Assessing Levels of Stigma and Accessing Mental Health Services

It could be regarded as a cultural phenomenon that mental health issues of post-secondary students have become a growing concern for governing bodies due to the high prevalence of these issues (Samuolis, Barcellos, LaFlam, Belson, & Berard, 2015). This pressing matter suggested that it was important to uncover the barriers to help-seeking, and what could have improved the utilization of counselling services due to the high prevalence of mental health challenges among post-secondary students. The Ontario College Health Association reported that university students were more likely to have reported mental illness symptoms than non-university youth (Heck et al., 2014). To demonstrate this societal concern where young people are overwhelmed and struggling at the post-secondary level, Marsh (2011) studied our American counterparts. This study concluded that “40% of students enrolled on U.S. college and university campuses reported at least one mental health problem for every 12 months” (p. 6). Not only does this put an overwhelming strain on the individuals who provided mental health support to student populations, but this may have been translated into a lower level of quality of services, due to employees being overwhelmed and overworked. This may also have resulted in students not getting the support they required. These statistics depicted post-secondary communities who struggled to adapt to their environments, but this did not effectively capture the students who required help but were unable to utilize it due to the potential stigma associated with experiencing a mental health concern.

Definitions

For this study, mental health is considered being able to enjoy life and deal with the challenges that individuals face every day – whether that involved choices and decisions being made, adapting to and coping in difficult situations, or talking about needs and desires (CAMH,
Within this project, it was also recognized that there were many ways to conceptualize the term “mental illness.” Some define mental illness by a diagnosis from a health care professional (e.g., using the Diagnostic and Statistical Manual – 5) (APA, 2013) while others used the term more informally to refer to various struggles with mood or emotional regulation (e.g., anxiety, depression).

The focus of this study is not to determine whether or not a student has a “mental illness” but instead will assess various aspects of mood and coping. As a result, the study will conceptualize this as having challenges with one’s mental health but will not refer to this as “mental illness.” Within this study, challenges to one’s mental health will be understood as changes that occurred over a period or that significantly affect the way a person copes or functions. When these changes in thinking, mood, and behaviour were associated with significant distress and impaired functioning, it may be that the person experienced a difficulty in maintaining their mental health (CAMH, 2012). In addition, this project looks at utilization of Good2Talk which is a free, confidential helpline which provided professional counselling and information and referrals for mental health, addictions and well-being to post-secondary students in Ontario, 24/7/365 (Good2Talk, 2017).

**Prevalence**

Due to the stigmatization that can come with identifying as someone who is struggling with one’s mental health, (e.g., depression or anxiety), individuals may not exhibit help-seeking behaviour when they need it. As a result, the statistics regarding help-seeking behaviour may be unrepresentative, and the severity of mental health concerns may be underestimated compared to its reality. To solidify this claim Mason, Hart, Rossetto, & Jorm (2015) discovered that one in four young people with a mental health problem received professional help, while Marsh (2011)
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stated that less than half of such students on university and college campuses ever utilized mental health services. While many students might not be accessing services, counselling offices are already understaffed/underfunded (Institute for Health Metrics and Evaluation, 2015). If the full range of students did seek help, then the system would be even more overwhelmed.

An example of the magnitude of this issue is from Ryerson University in Toronto, Ontario. The university saw a 200 percent increase in demand from students in crisis situations from 2011 to 2012 (Macleans, 2012). This increase in volume has the capability to overwhelm the services put in place to help students. In 2013-2014, 18% of inpatient hospitalizations for children and youth age 5-24 in Canada were for a mental disorder (Canadian Institute for Health Information, 2015). Additionally, mental health accounted for 10% of disease in Ontario, but only received about 7% of health care dollars (Brien et al. 2015). This exhaustion of the system clearly conveyed that students who experience difficulties with their mental health made up a large proportion of university populations, yet many would not actively seek out professional help (Marsh, 2011).

