediterranean (e.g., Afghanistan, Iraq, United Arab Emirates), and Western Pacific (Australia, New Zealand). The remaining participants or their parents were from traditionally stoic regions including Africa and Southeast Asia (Fisher, 2012).

Materials

Demographic questionnaire. Participants were asked to provide general demographic information including gender, cultural background, year in school, age, self-origin and primary care givers' origin.

Attitudes Toward Seeking Professional Psychological Help Scale. The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) is a 10-item, self-report measure of attitudes toward seeking mental health services (Fisher & Farina, 1995). Items are rated on a 4-point Likert-type scale from 0 (*disagree*) to 3 (*agree*). Items 2, 4, 8, 9, and 10 were reverse scored, then summed for a total rating. The higher the score, the more positive attitudes indicated towards seeking professional help. Evidence for the reliability and validity of this measure is reported by Elhai et al. (2008) and Picco et al. (2016). In the original psychometric study of the ATSPPH-SF scale done by Elhai et al. (2008), Cronbach's alpha was found to be 0.77, while in our present study the alpha was found to be 0.75. The proximity of alpha scores convey the scale to be reliable and sound. Criterion and construct validity of the ATSPPH scale were also found in these previous studies, where higher scores were correlated with greater intentions to seek mental healthcare services in the following month.

Vignettes and questions. Four vignettes were developed using the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5; American Psychiatric Association,

2013) to provide a brief description of a person experiencing mental health concerns. The vignettes had two types of mental health concerns of different severities: 1) depressive symptoms and 2) depressive symptoms with psychotic features. Each vignette type had two versions. One version per vignette type was composed as if the participant was in a situation in which they are experiencing symptoms that clearly outline mental health concerns. The second version of each vignette type was composed as if a close friend of the participant was experiencing symptoms of the same mental health concerns. There were four vignettes total, two types, each with two perspectives (self vs. other; See Appendix A). Participants were randomized to receive one of the four vignettes and provided recommendations for the friend or indicated what actions they would take themselves given the symptoms. Four hundred, twenty-two participants received a self-vignette type, composed as if the participant was in the situation in which they are experiencing the described symptoms. The remaining 439 participants received a friend=vignette type in which the outlined symptoms were being experienced by a close friend. Answers were categorized into formal (e.g. seeking services from primary care doctor, psychologist, psychiatrist) and informal (e.g. talking to friends, family, religious figure) treatment options. Data received was transcribed as dichotomous variables such that if participants recommended any formal mental health treatment options, they would receive a 1 and if they did not select any formal options, they would receive a 0.

Procedure

Participants who volunteered to participate in the study on the SONA research database website were redirected to Qualtrics, a survey software, where they provided informed consent. Participants then completed the demographic questionnaire, read a vignette and completed questions in relation to the vignette, and completed the ATSPPHS. Participants received a short

explanation of the study purpose at the completion of the study as well as course credit if it was completed through the SONA system as compensation for their time.

Data analytic plan. In order to address the first hypothesis that participants will undermine their own need for mental health services but refer peers and friends to seek professional mental health services for the same symptoms, we conducted two separate chi-square tests. In the first chi-square test, we compared type of vignette received, either self or other, on informal mental health care treatment recommendations made. In the second chi-square test, we compared type of vignette received on formal mental health care recommendations provided.

