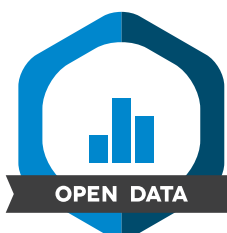


Predictors of Help-Seeking: Self-Concept Clarity, Stigma, and Psychological Distress

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ABSTRACT. Multiple studies have shown that individuals with low self-concept clarity (SCC) are highly susceptible to mental health problems (depression and anxiety). However, despite the increased vulnerability to psychopathology, prior research has not examined the relationship between SCC and help-seeking. Hence, to develop a comprehensive understanding of the aforementioned relationship, well-established predictors of help-seeking (psychological distress and stigma) were included in this study. A total of 111 students completed an online survey. Results indicated that lower SCC was associated with higher psychological distress, lower help-seeking propensity, and higher stigma. However, SCC was not found to be a unique predictor of help-seeking above and beyond the established predictors in the multiple regression analysis. Stigma was further divided into perceived public, personal, and perceived peer stigma. The past literature showed no association between perceived public stigma and help-seeking. In addition, perceived public stigma has been found to be higher than personal stigma. Thus, the current study altered the perceived stigma reference group (from “public” to “peer”) to investigate if this change would influence the association with help-seeking. Consistent with prior research, a significant mean difference was found such that perceived public stigma remained significantly higher than personal stigma (95% CI [1.45, 2.34]) and was not correlated with help-seeking or personal stigma. However, both personal and perceived peer stigma were negatively correlated with help-seeking and positively correlated with each other, such that high personal and peer stigma were associated with lower help-seeking. The results can provide insight for future help-seeking intervention programs and mental health stigma reduction campaigns.

Keywords: self-concept clarity, help-seeking, mental illness stigma, psychological distress, perceived peer stigma



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Epidemiological data showed that about 46.4% of the general population has a lifetime prevalence of being affected by a mental illness (Kessler et al., 2005). According to

the 2019 National Survey on Drug Use and Health (NSDUH) by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2019), one in every five U.S. adults (51.5 million) lives with

a mental illness. Despite the widespread prevalence of mental illnesses, only about 23.0 million adults out of 51.5 million received treatment. As early as 1999, the discrepancy was attributed to stigma, cited in the mental health report by the U.S. Surgeon General David Satcher (U.S. Department of Health & Human Services, 1999).

Moreover, mental health stigma has been shown to be a foremost barrier in help-seeking, not only in the United States, but also globally (Thornicroft, 2007). Approximately 30% of the worldwide population is affected by a mental illness every year; however, two-thirds of people do not seek help (Kessler et al., 2005). Hence, the topic of help-seeking and its predictors in addition to stigma remains essential in an effort toward improving mental health campaigns.

One such predictor that has not been examined before is self-concept clarity (SCC). A lower SCC has been consistently associated with psychological maladjustment that contributed to the development of internalizing and externalizing disorders (Bigler et al., 2001; Parise et al., 2019). However, despite the strong association between SCC and psychological maladjustment, there was a lack of literature exploring the influence of SCC on help-seeking. Hence, for the current study, we attempted to bridge the gap by examining the association and the strength of SCC as a predictor of help-seeking behavior.

Self-Concept

The broad definition of self-concept is the perception of oneself, influenced by the interaction between the environment and subsequent experiences. There are two key aspects of self-concept: SCC and self-concept differentiation (SCD). SCC is defined as the extent to which self-beliefs are clearly and confidently defined, internally consistent, and stable over time (Campbell et al., 1996). For example, if the description of one's personality fluctuated from one day to the other, that would indicate a lower SCC. The results from Campbell et al. (1996) suggested that a lower SCC is associated with psychological maladjustment, which can be operationally defined as the individual's inability to meet the demands of life resulting in psychological distress. Moreover, respondents with a lower SCC had lower self-esteem, conscientiousness, agreeableness, and higher neuroticism.

On the other hand, self-concept differentiation is the extent to which self-conceptions vary across different roles (e.g., general, student, friend,

romantic partner, offspring, and worker; Donahue et al., 1993). Donahue et al. (1993) suggested that differentiation across roles results in fragmentation of the self-system, which correlates with psychological maladjustment. Hence, respondents with a higher self-concept differentiation were more vulnerable to depression, neuroticism, and lower self-esteem (Donahue et al., 1993).

Bigler et al. (2001) is among the few studies that examined SCC and SCD together. Researchers found that both SCC and SCD were independent constructs. Both SCC and SCD predicted psychological maladjustment, but SCC was a better predictor in both samples (college students and inpatient schizophrenia patients). A similar trend was supported by Diehl and Hay (2011). Hence, for the current study, we decided to focus on SCC as a predictor of help-seeking instead of SCD.

Self-Concept Clarity

An important developmental task during adolescence is establishing more clarity in one's self-concept. A longitudinal study showed small increases in SCC during adolescence supporting that SCC is subject to change (Schwartz et al., 2012). One of the factors that have been shown to mediate the association between SCC and psychological maladjustment is emotional regulation (Parise et al., 2019). Emotional regulation refers to how effectively an individual regulates their affect (Caprara et al., 2008). If adolescents regulated their negative and positive affect relatively well, they were more likely to have a higher SCC (Parise et al., 2019). As a result, the likelihood of developing internalizing and externalizing problems or experiencing psychological distress decreased. Hence, efficient emotional regulation was directly associated with higher SCC and inversely associated with psychological maladjustment.