When students have not accessed services, they are at risk to develop increased health concerns, and Oexle (2015) stated that poor psychological outcomes can result. A study that investigated the waiting times for a psychiatrist’s service concluded that 3% of the 230 psychiatrist offices contacted were offered immediate appointment times, with their wait times ranging from 4 to 55 days (Goldner, Jones, & Fang, 2011). The low response rate of psychiatrists in Canada depicts another potential additional barrier which individuals must overcome to receive the help they required.
High Stakes Testing and Risk of Academic Failure

The culture of academia consists of high-stakes testing, short periods of time to complete large quantities of work, and an extremely large importance being placed on Grade Point Averages (GPAs). For some students, high stakes testing has not proved beneficial to their academic success (Nichols, 2007). This style of education may have resulted in increased levels of stress and pressure placed on the student, which could be detrimental to the quality of their work. Many post-secondary students have tended to carry this burden on their shoulders throughout their academic career, while simultaneously being encouraged to maintain a healthy lifestyle which included being mindful of one’s mental state, maintaining connections to family and friends, and ensuring that they are physically active.

For many students, maintaining positive health has become compromised to focus their efforts on obtaining and maintaining a strong academic record. If an individual does not maintain a healthy mental state due to the pressures imposed on them, a higher risk of depression and anxiety would result due to the student’s reaction to the stressors in their life (Mahmoud, Staten, Hall, & Lennie, 2012). These diagnoses could create a vicious cycle in which poor academic achievement could influence how well an individual functioned throughout their day, which may result in further academic failure or underperformance, as well as potential concerns regarding their physical health.

This cycle was highlighted in research conducted by Hartley (2013) in which he discovered in a sample of 121 undergraduate students that students with lower mental health scores completed fewer credits over time compared to students who were not seen as having mental health concerns. The societal expectations of academic achievement created an unnecessarily large burden on students and promoted the inclusion of students who do not suffer
from mental health issues. This created an atmosphere where students who were struggling are left to cope and function without appropriate supports. In contrast, students who were not struggling were under pressure as well, but were better able to cope with the challenges they face daily. Some aspects that may account for these differences could have been varying levels of social support.

In a long-term lens, students who completed the Mental Health Inventory-5 (MHI-5) and had identified as having mental health challenges were at greater risk of academic failure, and completed fewer credits over time which could pose as a barrier to academic success (Fink, 2014; Hartley, 2013). This finding illustrated an atmosphere where it had been normalized for struggling individuals to be unable to function throughout their day to day activities. This resulted in a large quantity of students who were unable to apply their skills to real world situations, and to contribute to society. In many instances, these individuals had the potential to do so, but the challenges to maintain their health and well-being stood in the way which created unequal opportunity among university students.

The current state of post-secondary education presents themes of “the survival of the fittest,” in this case whoever possessed the mental stamina to endure the stressors of university life would “survive” while those who struggled with mental health issues may have had trouble completing their academic requirements. To support this claim, Shamsuddin (2013) stated that high expectations of academic achievement created a stressful environment for students, and if left untreated could be hazardous to physical and mental health. Fink (2014) stated that college students more frequently screened positive for generalized anxiety, major depression, and panic attacks, while Huz (2016) found that suicide was the second leading cause of death among American college students. Additionally, Statistics Canada reported that suicide was the second
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leading cause of death for people between the ages of 15-34 (2015). These findings were indicative of some of the stressors facing those in later adolescence and young adulthood. This can then leave some students with multiple barriers that they need to manage and/or overcome. It can be concluded that the pressures institutions imposed on students resulted in increased levels of anxiety and depression (Fink, 2014) which in some situations could have led to the risk for suicidal ideation or attempts (Huz, 2016).

**Stigmatization**

The rising instances of mental health concerns across post-secondary populations was widely prevalent with research that stated that young people aged 15-24 were more likely to experience mental health concerns than any other age group (Pearson, Janz, & Ali, 2013), yet stigma still existed regarding the discussion of suicide. Stigma can be defined as negative attitudes (prejudice) and negative behaviour (discrimination) toward people with substance use and/or mental health problems (CAMH, 2012). This reluctance to speak about individuals who complete suicide can stem from suicide being a taboo topic for many years, with it potentially having a stigmatizing effect on the family (CMHA, 2016). For example, the term “commit suicide” is an example of the stigma as “commit” is often associated with a crime or sin. Mental health advocates suggested the use of “completed suicide” or “died by suicide” to reduce the stigma and recognize suicide as a health concern, not a “choice.” Recent research stated that stigma against persons with mental illness remained the strongest negative connotation of all social relations (Pingani, 2016), and this statement enforced how powerful stigmatization can truly be. It is important to note that stigma may have severely influenced the helping seeking behaviours of those who identify as having mental health concerns (Mason, 2015).
An excellent example of this comes from Andrade (2015) in which he reported that students frequently indicated a fear of being labeled or stigmatized as a reason for not seeking psychological help or counselling, even though they know they could have benefitted from it. Stigmatization has short term impacts such as a reduction in help-seeking behaviour, and long term impacts such as difficulties finding a job, discontinuation of studies, decrease in social network, reduced access to mental healthcare and low adherence to treatment (Pingani, 2016).