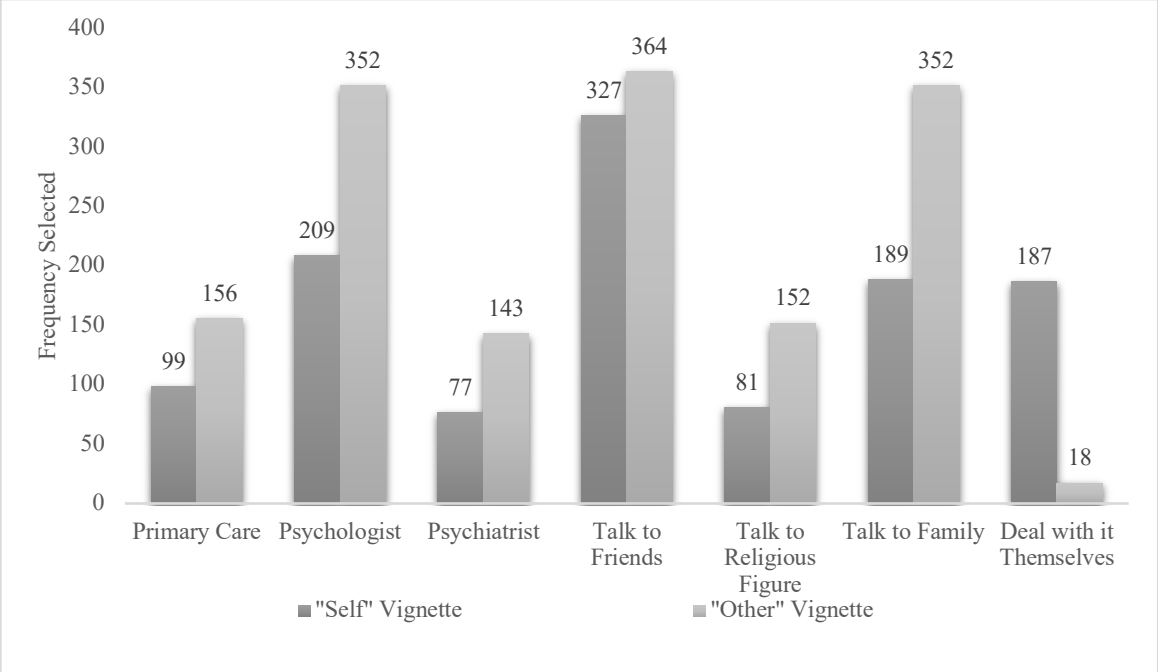
To test the second hypothesis that participants from less emotionally-open, or stoic, backgrounds will be less likely to seek mental health service and have less favorable attitudes towards seeking services, a chi-square test and *t*-test were performed respectively. In the chi-square test, we compared individuals from stoic or emotionally-open backgrounds with their likelihood to recommend formal treatment options. In the *t*-test, we compared emotional-openness of an individual's background in regard to their mean scores on the ATSPPHS.

All analyses were run in the Statistical Package for the Social Sciences (SPSS) v24 statistical analysis software (IBM Corp, 2016).

Results

Participants were equally likely to recommend informal MH services regardless of the subject of the vignette they received, χ^2 (1, N = 861) = 2.20, p = .138. Participants were significantly more likely to recommend formal MH services when the subject of the vignette was a friend rather than themselves, χ^2 (1, N = 861) = 96.67, $p < 0.001$. See Figure 1.

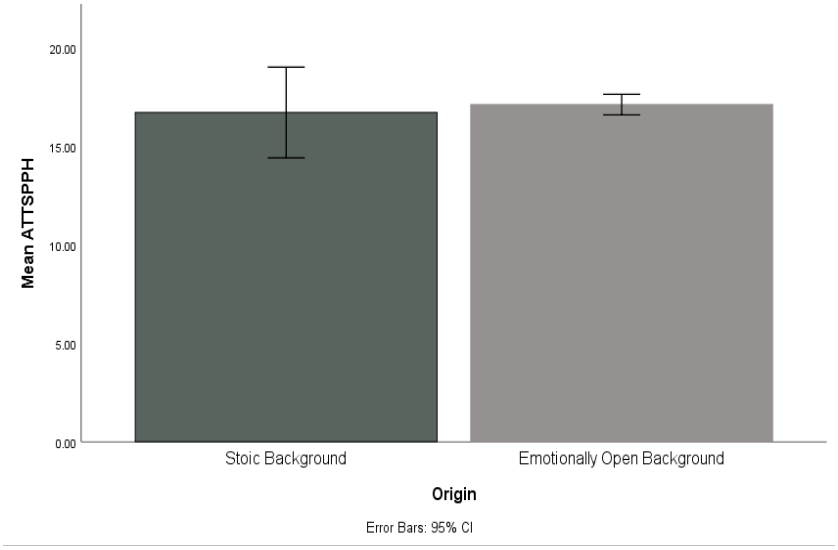
Figure 1. Recommendations by Vignette Type