Furthermore, another factor that has been shown to influence SCC is parental bonding. In Perry et al. (2008), parental care and warmth were positively associated with SCC. The increase in SCC was attributed to the confidence that parents gave to their children during their self-concept exploration phase. In addition, the likelihood of developing more clarity in self-concept was higher if the communication between parents and children was clear and open compared to if the child kept secrets (Frijns & Finkenauer, 2009; Van Dijk et al., 2014). Moreover, a longitudinal study showed that a higher SCC in adolescents was associated with a better relationship with their parents that was

indicated by a lower frequency of negative interaction (Becht et al., 2017).

SCC has also been shown to predict healthy identity development (Campbell et al., 1996; Schwartz et al., 2012). A higher SCC was associated with higher self-esteem, affect balance, and lower depression and anxiety (Bigler et al., 2001; Butzer & Kuiper, 2006; Cicei, 2012). On the contrary, people with lower SCC were found to be more susceptible to internalizing disorders, such as anxiety and depression indicative of psychological distress. Psychological distress can be operationally defined as a state of emotional suffering that involves symptoms of depression and anxiety (Mirowsky & Ross, 2002). This is also supported by several longitudinal studies through adolescence that showed the relationship between lower SCC and internalizing problems (Schwartz et al., 2012; Van Dijk et al., 2014).

Elements of internalizing problems (e.g., loneliness, chronic self-analysis, low internal state awareness, and rumination) have been shown to be significantly associated with lower SCC (Campbell et al., 1996; Richman et al., 2016). Intolerance of uncertainty model and SCC are good predictors of generalized anxiety disorder (GAD; Kusec et al., 2016). The intolerance of uncertainty model posited that the development of GAD could be explained through excessive worry, which is a natural response to modulate feelings of uncertainty (Dugas et al., 1998). As prior research showed that lower SCC was indicative of uncertainty about the self, it was found to be a salient predictor of GAD (Kusec et al., 2016). In addition, Stopa et al. (2010) found that a lower SCC was associated with higher social anxiety. Moreover, previous literature showed that lower SCC was not only associated with internalizing and externalizing disorders, but also with eating disturbances (Perry et al., 2008). Hence, a lower SCC was indicative of higher psychological distress and increased susceptibility to psychopathology.

Help-Seeking

The theory of planned behavior can be useful in understanding human behavior, such as help-seeking. The theory outlines three types of beliefs: behavioral beliefs (experiences or consequences associated with help-seeking), normative beliefs (expectations or behaviors of significant others regarding help-seeking), and control beliefs (factors that increase/decrease help-seeking). According to this theory, an attitude toward a behavior such as help-seeking is formed by behavioral

beliefs associated with mental health help-seeking (e.g., prior experience with seeking help for mental health concerns). Normative beliefs tap into perceived social norms and control beliefs tap into how much power the person believe they have in seeking help. A positive attitude and perceived social norm together with higher perceived control are associated with an increase in help-seeking (Ajzen, 1991).

The two salient factors that have been found to consistently predict help-seeking behavior are psychological distress and mental health stigma (Boerema et al., 2016; Wadman et al., 2017). Mental health stigma can be further classified into personal and perceived public stigma. Personal stigma is defined as an individual's stereotypes, prejudices, and behavior, whereas perceived public stigma is defined as an individual's perception of the extent to which the public holds negative attitudes, stereotypes, and prejudice towards those who seek mental health treatment (Corrigan, 2004). Several studies have found that perceived public stigma is higher than personal stigma and both are positively correlated (Eisenberg et al., 2009; Lally et al., 2013). In addition, personal stigma has been shown to be negatively associated with help-seeking, but perceived public stigma was not found to be associated with help-seeking (Boerema et al., 2016; Eisenberg et al., 2009). A longitudinal study conducted with college students by Golberstein et al. (2009) continued to support that perceived public stigma was not associated with help-seeking behavior. Hence, personal stigma independently influenced help-seeking. However, several studies showed otherwise that higher public stigma is indeed a barrier to help-seeking (Kulesza et al., 2015; Nearchou et al., 2018; Phelan et al., 2000). As personal attitudes are shaped by public attitudes (Link, 1987), it is logical to think that both personal stigma and perceived public stigma should be related to help-seeking.

Current Study

The relationship between low SCC and psychological maladjustment and what factors may influence the association are well established. However, previous research has not studied whether the individuals who have a lower SCC and are subsequently highly susceptible to psychological maladjustment would be more or less likely to seek help. Hence, the purpose of the current study was to explore the influence of SCC on the likelihood of help-seeking.

In addition to SCC, psychological distress and stigma were included in this study because they

have been established as reliable predictors of help-seeking. The inclusion of these predictors allowed us to answer an additional research question of whether SCC predicted help-seeking above and beyond the established predictors.

How an individual perceives a behavior or an attitude of their peers toward something is a key predictor of health behavior. This is because the perception creates a perceived social pressure that pushes the individual either to engage or not in a particular behavior (Ajzen, 2001). Hence, in the current study in addition to perceived public stigma and personal stigma, we measured perceived peer group stigma. Perceived peer group stigma gauges to what extent one thinks their peers hold negative attitudes toward those who seek mental health treatment. If the peer group held negative attitudes or perceptions toward those who sought help for their mental health, that would demonstrate a higher perceived peer group stigma. The current study addressed the research question of whether the respondent's personal stigma would also be higher to be concordant with their peers given their high perceived peer group stigma or vice versa.