Theoretical Rationale

Three theories help explain why an individual who experiences mental health concerns may not have sought help for their concerns. These theories include Astin’s Input-Environment-Outcome (I-E-O) (Fink, 2014), Theory of Planned Behaviour (Marsh, 2011), and Self-Regulatory Model (Oexle, 2015). The I-E-O Model suggests that social contexts, such as institutional environments and background characteristics of students, explains student’s change in college (Fink, 2014). Within the context of this study, the stressful environment of college was judged to be responsible for the shift in student’s mental health.

The Theory of Planned Behaviour states that the most salient predictor of behaviour is an individual’s decision or intention to perform the behaviour, based on their attitude, subjective norms and perceived ability to perform the behaviour (Marsh, 2011). Within the context of this study this theory could explain student’s help-seeking behaviours. If a student did not have the intention to get help, then the likelihood that they utilized counselling services was slim according to this theory. Important factors that could inhibit help seeking behaviour can include the stigmatization associated with mental illness.

Lastly, the Self-Regulatory Model states that the individual is an active problem solver and when they are faced with a mental health threat, the individual will have tried to identify and
understand the problem at hand while finding solutions for it (Oexle, 2015). Within the context of this study, the individual understood that they are mentally unwell, and wished to understand their current state and this understanding could result from visiting a counselling service.

Solutions toward alleviating stigmatization towards mental health concerns among post-secondary students can take form in counselling centres on campuses, since these services play an important role in increasing student retention and graduation rates (Marsh, 2011). It becomes obvious how important counselling centres were and remain to mentally ill individuals, and the positive effects that they can have on students. Without services like these, lower amounts of graduates may have resulted and the reputation of a post-secondary institution can become jeopardized. In contrast, not all individuals will prefer to have utilized professional resources, and may prefer to reach out to more informal sources of help such as friends or family (Mason, 2015). This can be typical behaviour of an individual who resisted authority, or does not feel comfortable to have disclosed their innermost thoughts to a stranger yet can still provide comfort to those who need it most.

Additional ways to improve an individual’s perceived sense of stigmatization can be through empathy and increased social activity to promote the importance of mental health and well-being (Wynaden, 2014). Not only would this have benefitted the individual who had experienced stigma towards them, but this may have developed a sense of tolerance within the companion. This could have increased levels of acceptance toward those with mental illnesses, which is essential to create a society that is inclusive in nature.

The Present Research

It is stated in recent research that it is crucial to detect factors that predict and have increased help seeking behaviour (Oexle, 2015), and that was the goal of this current study. Post-
secondary students suffer from increasing levels of mental health challenges, and if a greater understanding of this issue is developed, then this could provide a greater quality of life. This could be done through increasing levels of help-seeking behaviour while levels of felt stigmatization are decreased. There was plenty of research that discussed the deteriorating mental health of post-secondary students, but little research that discussed barriers to access Good2Talk, or in-person counselling services on university campuses.

The present study focused specifically on demographic, mental health, and situational factors that predicted use of counselling services as well as strategies that would make the service easier to use by students and the wider public. Past research has stated that stigma towards receiving treatment is a challenging barrier for individuals who experience mental health difficulties (Mason, 2015). Specifically, this study focused on phone-in counselling services such as Good2Talk, and in-person counselling services offered on Western University campus. The sample included 153 male and female students at Western University and its affiliate campuses (King’s, Huron, and Brescia) from the ages of 18-24 who completed the Discrimination and Stigma Scale, the Mood and Anxiety Questionnaire D-30, and the Satisfaction with Life Scale. In addition, a short survey consisted of closed-ended and open-ended questions that was utilized regarding usage of the phone support line Good2Talk and/or other in-person counselling supports on campus. As well individuals were asked how to improve accessibility of these services.

The study is guided by the following hypotheses:

1. Those with higher ratings of stigma will have higher ratings of depression and anxiety and lower ratings of life satisfaction.

2. Those with higher levels of discrimination and stigmatization will use services less.
3. Women will indicate utilizing counselling services more than men.