To test whether participants from less emotionally open or stoic cultures were less likely to seek mental health services, a chi-squared test of independence was performed on data from participants who received the self-vignette. Participants of stoic and emotionally-open backgrounds were equally likely to recommend formal mental health services χ^2 (1, N = 422) = .549, p = .459. Those from stoic backgrounds were as likely to self-refer to formal mental services as those from emotional open backgrounds.

To test whether attitudes towards seeking professional psychological care were related to the emotional-openness of an individual's background, an independent samples *t*-test was conducted. The results showed no significant differences in attitudes between those from emotionally open backgrounds (M = 16.89, SD = 5.18) compared to those of stoic backgrounds (M = 16.45, SD = 4.42), t(832) = -0.592, p = 0.554, d = 0.091. The magnitude of the differences between the means (mean differences = -0.592, 95% CI: -1.90 to 1.02) was small to nonexistent. See Figure 2.

Figure 2. ATSPPHS Score Difference by Cultural Background



Discussion

The results of this study supported the notion that there is a relationship between formal mental health treatment recommendations being recommended for others compared to one's self. These results are similar to previous research conducted on the effects of self-perception on the decision to seek mental health services. Sen (2002) reviewed work on discrepancies between self-report and objective measurements of health and concluded that individuals have an "internal" view and an "external" view on assessments of well-being. This "internal" view includes personal views on one's own state of well-being, and health concerns or difficulties perceived with this view are often normalized. An "external" view encompasses how the same individual views the identical health concerns and difficulties but in the life of another individual, and these concerns are often perceived as more significant (i.e. peer, friend). A study by Lee & Dugan (2015) on the gap between self-reported and assessed mental health in older adults found that nearly one out of three participants had discrepancies in self-reported and assessed status, and as expected, this discrepancy did have implications on mental health service

utilization. Patients who do not perceive a problem in their mental well-being are unlikely to request or receive help (Garrido, Kane, Kaas, & Kane, 2009). However, the results of the study did not find a similar significance in relationship between informal mental health treatment recommendations being recommended for others versus self. Participants were equally as likely to refer informal mental health care options for themselves versus others. Thus, they did not fail to perceive that assistance was needed. However, participants were significantly less likely to indicate behavioral intent to seek formal treatment for themselves than they were to refer a friend. This pattern of results implicates some other underlying factor besides a bias towards normalization of symptoms which may be driving these differences with formal care utilization such as attitudes towards treatment seeking and stigma. In contrast, talking to your friends, family, or a religious leader may be perceived as less threatening than seeking formal mental healthcare. Informal mental health treatment options offer little-to-no backlash, whereas obtaining formal treatment can be intertwined with public stigma, or even self-stigma one perceives themselves. An individual can also view obtaining formal care as an extreme option when referring to their own mental health concerns but not when considering the similar concerns of others. Similarly, a meta-analysis conducted by Leong and Lau (2001) concluded that perceived stigma hinders help-seeking behaviors to the intensity that individuals may confine their mental health concerns until behaviors become unmanageable. From this point, we can conclude that while individuals were less likely to utilize formal treatment measures themselves, they did make formal treatment recommendations to others, indicating it is not a lack of knowledge nor awareness of need that prevents formal service utilization. The present research adds to the literature on self-perception and self-recommendation, as students in our sample did recommend professional treatment, if the subject of the vignette was a friend rather than themselves. Thus, future research should examine what specific barriers, such as possible

stigma, hesitations, or uncertainty on whether they need formal care, students may perceive when considering formal treatment measures for themselves.