In the literature, there are mixed findings regarding the relationship of public and personal stigma with help-seeking. Some studies showed that public stigma was related to help-seeking (Kulesza et al., 2015; Nearchou et al., 2018; Phelan et al., 2000), whereas other studies showed that only personal stigma was related to help-seeking (Boerema et al., 2016; Eisenberg et al., 2009). In addition, public stigma was not found to be associated with help-seeking (Golberstein et al., 2009). Hence, the current study disentangled the relationship between not only the different types of stigmas (personal, perceived public, and perceived peer group stigma), but also their association with help-seeking.

The following hypotheses were formulated in the light of literature: (a) SCC would positively correlate with help-seeking; (b) SCC would negatively correlate with psychological distress; (c) a positive correlation would be found between personal and peer-group stigma; and (d) no correlation would be found between perceived public stigma and help-seeking, but a negative correlation would be found between help-seeking behavior and personal stigma as well as perceived peer stigma.

Method

Participants

A total of 111 undergraduate students from Hollins University, a small, women's liberal

arts institution, between the ages of 18 and 46 ($M = 20.69$, $SD = 3.83$) participated in the study. Most participants identified as women ($n = 101$). Nine participants identified as nonbinary, and one participant preferred not to say. The sample was predominantly White/non-Hispanic/European ($n = 61$), with Black/African American ($n = 14$), Asian ($n = 13$), multiracial ($n = 8$), Asian American ($n = 6$), Hispanic/Latino ($n = 4$), American Indian/Alaska Native ($n = 2$), Native Hawaiian or Pacific Islander ($n = 1$), and Middle Eastern ($n = 1$) participants.

Measures

Self-Concept Clarity Scale

The scale was developed by Campbell et al. (1996) and consists of 12 items ($\alpha = .86$). All items are reverse scored except 6 and 11. The scale uses a 5-point Likert scale with anchors (*strongly disagree* to *strongly agree*) and gauges the beliefs held by the individual about themselves (e.g., "Sometimes I think I know other people better than I know myself"). Higher scores indicate higher SCC and vice versa. The internal reliability for this scale in this sample was good ($\alpha = .86$).

Help-Seeking

To measure help-seeking, the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) and Mental Help Seeking Intention Scale (MHSIS) were combined. The questions of MHSIS were interspersed in the IASMHS as per the guidelines provided by the scoring key of MHSIS (Hammer & Spiker, 2018).

Inventory of Attitudes Toward Seeking Mental Health Services.

IASMHS was developed by Mackenzie et al. (2004), which consists of 24 items ($\alpha = .87$) and has three factors. Each factor has eight items whose internal consistency is good. The first factor is Psychological Openness, which is an individual's openness to acknowledge their psychological problems and seek help for those problems ($\alpha = .82$; e.g., "There are certain problems which should not be discussed outside of one's immediate family"). Help-Seeking Propensity is the second factor, which is an individual's belief about their willingness and ability to seek help for psychological problems ($\alpha = .76$; e.g., "I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems"). Lastly, Indifference to Stigma refers to an individual's concern about how the significant others will think or feel when they find out that they are seeking help for their

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psychological problems considering social norms ($\alpha = .79$; e.g., “I would not want my significant other [spouse, partner, etc.] to know if I were suffering from psychological problems”). Participants indicate their level of agreement with each statement using a 5-point Likert scale with anchors (*disagree* to *agree*). A higher cumulative score indicates having a more positive attitude toward help-seeking behavior.

The internal reliability for this scale in the current sample was good ($\alpha = .84$). The Psychological Openness subscale had a questionable internal consistency ($\alpha = .66$); Help-Seeking Propensity ($\alpha = .78$) and Indifference to Stigma ($\alpha = .79$) had acceptable internal consistency.

Mental Health Seeking Intention Scale. MHSIS was developed by Hammer and Spiker (2018) and consists of three items (e.g., “If I had a mental health concern, I would intend to seek help from a mental health professional”). Participants indicate their intention to seek help for their mental health concerns using a 7-point Likert scale with anchors (*extremely unlikely* to *extremely likely*). The internal reliability for this scale in this sample was excellent ($\alpha = .96$).

Perceived Need for Help and Mental Health Services Utilization

Perceived need for help was measured by an item, “In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, blue, anxious or nervous?” To measure mental health services utilization, a single item asked participants whether, in the past year, they received treatment for mental health problems. If the participant answered yes, they were asked what type of treatment they received (psychotropic medication or therapy/counseling). These items were taken from the Healthcare for Communities Study, a national study of mental health care use questionnaire (Wells et al., 2006), and were also utilized by Eisenberg et al. (2009).

An additional item asking if mental health problems were affecting the respondent’s academic performance was taken from Eisenberg et al. (2009). If so, the respondents were asked if they would talk to no one or write whom they would talk to as a text entry. The responses were categorized into four categories: mental health professional (therapist/counselor) or primary care physician, family member (parents, siblings, and grandparents), friend or partner, and college faculty (professor, advisor, and dean).

Kessler Psychological Distress Scale

The scale was developed by Kessler et al. (2003) and consists of 10 questions ($\alpha = .93$) e.g., “During the last 30 days, about how often did you feel nervous?”). Participants indicate how they have been feeling over the last 30 days (i.e., 4 weeks) using a 5-point Likert-type scale with anchors (*none of the time* to *all of the time*). The cumulative score range is 0–40 where higher scores are indicative of higher psychological distress and vice versa. The cumulative score can be categorized according to the following cutoffs mentioned in the Victorian Population Health Survey (Department of Human Services, Victoria, 2001): 10–19 (likely to be well), 20–24 (likely to have a mild disorder), 25–29 (likely to have a moderate disorder), and 30–50 (likely to have a severe disorder). The reliability for this scale in this sample was excellent ($\alpha = .93$).