Method

Participants

Participants were approximately 153 undergraduate students recruited from a large university in Southwestern Ontario. Individuals who participated in exchange for 2.0 SONA credits were instructed to complete an associated assignment regarding the research study which was then submitted to their instructor by the researcher ($M_{age} = 20.33$, 40 males, 106 females, 1 other). Participants who were recruited through posters distributed on the university campus were placed in a draw for a $50.00 VISA gift card.

Measures

Demographics. Demographics was assessed through four questions inquiring about age, gender, year of study, and major studied. Participants had the option to provide as much information as they were comfortable with.

Usage of Good2Talk and in-person counselling services. Usage of Good2Talk and in-person counselling services was assessed through various questions concerning counselling service usage. Participants then completed the following questions where they checked all that applied in each case: “If you were to use Good2Talk, would you use a) Text Messaging, b) Phone Calls, c) Social Media, d) Other,” “For what concerns would you use a service such as Good2Talk? a) Depression, b) Breakups, c) Stress, d) Anxiety, e) Roommates, f) Exams, g) Other,” “Have you called for these concerns? a) Depression, b) Breakups, c) Stress, d) Anxiety, e) Roommates, f) Exams, g) Other,” and “If you have not called Good2Talk, why not? a) Embarrassed, b) Busy, c) Stigma, d) Skeptical of treatment, e) Preference to deal with problems on own, f) “I don’t need it.” These questions were also repeated for in-person counselling
services that are on campus. For each of these questions, participants had an open-ended box where they were asked to elaborate on each box they checked. Participants had the option to not answer questions, at their discretion. Definitions of Good2Talk, and in-person counselling were provided.

**Discrimination and Stigma.** Levels of felt discrimination and stigmatization were assessed using the 34-item scale developed by Brohan et al. (2013), with the first 22 items focused on being treated unfairly being used for the purposes of this study. Tests of reliability for this measure have shown Cronbach’s alpha to be reported as $\alpha = 0.78$ (Brogan, Clement, Rose, Sartorius, Slade, & Thornicroft, 2013). In the present study, reliability was adequate, $\alpha = .88$. Respondents were asked to indicate how they have been treated in various situations due to mental health difficulties they may have experienced. If participants have not experienced a mental health difficulty, there was the option to state that the situation was not applicable to them. Various examples from this item include “Have you been treated unfairly in making or keeping friends,” “Have you been treated unfairly by the people in your neighbourhood,” and “Have you been treated unfairly in keeping a job.” Participants were asked to indicate the extent of their personal agreement with each item by completing a 4-point Likert scale (Not at all, A little, Moderately, and A-lot). Scale scores were computed for discrimination and stigma felt by averaging item responses.

**Mood and Anxiety.** Mood and anxiety were assessed by using the 30-item, 5-point scale titled Mood and Anxiety Questionnaire-D30 (Wardenaar et al., 2010). Examples from this measure include “During the past week, I have felt confused”, and “During the past week I have felt nauseous”. Respondent’s completed a 5-point Likert Scale ranging from 1= Not at all, to 5= Extremely, regarding feelings, sensations, problems, and experiences they may have endured.
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during the past two weeks. Scale scores were computed by averaging relevant item responses. These were in turn divided into three subscales: anxious arousal (symptoms of anxiety and worry) \( (\alpha = .86) \), anhedonic depression (general disinterest and listlessness) \( (\alpha = .91) \) and general distress (depressed mood and unhappiness) \( (\alpha = .90) \).

**Satisfaction with Life.** Life satisfaction was assessed by using the 5-item measure described by Diener (1985). Cronbach’s alpha was reported to be \( \alpha = .87 \) (Zanon, Bardagi, Layous, & Hutz (2014). Reliability in the present study was strong, \( \alpha = .86 \)). Various examples of items from this measure include “In most ways my life is close to ideal,” “The conditions of my life are excellent,” and “I am satisfied with my life.” Participant’s respond on a 7-point Likert Scale (1 = Strongly, 2 = Disagree, 3 = Slightly Disagree, 4 = Neither agree nor disagree, 5 = Slightly agree, 6 = Agree, and 7 = Strongly Agree) regarding how satisfied they are with their life. Scale scores were computed by averaging relevant item responses.

