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The Relationship Between Campus Climate, Perceived Stigma, Perceived Social Support, and Students' Decisions to Disclose Their Mental-health Problems on Campus

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THE RELATIONSHIP BETWEEN CAMPUS CLIMATE, PERCEIVED STIGMA, PERCEIVED SOCIAL SUPPORT, AND STUDENTS' DECISIONS TO DISCLOSE THEIR MENTAL-HEALTH PROBLEMS ON CAMPUS

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Dissertation Approval

This is to certify that the thesis presented to us by Erin Potts

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Dedication

i feel older than i did when this journey started. more
tired. exhausted. weathered.
but a lot more sure of myself. with a better sense of what
i'm doing and why.
i am a body within a body. more than one life at once.
every day a new person becomes inside me
i think this is what growth feels like…

- rupi kaur

to all who have been a part of this journey … who gave me strength when i was certain none existed … who held my head higher when i was certain it would stay low forever … who reminded me of the healing power of laughter … who made every moment of this worth fighting for …

thank you, from the bottom of my heart.

this, this is for you.

Abstract

The purpose of the current study was to determine the relationship between the overall campus climate with regard to mental-health problems, students' perceptions of stigma, students' perceived social support, and their decisions to disclose their mental-health problems on their college or university campuses. Data were collected from 223 participants between the ages of 18 and 59 years who identified as being currently enrolled in an undergraduate or graduate program and who had engaged in disclosure and/or concealment in the 6 months prior to the study. The findings of the current study suggest that positive perceptions of campus climate are associated with students' experience of regret for their disclosures. Also, students' decisions to disclose their mental-health problems are positively associated with their decisions to disclose this information again in the future. Stigma had a negative effect on disclosure, making students less likely to disclose their mental-health problems in the future. Based on these findings, college and university campuses should have a unique responsibility to provide a welcoming and supportive environment within which students can feel comfortable to disclose their mental-health problems.

Keywords: mental-health problems, disclosure, college students, campus climate, stigma, perceived social support

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Chapter 1: Introduction

Statement of the Problem

Over the past 2 decades, mental-health problems have increased across the United States (U.S.), with the highest prevalence rates among individuals aged 15 to 24 years. Of significant importance is that this age range corresponds with the typical age of onset of mental-health problems (Collins & Mowbray, 2005; Hunt & Eisenberg, 2010; Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, & Walters, 2005; Mowbray et al., 2006). Thus, the first onset of most mental-health problems is likely to occur during an individual's undergraduate college career (Beiser, Erickson, Fleming, & Iacono, 1993; Eisenberg, Gollust, Golberstein, & Hefner, 2007b; Kessler, Berglund, et al., 2005; Kitzrow, 2003; Mowbray et al., 2006). Evidence further shows that individuals often fail to seek help for their mental-health problems, with an estimated 11-year gap between the onset of mental-health problems and the time at which individuals seek help (Kessler, Demler, et al., 2005; Wang et al., 2005). This gap is of significant importance when considering the typical age of onset, as it often overlaps with traditional college years. Given that this time of life often corresponds with postsecondary education, institutions of higher education have come into focus as spaces in which supports can be increased and mental-health problems can be supported.

Postsecondary institutions have experienced an increase in enrollment of individuals with mental-health problems over the past several decades (Planty et al., 2009; Stein, 2005). This increase has since caused postsecondary institutions to consider how to provide services for students with mental-health problems on campus. College and university campuses have a variety of resources, such as campus counseling centers,

disability services, and peer supports. One important support that is present on all college and university campuses is protection from discrimination for individuals with disabilities under the Americans with Disabilities Act (ADA) of 1990, which also provides opportunities for students to receive reasonable accommodations on campus (Hartley, 2013; Mowbray et al., 2006). In order to use this resource, however, students are legally required to disclose their mental-health problems on their college or university campus to the office of disability services (Mowbray et al., 2006). Studies show that while students may be aware of this resource, they are reticent to disclose their mental-health problems, ultimately impeding their access to ADA accommodations and campus supports (Gruttadaro & Crudo, 2012). The question arises as to what factors play a part in impacting students' decisions to disclose their mental-health problem(s) on campus in order to seek services that provide support.

The disclosure decision-making model (DDM) provides a framework that sheds light on the process by which individuals reach a decision as to whether or not to disclose their mental-health problem(s). The model is composed of three stages, each of which provides a set of decision-making processes that aid in the de3cision of disclosure (Omarzu, 2000). According to the DDM, when individuals are faced with the decision of whether or not to disclose, they must first assess the situation and identify whether or not a salient goal for disclosure exists (Omarzu, 2000). Individuals who are faced with the decision of whether or not to disclose their mental-health problem(s) on campus may identify a variety of different goals, such as accessing accommodations or receiving support. Factors that may impact students' abilities to identify a salient goal, however, include whether or not students are aware that accommodations are available, whether or

not they believe accommodations would be helpful, and whether or not they believe stigmatization of mental-health problems exists on campus.

Research shows that students often fail to seek services on campus, specifically academic accommodations (Gruttadaro & Crudo, 2012; Kessler, Demler, et al., 2005; Wang et al., 2005). While a subset of students is unaware of the resources available through accommodations, another subset of students is aware of the resources but chooses not to use them (Gruttadaro & Crudo, 2012). One of the major barriers for students accessing these resources is stigma, which interferes with students identifying accommodations as a salient goal within the decision-making process (Gruttadaro & Crudo, 2012). If students perceive potential stigmatization based on the disclosure of their mental-health problem(s) for the purpose of receiving accommodations, students likely will no longer regard accommodations as a supportive experience.