Adapted Devaluation-Discrimination Scale for Stigma Perceived Public/Peer Stigma Scale.

The current study used the devaluation-discrimination scale which was adapted by Lally et al. (2013) from the original version (Link, 1987). One of the main changes in the adapted version is altering the wording from “mental patients” to “people who have received mental health treatment.” The Perceived Public Stigma Scale consists of 12 statements ($\alpha = .86$; e.g., “Most people think less of a person who has received mental health treatment”). The internal reliability for this scale in the current sample was good ($\alpha = .85$).

For this study, the Perceived Public Stigma Scale by Lally et al. (2013) was adapted to measure perceived peer stigma by changing the wording from “most people” to “my peers” (e.g., “My peers would think less of a person who has received mental health treatment”). The perceived peer stigma scale also consists of 12 statements and the internal reliability in this sample was found to be good ($\alpha = .89$).

The perceived public and peer stigma scales were equally randomized between participants and indicated their level of agreement using a 5-point Likert scale with anchors (*strongly agree* to *strongly disagree*). Question 5, 6, 7, 9, 11, and 12 are reverse coded, and the higher the average score, the higher is the perceived public or peer-group stigma held by the respondent.

Personal Stigma Scale. Lally et al. (2013) adapted four items ($\alpha = .78$) from the original version by changing the wording from “most people” to “I.” The first two statements measure

a respondent's behavior, (e.g., "I would willingly accept a person who has received mental health treatment as a close friend") and the last two statements measure an attitude, (e.g., "I believe that a person who has received mental health treatment is just as trustworthy as the average citizen"). The scale uses a 5-point Likert scale with anchors (*strongly disagree* to *strongly agree*), and items 3 and 4 are reverse coded. The internal reliability for this scale in this sample was poor ($\alpha = .52$).

Procedure

After receiving approval from the Human Research Review Committee at Hollins University, an online Qualtrics survey was open for approximately two months for the undergraduate students (age 18 and or above). The survey link was distributed through class announcement emails by psychology professors, international departmental emailing list, and Facebook posts on various university pages. The completion time was between 20–25 minutes, and the survey began with an informed consent. If the participants chose to participate, they completed a demographics questionnaire (age, major, gender, race/ethnicity) followed by a series of measures. The first measure was the SCC questionnaire that focused on the beliefs held by the individual about themselves. The second questionnaire was the IASMHS combined with the MHSIS, both of which have the same instructions (definitions of the terms that will be used in IASMHS and MHSIS) to measure help-seeking behavior. The third questionnaire was the Kessler Psychological Distress Scale followed by the Personal Stigma Scale. The fifth questionnaire presented gauged the perceived need for help and mental health utilization. The sixth questionnaire was equally randomized between participants, so they either received the Perceived Public Stigma or Perceived Peer-Group Stigma Scale. In between all the measures, each participant answered two instructed response items that were randomly embedded to check participant attention. After the completion of the questionnaires, participants read a debriefing statement and were redirected to the extra credit information portion if the participant wished to receive extra credit in one psychology undergraduate-level course.

Results

Out of the total 113 participants, two participants were removed because they answered all instructed response items incorrectly, resulting in 111 participants. All results are reported at an alpha level of .05. Internal reliability of all scales was found to be

close to the original internal reliability values except for the IASMHS Psychological Openness subscale, which had questionable internal consistency ($\alpha = .66$), and the Personal Stigma Scale, which had poor internal consistency ($\alpha = .52$). All analyses were conducted using SPSS statistical software.

Correlations Between SCC, Help-Seeking Behavior, and Psychological Distress

To test the relationship between SCC and help-seeking, a Pearson correlation coefficient was calculated between SCC and help-seeking scales (IASMHS and MHSIS). A weak, positive correlation between SCC and IASMHS was found, $r(103) = .25, p = .005$, indicating a significant relationship between the variables. Hence, a higher SCC was associated with a more positive attitude toward seeking mental health services.

A significant correlation was not found between SCC and MHSIS, $r(108) = .14, p = .08$. A ceiling effect was found as respondents clustered around higher scores on the MHSIS as evident by a skew of -0.67 . After recoding the data as a dichotomous variable (1 and 0), no significant changes in the results were found.

Next, the correlations between SCC and IASMHS inventory subscales were calculated. There was not a significant correlation between SCC and Psychological Openness. However, a weak, positive correlation between SCC and Indifference to Stigma was found, $r(104) = .25, p = .005$, indicating a significant relationship between the variables in the expected direction. Having a high SCC was associated with lower mental health stigma. A weak, positive correlation between SCC and Help-Seeking Propensity was found, $r(107) = .21, p = .02$, indicating a significant relationship between the variables. Participants with higher SCC responded as having a greater tendency towards help-seeking.

To test the relationship between SCC and psychological distress, a Pearson correlation coefficient was calculated between SCC and Kessler Psychological Distress Scale. A moderate, negative correlation was found, $r(108) = -.58, p < .001$, indicating a significant relationship between the variables such that higher SCC was associated with lower psychological distress. All means, standard deviations, and correlations between self-concept, help-seeking measures, and psychological distress can be found in Table 1.

Correlations Between Stigma (Personal and Perceived Public/Peer)

Perceived public stigma was found to be higher

($M = 2.89$, $SD = 0.60$) than perceived peer stigma ($M = 2.27$, $SD = 0.64$) and personal stigma ($M = 1.34$, $SD = 0.52$) as shown in Table 2. A paired-samples t test was calculated to find if the mean difference in the perceived public stigma and personal stigma was significant. Results show that the difference in means was significant such that perceived public stigma was higher than personal stigma, $t(54) = 14.11$, $p < .001$, 95% CI [1.46, 2.35].