The materials were not counterbalanced due to the sensitive nature of the measures. It was decided that usage of Good2Talk and in-person counselling services should be completed first to avoid any negative effects that may arise if a measure was completed beforehand. The researchers wanted an extremely candid response for this measure, and determined that by placing it first, the likelihood that we would receive this candid response was highest. The Discrimination and Stigma Scale was placed second to ensure that any negative affect would not influence the answers for usage of Good2Talk and in-person counselling. Since the depression and anxiety measure asked questions of a sensitive nature, it was determined that it was best to be completed third so the participant did not finish the study with such negative thoughts. The Satisfaction with Life Scale was determined the most suitable measure to be last, since there
were not many questions, and the questions are worded positively. The expectation was that participants would complete the study with a neutral or positive mind.

**Procedure**

During the 2016-2017 academic school year, participants were recruited through the SONA website or through a poster on campus which provided a link to a webpage indicating for consent to be given. Once consent was provided, participants completed the Demographics measure, and their usage of Good2Talk and in-person Counselling Services. Participants then completed the Discrimination and Stigma Scale (Brohan et al. 2013), then the Mood and Anxiety Questionnaire-D30 (Wardenaar et al., 2010), and then the Satisfaction with Life Scale (Diener & Emmons, 1985).

Once completed, the participant was debriefed and then taken to a new page which recorded participation. This information was used for the purposes of assigning course credit and/or entering the VISA gift card lottery. Participants were free to withdraw at any time and still received credit for their written assignment. The participant was then thanked for their involvement in the study. All data was measured and recorded using Qualtrics Survey Software, and all analyses were conducted using SPSS Data Analyses Software.

**Design**

The design is a correlational design, investigating relationships between participant’s feelings of discrimination and stigma, mood and anxiety, and satisfaction with life. In addition, demographic information was collected, as well as qualitative information that inquired about an individual’s usage of Good2Talk and in-person counselling services, how to improve utilization of Good2Talk and in-person counselling services, and how participants generally support their mental health. Continuous variables include age, and categorical variables include gender, year
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of study, and major studied. The two main dependent variables were utilization of services and stigmatization and our predictor variables were the demographic variables, mood and anxiety, life satisfaction and desire to use text-messaging services for Good2Talk.

Results

Mental Health and Stigma Measures. Descriptive statistics for the primary measures are provided in Table 1. We further examined the extent to which our measure of stigma predicted measures of anhedonic depression, general distress, anxiety and life satisfaction through a series of multiple regression models (see Table 2). Stigmatization was a significant predictor of anxiety, $\beta = .20$, $p = .02$ and life satisfaction, $\beta = -.27$, $p < .001$ when controlling for other mental health variables. Stigmatization was a significant predictor of general distress, $\beta = .34$, $p < .001$ and anhedonic depression, $\beta = .17$, $p = .03$ but not when controlling for other mental health variables $\beta = .03$, $p = .75$, $\beta = .08$, $p = .50$ respectively. As a result, the first hypothesis received partial support.

We also examined predictors of stigmatization itself. In including the other mental health variables in a regression model, anxiety predicted higher stigmatization, $\beta = .25$, $p = .02$, and life satisfaction predicted lower stigmatization, $\beta = -.36$, $p = .001$, when controlling for other mental health variables.

Utilization of Counselling Services. To measure hypothetical and actual usage of counselling services, variables were computed for hypothetical and actual usage of Good2Talk and in-person counselling services. The hypothetical usage for Good2Talk variable was computed by including any participant who chose at least one reason why they would utilize Good2Talk. The hypothetical usage for the in-person counselling variable was computed by including any participant who chose at least one reason why they would utilize in-person
counselling. The same process was completed for actual usage of Good2Talk and in-person counselling. Overall, 95% of participants reported they would use Good2Talk for at least one reason, but only 52% indicated they had used Good2Talk. Furthermore, 94% of participants indicated they would use in-person counselling for at least one reason, but only 61% reported that they had used in-person counselling.

**Predictors of Counselling Usage.** Refer to Table 3. We next explored the second hypothesis regarding the role of stigma in predicting usage of counselling services. Stigmatization predicted use of Good2Talk, $\beta = .28, p < .01$, and in-person counselling services, $\beta = .29, p < .01$ when other mental health variables were controlled for.

Additionally, stigmatization predicted not using counselling services for reasons of stigma, $\beta = .21, p = .03$, but not when other mental health variables were controlled for, $\beta = .18, p = .09$.