The results of the present study were not consistent with previous research as there was not a significant relationship between coming from a less emotionally-open, or stoic background and a decreased likelihood to seek mental health services. Participants from stoic backgrounds were equally as likely as those from emotionally-open background to recommend formal mental health services. Similarly, results of this study did not find a significant association between cultural openness of one's background and attitudes toward seeking professional psychological help. Participants of less emotionally-open backgrounds did not have any less favorable attitudes than those of emotionally-open backgrounds. This is in contrast to previous research such as Komiya et al. (2000), who found that young people from ethic minority groups, such as Asian cultures, are more reluctant to seek mental health assistance. Komiya and colleagues hypothesized that this reluctance may root from such cultures valuing inhibition of emotion, strong individualism, and stoicism and therefore, are associated with decreased levels of mental health service utilization. Inconsistencies between this study and previous studies could be due to the small group of individuals in the present study who self-reported being first- or second-generation individuals of a geographic region known to be more stoic in nature, such as the Asian and African regions as compiled by Fisher (2012). Additionally, another possible explanation could be that participants of the sample from self-reported stoic backgrounds may be more accultured. Leong and Lau (2001) conducted a meta-analysis and concluded that individuals from stoic cultures who are more highly accultured tend to possess more positive attitudes toward help-seeking behaviors. A study conducted similar to the once present also found that degree of need, or one's level of psychological distress, was not associated with help-seeking attitudes among Asian American college students (Ying & Hwang, 2009). They

speculated that it may be other variables (i.e., culture-related or predisposing characteristics) that may be more influential in help-seeking attitudes. However, in order to make any conclusions and determine if there was a confounding factor of acculturation in variability, future studies need a large enough sample size of individuals self-identifying as being from or having a primary caregiver from a stoic region.

The strengths of this study such as large sample size should be considered in the context of several limitations. The data were derived from self-report measurement tools. Thus, it is possible that data were biased by the effects of social desirability or low motivation resulting in random responding. However, we attempted to minimize this bias through confidential participation and screening responses for patterns consistent with random responding (e.g., minimal time completing the survey, incorrect responses to validity items). Fewer than 8% of the survey population indicated that they or their parents came from a stoic cultural background, which may have resulted in lower power to find significant results. Future studies with a larger sample size of stoic-background reporting participants may increase confidence in this null finding. External generalizability may be limited as this sample was fairly homogenous in regard to racial/ethnic diversity.

The present study primarily surveyed those who were White and in their first year of college. Expanding the study to include a more diverse sample may provide a more representative sample and thus increase generalizability of the results. Further, it would be important to expand the study to other universities or settings to explore the prevalence and influence of other barriers such as lack of diversity in counselors, lack of accessibility, or simply lack of knowledge on how and where to obtain services. In accordance with results that found participants were more likely to recommend formal services for their friends compared to themselves, future efforts to decrease psychological barriers to seek service may be more

successful by pinpointing and researching particular hesitations and misgivings the participants may have when managing their personal mental health concerns in a formal manner. Additionally, this study used only quantitative measures and adding qualitative measures asking students about barriers they believe prevent them from pursuing mental health care services on campus may help uncover obstacles overlooked by the present study, as well as previous, studies. This will reduce assumptions of previous data and provide specific barriers or hesitations that students possess on utilizing on-campus services, directly from the population target.

In conclusion, contrary to what was predicted, those from less emotionally-open backgrounds were not any less likely to recommend formal mental health care options, nor were they more likely to have less favorable attitudes towards seeking professional psychological care. However, the results of this study did illuminate that there is some barrier or hesitation present that prevents students from seeking formal mental health care services for themselves, even when they are willing to recommend such measures for their friends. Mental health issues are increasingly becoming a concern for all individuals; however, young adults, especially those attending colleges and universities, are especially susceptible. The relevance of the topic, especially in academic settings, is a topic of great importance. By further researching the influence of culture and self-perception in regard to care-seeking intentions, we can pinpoint factors that may influence service utilizations and develop future directions for how to best provide mental health care services to a diverse academic population. As mental health concerns, specifically in the lives of college students, continue to increase rapidly, it is vital to identify any physical, psychological, and social barriers that may exist and prevent students from seeking care. Addressing and reducing these barriers may decrease untreated mental health concerns,

and in turn, increase the mental well-being of college and university students to allow students to lead a more holistic, positive life.