To test the relationship of personal stigma with perceived public stigma and perceived peer stigma, a Pearson correlation coefficient was calculated. A moderate, positive correlation between personal stigma and perceived peer stigma was found, $r(52) = .34$, $p = .006$, indicating that a lower personal stigma was associated with a lower perceived peer stigma and vice versa. A significant correlation was not found between personal and perceived public stigma, $r(53) = .06$, $p = .32$.

TABLE 1

Descriptive Statistics and Correlations Between Self-Concept Clarity Scale, Help-Seeking Measures, and Psychological Distress

Measure	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
1. Self-Concept Clarity	31.91	9.42	—					
2. IASMHS	86.20	12.64	.25**					
3. Psychological Openness	27.90	5.28	.08					
4. Indifference to Stigma	27.90	6.69	.25**					
5. Help-Seeking Propensity	28.58	6.19	.21*					
6. MHSIS	4.84	1.78	.14	.66**	.23**	.38**	.81**	—
7. Psychological Distress	29.85	9.41	-.58**	-.28**	-.03	-.32**	-.24**	-.21*

Note. IASMHS = Inventory of Attitudes Toward Seeking Mental Health Services. MHSIS = Mental Health Seeking Intention Scale.

* $p < .05$. ** $p < .01$.

TABLE 2

Descriptive Statistics and Correlations Between Help-Seeking and Stigma Measures

Measure	<i>M</i>	<i>SD</i>	1	2	3	4	5
1. Help-Seeking Propensity	28.58	6.19	—				
2. MHSIS	4.84	1.79	.81**	—			
3. Personal Stigma	1.34	0.52	-.19*	-.14	—		
4. Peer Stigma	2.27	0.64	-.27*	-.15	.34**	—	
5. Public Stigma	2.89	0.60	.03	-.12	.06	—	
6. Indifference to Stigma	29.70	6.69	.36**	.38**	—		

Note. Peer and Public stigma measures were equally randomized between participants thus, their correlation was not computed. MHSIS = Mental Health Seeking Intention Scale.

* $p < .05$. ** $p < .01$.

Correlations Between Help-Seeking Propensity, MHSIS, and Stigma

To test the relationship between help-seeking measures and stigma scales, a Pearson correlation coefficient was calculated. A weak, negative correlation between the Help-Seeking Propensity subscale and Personal Stigma Scale was found, $r(108) = -.19$, $p = .02$, indicating that a high help-seeking propensity was associated with having a lower personal stigma. A significant correlation was not found between the Help-Seeking Propensity subscale and Perceived Public Stigma Scale, $r(53) = .03$, $p = .41$.

A weak, negative correlation between the Help-Seeking Propensity subscale and Perceived Peer Stigma Scale was found, $r(51) = -.27$, $p = .03$, indicating that high help-seeking propensity was associated with having a lower perceived peer stigma. There were no significant correlations between MHSIS and stigma: personal stigma: $r(108) = -.14$, $p = .13$; perceived public: $r(53) = -.12$, $p = .18$; and perceived peer: $r(52) = -.15$, $p = .14$. A ceiling effect for MHSIS was observed. However, a moderate, positive correlation between Indifference to Stigma subscale and MHSIS was found, $r(105) = .38$, $p = .001$, indicating that participants who were indifferent to stigma had a higher mental help seeking intention.

Multiple Linear Regression

A multiple linear regression was conducted to predict the Help-Seeking Propensity subscale based on SCC, personal stigma, and psychological distress. The data was screened for assumptions and outliers, and no outliers were found. All assumptions of linearity, normality, and homoscedasticity were found to be met, and multicollinearity was not found; however, the correlation between SCC and the Kessler Psychological Distress Scale was reaching the cut off of .6–.8 as seen in Table 3.

A significant regression equation was found, $F(3, 105) = 5.29$, $p = .002$, $R^2_{adj} = .11$. Accounting for all other variables in the model, a 1 unit increase in personal stigma was associated with a -3.02 decrease in help-seeking, $SE = 1.11$, 95% CI for b $[-5.21, -0.83]$, $\beta = -.26$, $p = .007$. Accounting for all other variables in the model, a 1 unit increase in psychological distress was associated with a $-.16$ decrease in help-seeking, $SE = 0.07$, 95% CI for b $[-.30, -.01]$, $\beta = -.24$, $p = .04$. Accounting for all other variables in the model, a 1 unit increase in SCC was associated with a $.07$ increase in help-seeking, but this was not significant, $SE = 0.07$, 95% CI for b $[-.07, .22]$, $\beta = .11$, $p = .31$.

Need for Help and Mental Health Services Utilization

Only 18% ($n = 18$) of the total participants ($N = 111$) responded that they would talk to no one if mental health problems were affecting their academic performance. Many other participants ($n = 91$) indicated they would speak with someone. Most respondents reported they would talk with a mental health professional or primary care physician ($n = 44$), college faculty ($n = 42$), friend or partner ($n = 36$), and family member ($n = 32$). If the participant's answer belonged to more than one category, the answer was counted in each category.

In the past year, 76 respondents reported that they needed help with their mental health problems, 25 selected maybe, and 10 selected the option no. In the past year, 50 of the respondents reported having received treatment for mental health problems, whereas only three refused treatment, and 58 reported that they did not receive any treatment. From those 50 respondents who received mental health treatment, 13.5% received psychotropic medication ($n = 15$) and 31.5% received therapy/counseling ($n = 35$).