In line with the third hypothesis, more women (71.7%) utilized in-person counselling services than men (40.0%), $\chi^2 (1) = 12.5, p < .01$. However, women (54.7%) were not more likely overall to have used Good2Talk services than men (50.0%), $\chi^2 (1) = .26, p = .61$. 
Table 1

*Descriptives of Self-Report Measures Used.*

<table>
<thead>
<tr>
<th>Self-Report Measure</th>
<th>Mean (M)</th>
<th>Standard Deviation (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination and Stigma Scale</td>
<td>1.41</td>
<td>.40</td>
</tr>
<tr>
<td>Mood and Anxiety</td>
<td>1.98</td>
<td>.77</td>
</tr>
<tr>
<td>a) General Depression</td>
<td>2.60</td>
<td>.92</td>
</tr>
<tr>
<td>b) Anxious Arousal</td>
<td>1.99</td>
<td>.77</td>
</tr>
<tr>
<td>c) Anhedonic Depression</td>
<td>3.22</td>
<td>.84</td>
</tr>
<tr>
<td>Satisfaction with Life</td>
<td>4.55</td>
<td>1.30</td>
</tr>
</tbody>
</table>

*Note.* These scores were derived from self-report measures, which are subject to various biases.
Table 2

*Summary of Multiple Regression Predicting General Depression, Anhedonic Depression, Anxious Arousal and Life Satisfaction.*

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>General Distress</th>
<th>Anhedonic Depression</th>
<th>Anxious Arousal</th>
<th>Life Satisfaction</th>
<th>Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigmatization</td>
<td>.03</td>
<td>-.07</td>
<td>.20*</td>
<td>-.27**</td>
<td>0</td>
</tr>
<tr>
<td>Anxious Arousal</td>
<td>.51***</td>
<td>.04</td>
<td>0</td>
<td>-.10</td>
<td>.25*</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>-.30***</td>
<td>.49***</td>
<td>.10</td>
<td>0</td>
<td>-.36***</td>
</tr>
<tr>
<td>General Distress</td>
<td>0</td>
<td>.08</td>
<td>.60***</td>
<td>.34***</td>
<td>.04</td>
</tr>
<tr>
<td>Anhedonic Depression</td>
<td>.08</td>
<td>0</td>
<td>-.001</td>
<td>.36***</td>
<td>-.08</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01, ***p < .001.*

*Note.* Standardized Betas have been used within this table.
Table 3

*Summary of Multiple Regression Predicting Actual use of Good2Talk and In-Person Counselling Services.*

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>Good2Talk – Actual</th>
<th>In-Person Counselling - Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anhedonic Depression</td>
<td>-.04</td>
<td>.02</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>.28**</td>
<td>.29**</td>
</tr>
<tr>
<td>Anxious Arousal</td>
<td>-.01</td>
<td>.13</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>-.09</td>
<td>.14</td>
</tr>
<tr>
<td>General Distress</td>
<td>.15</td>
<td>-.08</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01, ***p < .001.

*Note.* Standardized Betas have been used within this table.
Discussion

Overview

The current research adds to the literature on our understanding of utilization of counselling services and the role of stigma in mental health and utilization of mental health services. The goals of the current research were a) to better understand how stigma, depression, anxiety, and life satisfaction interact with one another, b) to better understand levels of discrimination and stigmatization and how this interacts with usage of services, and c) whether there were any gender differences within utilization of services. Participants were asked open-ended and close-ended questions regarding their use of counselling services. Additionally, participants completed a Discrimination and Stigma Scale (Brohan et al., 2013), a Mood and Anxiety Symptomology Scale (Wardenaar, Van Veen, Giltay, De Beurs, & Penninx, 2010), and a Satisfaction with Life Scale (Diener, 1985). The Mood and Anxiety Symptomology Scale was reduced to three variables: Anxious Arousal (i.e., anxious thoughts, or bodily symptoms), Anhedonic Depression (i.e., loss of interest), and General Distress (i.e., physical and mental symptoms of unhappiness).

Hypothesis

This study was guided by the following hypotheses:

1. Those with higher ratings of stigma will have higher ratings of depression and anxiety and lower ratings of life satisfaction.