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APPENDIX A: VIGNETTES

Vignette 1 (Friend as Subject, MDD): Your friend works outside of school as a laboratory technician. Their supervisor has become concerned after they became tearful while being mildly criticized during an otherwise positive annual performance review. They realize that they have been "feeling low for years" and that hearing criticism at work feels like it is "just too much." They've been feeling low for the past three years though sometimes they feel worse than others. Your friend feels frustrated with their job, which they see as a "dead end," yet fear that they lack the talent to find more satisfying work. As a result, they struggle with guilty feelings that they "haven't done much" with their life. Despite troubles at work, your friend can concentrate without difficulty. They are not having any suicidal thoughts, yet sometimes wonder, "What is the point of life?" They occasionally have trouble falling asleep. However, have not had any changes in their weight or appetite. Although they occasionally go out with friends, your friend feels shy and awkward in social situations unless they know the people well. They acknowledge that they have few friends. They are still able to enjoy activities, such as jogging and being outdoors. In the past, their romantic relationships tended "not last long," but they feel like their sex drive is normal.

Vignette 2 (Self as Subject, MDD with Psychotic Features): You have begun to "lose interest in life" about 4 months ago. During this time, you have felt excessively sad. You have lost 9 pounds without dieting because you do not feel like eating. You have trouble falling asleep almost every night and wake at 3:00 a.m. several mornings per week (you normally wake at 6:30 a.m.). You have diminished energy, concentration, and ability to do your job at a dog food processing plant. You are convinced that you made a mistake that could lead to the deaths of thousands of dogs. You describe the mistakes you have believed to have made at work and insist that you would soon be apprehended for your mistake. Your boss tells you that you have not

made any mistakes and that you are worrying over nothing. You begin to hear a voice that tells you that you are "no good" and "not worth anything." This voice is not your own internal monologue. Others do not hear the voice and it makes you feel frightened. You go to see your doctor. Despite these troubles, your doctor tells you that you are healthy.

Vignette 3 (Self as Subject, MDD): You work outside of school as a laboratory technician. Your supervisor has become concerned after you became tearful while being mildly criticized during an otherwise positive annual performance review. You realize that you have been feeling low for years and that hearing criticism at work feels like it is just too much. You've been feeling low for the past three years though sometimes you feel worse than others. You feel frustrated with your job, which you see as a dead end, yet fear that you lack the talent to find more satisfying work. As a result, you struggle with guilty feelings that you haven't done much with your life. Despite troubles at work, you can concentrate without difficulty. You are not having any suicidal thoughts, yet sometimes wonder, "What is the point of life?" You occasionally have trouble falling asleep. However, have not had any change in your weight or appetite. Although you occasionally go out with coworkers, you feel shy and awkward in social situations unless you know the people well. You have few friends. You are still able to enjoy activities, such as jogging and being outdoors. In the past, your romantic relationships tended to not last long, but you feel like your sex drive is normal.

Vignette 4 (Friend as Subject, MDD with Psychotic Features): A friend tells you that they had begun to "lose interest in life" about 4 months earlier. During this time, they have conveyed feeling excessively sad. They have lost 9 pounds without dieting because they do not feel like eating. They have trouble falling asleep almost every night and wake at 3:00 a.m. several mornings per week (they normally wake at 6:30 a.m.). They have diminished energy, concentration, and ability to do their job at a dog food processing plant. They are convinced they

made a mistake that could lead to the deaths of thousands of dogs. They described the mistake they believed they made at work and insisted that they would soon be apprehended for their mistake even though their boss told them that they did not make any mistake. Your friend asks you if you hear anything and you do not. They acknowledge that they are hearing a voice telling them that they are “no good” and “not worth anything.” Your friend appears frightened by what they have been hearing. Despite these troubles, your friend tells you that her recent physical examination was normal and their doctor told them they were healthy.