Discussion

The purpose of the study was to develop a comprehensive understanding of the relationship between SCC, stigma, and help-seeking behavior. Despite the numerous studies including longitudinal that have established a strong association between lower SCC and susceptibility to psychopathology, there was a lack of literature on SCC and help-seeking behavior (Bigler et al., 2001; Kusec et al., 2016; Perry et al., 2008; Stopa et al., 2010; Schwartz et al., 2012; Van Dijk et al., 2014). To our knowledge, this was the first study to explore the concept of SCC and help-seeking together.

The first hypothesis (a) predicted a positive correlation between SCC and help-seeking. We correlated SCC Scale with help-seeking measures (IASMHS and MHSIS). Results from the IASMHS and Help-Seeking Propensity subscale show that individuals who have a higher SCC have a more positive attitude toward seeking mental health services and are more likely to seek help. Hence, the results show that lower SCC is associated with lower help-seeking. The Indifference to Stigma subscale was found to be positively correlated with SCC, indicating that lower SCC is associated with higher stigma.

We did not find a significant correlation between SCC and the MHSIS. Although the

internal validity of the 3-item MHSIS in our sample was excellent, there was a ceiling effect (i.e., all respondents clustered around higher scores on the scale). This ceiling effect further echoed in the results as only 18% of the respondents were not willing to talk to anyone if their mental health was affecting their academic performance. Hence, the inability to find a significant correlation between SCC and MHSIS is unique to the population used by the study. Moreover, a dissertation showed that the internal validity for MHSIS in their sample was unacceptable (Miller, 2020). They recoded their data as a dichotomous variable (0 and 1a), but when the same was done for this study, it made no significant changes in the results. In addition, the MHSIS was developed using volunteers from ResearchMatch, limiting the generalizability of the scale because it has not been validated outside of the original study (Hammer & Spiker, 2018). Hence, the Help-Seeking Propensity subscale of the IASMHS was used as the dependent variable for the multiple linear regression analysis instead of MHSIS.

The second hypothesis (b) predicted a negative correlation between SCC and psychological distress. This is because previous research has supported that lower SCC predicts psychological maladjustment, which increases the susceptibility to developing internalizing and externalizing disorders (Bigler et al., 2001; Campbell et al., 1996; Stopa et al., 2010; Van Dijk et al., 2014). We found that as SCC increased, the psychological distress gauged by the Kessler Psychological Distress Scale decreased supporting the previous literature and current hypothesis. In conjunction with the results of the previous hypothesis, this means that having a lower SCC is associated with higher psychological distress but despite that, there is a negative association between SCC and help-seeking such that a lower SCC was associated with lower help-seeking.

To investigate whether SCC predicts

TABLE 3

Multiple Regression Results for Predictors of IASMHS Help-Seeking Propensity Subscale

	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>	Collinearity Statistics	
					Tolerance	VIF
SCC	0.07	0.07	1.01	.314	.65	1.53
Personal Stigma	−3.02	1.11	−2.73	.007	.95	1.05
Psychological Distress	−0.16	0.07	−2.21	.036	.65	1.54

Note. SCC = self-concept clarity. IASMHS = Inventory of Attitudes Toward Seeking Mental Health Services.

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Help-Seeking Propensity above and beyond the established predictors (mental health stigma and psychological distress), a multiple regression analysis was conducted. Personal stigma and psychological distress continued to be unique predictors of help-seeking propensity as suggested by the previous literature (Boerema et al., 2016; Wadman et al., 2017). Results show that personal stigma was the strongest predictor followed by psychological distress. SCC was not found to be a unique predictor of help-seeking in the presence of personal stigma and psychological distress. This means that there is a possibility that SCC does predict help-seeking to a certain degree, but the strength of its predictability does not surpass that of the established predictors. Moreover, the inability to find SCC as a significant predictor could be due to the high correlation of -5.8 between SCC and psychological distress that was reaching the cutoff of $.6-.8$ for multicollinearity.

The third hypothesis (c) predicted a positive correlation between personal and peer-group stigma. This was the first study to investigate peer-group stigma and the results supported the hypothesis such that, when personal stigma increased, peer-group stigma also increased. This is consistent with the conceptualization presented by Ajzen (2001) that how people perceive their peers attitude toward a behavior creates a perceived social pressure that pushes the individual to engage or not in that behavior. In the context of the results, this means that a higher peer group stigma is indicative of a perception that peers hold a negative attitude toward mental health help-seeking. As perceptions help shape personal beliefs, the direction of respondents' personal stigma matched their perceived peer group stigma. Hence, the positive correlation between personal and peer group stigma.

Consistent with previous literature, a significant mean difference was found such that perceived public stigma was higher than personal stigma (Eisenberg et al., 2007; Lally et al., 2013). However, no association between personal and perceived public stigma was found contrary to the findings reported in Eisenburg et al. (2009). This implies that the perception of the level of stigma held by the public is not associated with personal stigma and vice versa, which indicates that both public and personal stigma might be independent constructs.

The fourth hypothesis (d) predicted no correlation between perceived public stigma and help-seeking, but a negative correlation between both personal and peer stigma with help-seeking behavior. Consistent with previous literature,

personal stigma continued to be associated with help-seeking, whereas perceived public stigma was not associated with help-seeking (Golberstein et al., 2009). In addition, a negative correlation was found between peer stigma and help-seeking propensity. Hence, changing the reference group from perceived "public" stigma to perceived "peer" stigma did help change the association with help-seeking. To summarize, personal and perceived peer stigma were inversely associated with help-seeking propensity, and perceived public stigma had no relationship with help-seeking.