2. Those with higher levels of discrimination and stigmatization will use services less.

3. That more women will utilize counselling services than men.
Regarding the data, the first hypothesis was not entirely supported within our results. Ratings of discrimination and stigmatization did not significantly predict higher ratings of anhedonic depression, general distress, and anxiety and lower ratings of life satisfaction; however, discrimination and stigmatization was no longer a significant predictor of either measure of depression when the other mental health variables were controlled for. The fact that our measure of depression and anxiety was split up into three variables provided a more comprehensive, yet complicated understanding of the first hypothesis. These findings suggest that the relationship between discrimination and stigmatization, anxiety and depression, and life satisfaction is more complicated than once anticipated, especially when considering different types of anxiety and depression an individual may experience. Andrade (2015) stated that 15% of women and 10% of men may suffer from panic disorders, generalized anxiety, separation anxiety, and phobias, to name a few. Anxiety can be present itself in many ways, so it is important to have a measure that captures many types of anxiety as well.

The second hypothesis was that higher levels of discrimination and stigmatization would predict lower usage of counselling services. The data did not support this hypothesis, and reported the opposite effect; those who reported higher stigma utilized services more than those who reported feeling lower levels of stigma. There was a positive, significant, correlational relationship between using counselling services (including both Good2Talk and in-person counselling services), and discrimination and stigmatization felt. This relationship held even when controlling for other mental health variables. Those who felt higher rates of stigmatization and discrimination, were more likely to utilize Good2Talk and in-person counselling services.

Lastly, the third hypothesis suggested that more women will utilize counselling services than men. The data supported one aspect of this hypothesis with more women utilizing in-person
counselling services, but there were no significant differences between men and women in usage of Good2Talk. These findings suggest that certain counselling services may be more attractive to different genders.

**Explanations**

This suggests that discrimination and stigmatization may be a contributing factor to one’s counselling service usage. According to Surf and Lynch (1999), it appears that those who seek help are strong, and know how to ask for the help that they need. It may be that those who feel stigmatized and utilize counselling services more, may just know how to ask for help. It is also evident that those who indicated higher levels of stigma and discrimination had higher rates of anxiety and lower rates of life satisfaction, so may be experiencing more life problems that require more professional mental health support. That said, our data did indicate that stigma can still serve as a barrier to seeking help as ratings of our stigma and discrimination measure were significantly positively correlated with responses of not seeking in-person counselling for fear of stigma. The relationship between stigma and discrimination and usage of counselling services is complex and our data points to the need for further research to further explore the underlying factors of this relationship in greater depth.

It is important to note that anxiety and depression was measured with three variables, anxious arousal (AA), anhedonic depression (AD), and general distress (GD). Along with discrimination and stigmatization, anhedonic depression and general distress also played a significant role in predicting life satisfaction, which suggests that listlessness may influence the amount of satisfaction that one receives from life. As well, anxious arousal played a significant role in the predicting amount of discrimination and stigmatization felt, which suggests that the more anxious an individual is, the more stigma they may perceive. It is questionable whether this
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is the result of expressing concern about being stigmatized, or if the discrimination and stigmatization is the result of suffering from anxiety.

The second hypothesis regarding discrimination and stigmatization, and utilization of services was not supported. The data suggest the opposite effect, in which those who are more stigmatized tend to utilize Good2Talk, and in-person counselling services more. This finding may be due to the potential interaction that occurs for those who experience mental health challenges, and their experience of feeling stigmatized. Due to these mental health challenges, the individual may feel more inclined to utilize a counselling service. Mason (2015) suggested that stigma can severely influence the help-seeking behaviours of those who identify as having mental health challenges, but not in this direction. As well, this data contradicts the findings of Pingani (2016), in which he stated that discrimination and stigmatization has short-term impacts such as a reduction in help-seeking.

Lastly, the third hypothesis was somewhat supported with women utilizing in-person counselling services more than men, and women using Good2Talk less than men. This finding may be supported with Affsprung (1996) stating that females were highly likely to see a counselling center as a service utilized primarily by women. Additional exploratory research would need to be completed to develop a greater understanding of this finding.

These findings relate back to the theoretical rationale consisting of the I-E-O model, the Theory of Planned Behaviour, and the Self-Regulatory Model. According to the I-E-O model, social contexts explain a student’s change in college. Given our findings, it may be the case that the atmosphere provided by Western University may encourage help-seeking behaviours. In terms of the Theory of Planned Behaviour, individuals may have formed the intention to seek help for their mental health challenges through attitudes, subjective norms, and their perceived
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ability to perform such behaviours. This theory suggests that individuals do not allow
discrimination and stigma to prevent them from seeking help, due to their positive attitudes
towards mental health services. Lastly, the Self-Regulatory Model states that the individual is an
active problem solver when faced with a threat, and will try to find solutions for it. Post-
secondary students may be faced with mental health challenges, but will combat these challenges
through counselling services.

Importance

It is important to understand the complicated relationship that discrimination and
stigmatization has on counselling service utilization. Although it is noted in the literature that
discrimination and stigmatization can reduce help-seeking behaviour, the reverse effects are
being reported which suggests additional exploratory research needs to be conducted to better
understand this interaction within the post-secondary population. Additionally, female
undergraduate students utilize in-person counselling services more than male undergraduate
students, but do not utilize Good2Talk more than men. It would be useful to generate research
focusing on gender differences when utilizing counselling modalities to acquire a more
comprehensive understanding of these findings within this demographic. These data provide a
better understanding of counselling service usage and can inform policy makers, and
administration personnel at Western University, and Good2Talk, regarding how to tailor their
services to fit the needs of the university and college community.

The data collected regarding life satisfaction can be applicable to post-secondary
communities who may be suffering from an increased prevalence in anxiety and depression
(Heck et al., 2014). Efforts can be made to increase satisfaction of life among these students, and
improve the overall experience at Western University. Fink (2014) suggested that to improve
experience at post-secondary institutions, administrators should promote the implementation of living-learning programs (LLPs) and other learning communities (p. 386). Living Learning Programs are where post-secondary students live with those who are like-minded to them, and are academic majors within the same field. LLPs also seek to increase contact between students, faculty, and staff within the post-secondary institution to actively create connection within the campus community. The implementation of such initiatives within college and university communities provides social support, ease with transition to college, provide a sense of belonging, and a sense of civic engagement.

As well, the correlational relationship between anxious arousal and general distress can inform the practice of counselling services at Western University. Those who display symptoms of anxiety may be at a risk of developing greater general distress, and should be monitored if such developments should take place.

**Limitations**

In terms of the hypotheses, a more suitable measure for discrimination and stigma could have been selected, which had items that were more applicable to the post-secondary population. While some items in the scale were relevant, for example “Have you been treated unfairly in making or keeping friends?” and “Have you been treated unfairly in your education?” other items did not fit this demographic. For example, some questions included “Have you been treated unfairly in marriage or divorce?” and “Have you been treated unfairly by the police?”. Using a more suitable scale could have provided a more comprehensive understanding of discrimination and stigmatization given the age of participants.

It is also recognized that our sample did not have an equal number of males and females, and therefore is not a generalizable sample to the London community. Additionally, a selection
bias could have influenced which individuals participated in the study. Those who have a general interest in counselling, or who have undergone counselling themselves may have been attracted to this survey which may have negatively influenced generalizability. Demand and social desirability characteristics may have influenced participant’s responses if the hypothesis was made apparent throughout the study that more individuals may have indicated that they have used counselling services when they may not have done so. It is notable that more than half of our sample indicated they had used Good2Talk and in-person counselling services which is higher than previously available data has indicated is typically the case. This effect can also negatively influence the generalizability of this study.

Conclusions

This research adds to the literature on better understanding the mental health of post-secondary students, and how to better serve their needs through counselling services. In future, research should explore the effects of discrimination and stigmatization on the use of counselling services among the college and university population, the significance of gender differences when utilizing in-person counselling services, and factors that influence the use of Good2Talk. An age appropriate measure of discrimination and stigmatization should be implemented into future work to acquire a valid measure of discrimination and stigmatization among post-secondary populations.

Stigmatization and discrimination significantly predict variables like anxiety, life satisfaction, general distress, and anhedonic depression, which carry negative experiences among this demographic. Those who struggle with these health challenges experience the feeling of being stigmatized against, and discriminated against by others. The relationship between discrimination and stigmatization, life satisfaction, and depression and anxiety is extremely
complex, and requires additional research to better understand and assist post-secondary students in having adaptive and healthy ways to respond to their respective health concerns. In contrast, discrimination and stigmatization can positively influence help-seeking behaviour when utilizing Good2Talk or in-person counselling services. Lastly, gender differences highlight an important contrast in counselling usage, with female undergraduate students using in-person counselling services more than male undergraduate students, and females using Good2Talk less than males. By better understanding the utilization of counselling services and stigmatization of post-secondary students who suffer from mental health challenges, we can help offer a more supportive environment for help-seeking.
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