In terms of the need for help, most participants were willing to speak with someone if mental health services were affecting their academic performance. About half of the participants received mental health services, which is reassuring especially because the psychological distress mean score fell in the likely to have a moderate disorder range. This is a college student sample that cannot be directly compared to the adult sample in the SAMHSA (2019) report. Nonetheless, the results align well as the SAMHSA (2019) also showed that only half of the U.S. adults sought help. This shows that barriers to help-seeking are still persistent, thus research exploring this critical juncture should continue to inform the mental health campaigns.

Limitations

One of the major limitations that warrant attention is that the data was collected during a worldwide pandemic, COVID-19. This is evident by the mean score of the Kessler Psychological Distress Scale, which fell in the likely to have a moderate disorder range. The ceiling effect in the Mental Health Services Intention Scale (MHSIS) could also be influenced by the increase in mental health awareness and utilization amid the pandemic. In addition, the research participants consisted of college students who had access to mental health services via university counseling services.

As a self-report survey, social desirability bias is a key consideration while interpreting results, especially for variables such as personal stigma. Moreover, we utilized a convenience sample (undergraduate students from Hollins University, mostly women and White/non-Hispanic/European) which greatly limits the generalizability of our results. If compared to a co-ed institution or different ethnicities, there is a chance for the results to vary dramatically. Hence, results should be interpreted with caution, and the special demographics should be taken into account.

Implications and Future Research

One of the major strengths of the current study is that we investigated the relationship between variables that have not been studied before to help fill the gaps in the literature. Being the first study that we know of to explore SCC with help-seeking, replication is highly recommended. According to the current study, lower SCC is associated with a decrease in help-seeking, despite the association trending toward higher psychological distress. Moreover, lower SCC was found to be associated with higher stigma. Hence, this is a population that needs to be targeted by not only mental health help-seeking intervention programs, but also antistigma campaigns.

The results also call for direct intervention at improving SCC, especially when research shows that self-concept is changeable during the adolescent period (Schwartz et al., 2012). Other studies can focus on what are the factors that help shape self-concept. For example, Parise et al. (2019) showed that emotional regulation is a mediator between SCC and psychological maladjustment. Knowing that self-concept is shaped during the adolescence, schools should focus on developing emotional regulation skills. In addition, mental health care providers should also place a greater emphasis on emotional regulation skills, especially when seeing an adolescent. Moreover, a longitudinal study over the course of early developmental years until late adolescence could bolster knowledge regarding the developmental trajectory of SCC.

In addition to emotional regulation, parental factors such as warmth and clear communication (Perry et al., 2018; Van Dijk et al., 2014) influence the development of SCC. These factors should be clearly communicated to the public while explaining the importance of a healthy identity via SCC that influences psychological distress, stigma, and subsequent help-seeking. Caregivers should also be encouraged to speak to their child regarding mental health in order to work toward reducing personal stigma and improving help-seeking behavior. If one piece of the equation, such as emotional regulation, is improved, there might be a good chance to increase SCC that is associated with lower psychological distress, lower stigma, and higher help-seeking propensity as per our results. However, as this is not an experimental or a mediation-model study, causal statements cannot be made and warrant further research.

In terms of predicting help-seeking, SCC was not found to be a valid predictor, and future

studies should aim to replicate the finding to gauge whether this is true across different settings. Moreover, it is imperative to research additional factors that might influence help-seeking in order to inform and improve the mental health help-seeking interventions. Stigma and psychological distress continued to be salient predictors of help-seeking. This shows that stigma continues to be a barrier to seeking mental health services even after several decades and personal stigma stands to be the strongest predictor of help-seeking in the current study. Hence, there is a need to streamline mental health and help-seeking interventions to target personal stigma. Some of the ways include contact and psychoeducation (Corrigan et al., 2012). Contact can be increased by providing an opportunity to meet people with lived experience such as done in the School Space intervention (Chisholm et al., 2016). In terms of psychoeducation, the importance and ways to seek mental health should be highlighted while also focusing on improving mental health literacy to aid familiarity. This is because familiarity with mental health has been shown to be associated with lower stigma (Corrigan et al., 2012).

This is the first study to our knowledge that investigated perceived peer stigma in addition to personal stigma and perceived public stigma. Hence, this study should act as a catalyst to explore this new domain. This is especially important in the context of college students as the lifetime age of onset of 75% of mental health disorders is before the age of 24 (Kessler et al., 2005). In addition, mental health problems early in life have been shown to be associated with adverse outcomes in academics (Breslau et al., 2008); for example, depression is a predictor of lower GPA and dropping out (Eisenberg et al., 2009). Therefore, antistigma interventions should target ways to reduce perceived peer group stigma. Our results show that perceived peer group stigma is associated with personal stigma. Given the theory that peer perceptions (i.e., perceived peer group stigma) shape personal beliefs (i.e., personal stigma), future research should focus on causal experiments. Generally, increasing the sample size and random sampling would be beneficial for future studies. Overall, these findings hold immense significance for mental health educational programs that aim at reducing stigma and increasing awareness regarding the different types of stigma that impede help-seeking behavior.

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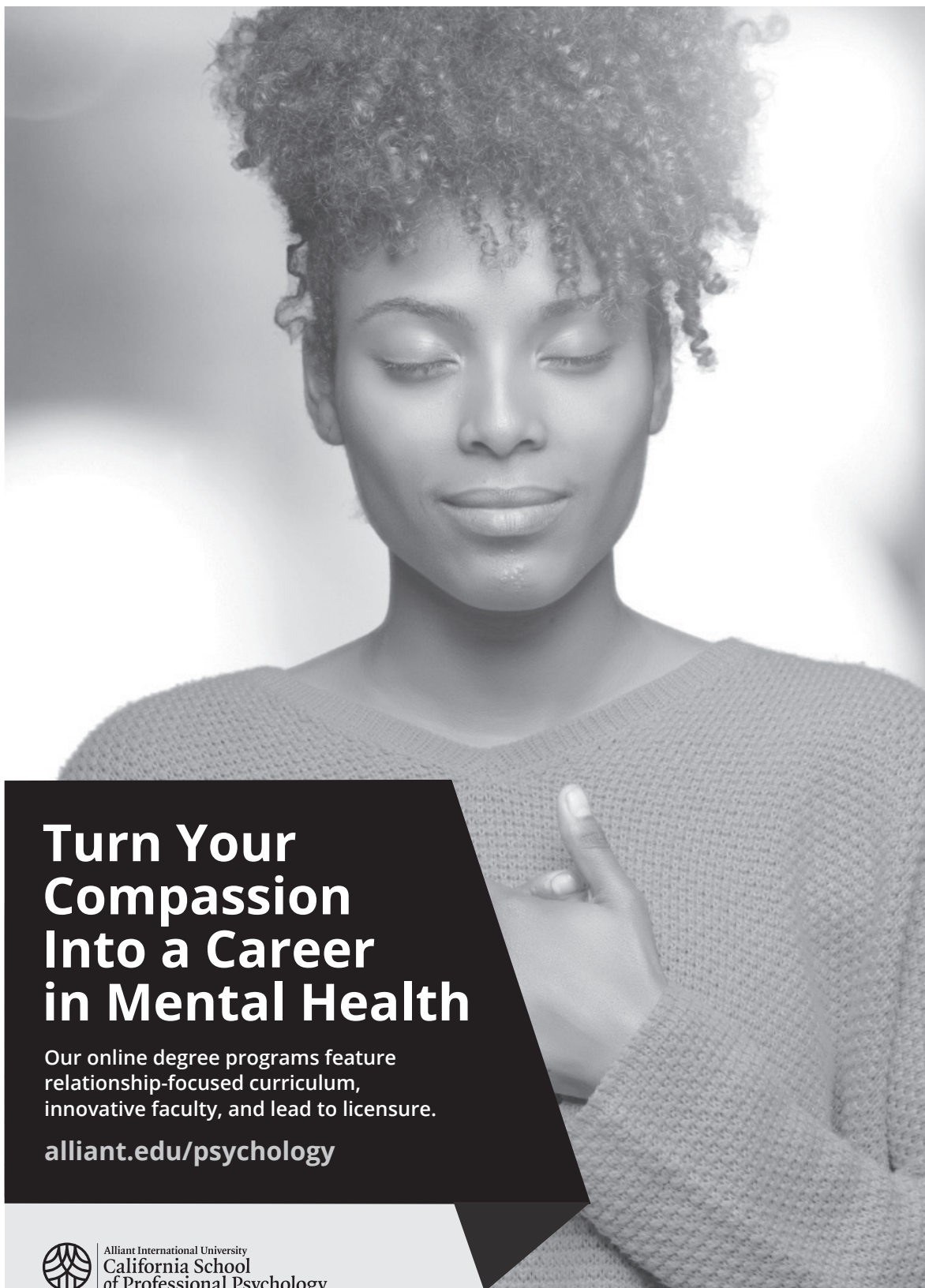
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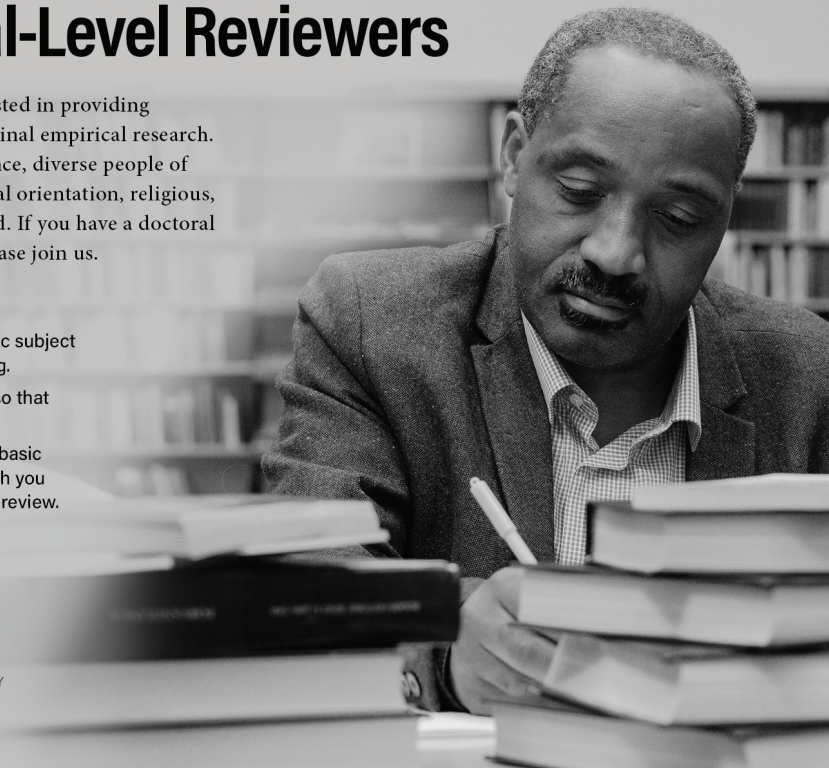
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