If students do, however, identify a salient goal, the next step in the decision-making process is identifying an appropriate target to whom they wish to disclose (Omarzu, 2000). When selecting an appropriate target person, individuals often choose to disclose personal information to someone they trust. A variety of factors, such as perceived level of social support, perceived level of stigma, and perceived environment within which students disclose may impact the level of trust between two individuals. Research has explored how students' perceptions of the campus climate impact their experiences on campus within a variety of settings. If students perceive a particular space on campus, or even the entire campus, as unwelcoming to those with mental-health problems, students likely will choose not to disclose. Further, the perception of the

campus climate makes identification of an appropriate and safe target person for disclosure difficult for students.

The final stage of the decision-making process involves exploring the potential risks and benefits of disclosure (Omarzu, 2000). Given that these risks and benefits can significantly impact the decision of whether or not to disclose, one must understand the factors students identify as risks and benefits to disclosure of their mental-health problem(s) on college and university campuses. Few studies to date have explored this area related to disclosure. Preliminary evidence has, however, indicated that one of the barriers that prevents students from disclosing their mental-health problem(s) on campus is fear of stigma (Gruttadaro & Crudo, 2012). As mentioned previously, if students perceive that stigma regarding mental-health problems may cause them to experience negative reactions and lack of support, this risk may override the potential benefits of disclosure. The negative effects disclosure may have on an individual are important to acknowledge, thereby ultimately indicating that disclosure is not always the appropriate decision unless the benefits outweigh the risks.

The DDM delineates a process that allows individuals to identify whether or not disclosure is an appropriate strategy to reach an identified goal. In examining this decision-making process, several factors appear to be associated with whether or not students will choose to disclose their mental-health problem(s) on campus. Perceived social support, perceived stigma, and perceived climate on campus have the potential to positively or negatively impact one's decision to disclose. By examining the relationship between these factors and disclosure of mental-health problems, college and university campuses may be provided with the knowledge needed to make the perceived benefits of

disclosure outweigh the risks. Studies indicate that students are accessing supports on campus, given an increase in the number of students seeking counseling services (Gallagher, 2014). This increase, however, does not account for the large number of students who are aware of other services on campus and who fail to use them. By exploring students' decisions to disclose their mental-health problem(s) outside of counseling centers, along with the relationship between perceived stigma, perceived social support, and overall campus climate with regard to mental-health problems, college and university campuses may have an increased ability to provide support for students.

Purpose of the Study

The purpose of this study is to explore factors suggested by the DDM that may impact students' decisions to disclose their mental-health problem(s) on their college or university campus. The factors identified for the current study include perceived stigma, perceived social support, and perceived overall campus climate as they relate to mental-health problems. It is hypothesized that a relationship exists between students' perceptions of campus climate, their perceptions of stigma, their perceptions of perceived social support, and their decisions of whether or not to disclose their mental-health problems on their college or university campus. In order to support this hypothesis, the current paper explores ways in which the increase in mental-health problems across the U.S. has also impacted the increase in mental-health problems present within postsecondary education institutions. It further explores the supports that are present on college and university campuses and whether or not students are accessing these supports. Unfortunately, research shows that despite students being aware of the supports

and services available to them on campus, students fail to use them. In order to access these supports, students are faced with decisions of whether or not to disclose their mental-health problem(s) to the overseeing office or individual. Therefore, this paper explores a DDM that provides a framework for how and when individuals make their decisions of whether or not to disclose their mental-health problem(s) within spaces on campus outside of campus counseling centers.

Chapter 2: Literature Review

Mental-health problems are increasingly prevalent across the United States (U.S.). In any given year, one in four adults aged 18 years and older experience symptoms concurrent with a diagnosable mental-health problem (Kessler, Chui, et al., 2005; Salzer, 2012). In 2002, mental-health problems reportedly affected an estimated 15 to 21 million Americans, and were three of the top 10 conditions accounting for 25% of disability worldwide (Salzer, 2012). Roughly a decade later, studies indicated that 43.8 million adults in the U.S. experience a mental-health problem in a given year, making up approximately 18.3% of the population (National Alliance on Mental Illness [NAMI], 2016). Further, 10 million (4.2%) of these individuals live with a mental-health problem that substantially interferes with or limits one or more major life activities (NAMI, 2016).

Mental-health problems are increasing across the general population; however, they are particularly impactful for adolescents and young adults. Epidemiological studies have reported that the prevalence rate of mental-health problems is highest among individuals aged 14 to 24 years; studies show that half of all chronic mental-health problems begin by the age of 14 years, and three quarters by the age of 24 years (NAMI, 2016). Interestingly, this statistic has remained fairly consistent over the years. A little more than a decade ago, researchers estimated that 37% of young adults between the ages of 15 and 24 years were diagnosed with a mental-health problem ranging from mild and short lived to chronic and severe (Kessler, Olfson, & Berglund, 1998). Of significant importance is that this age range corresponds to traditional college years (Collins & Mowbray, 2005; Hunt & Eisenberg, 2010; Kessler, Berglund, et al., 2005; Kessler, Chui, et al., 2005; Mowbray et al., 2006). One study found that 51.4% of respondents indicated

that their mental-health problem began prior to attending postsecondary education, whereas the other 48.6% experienced their onset during the course of their higher education (Megivern, Pellerito, & Mowbray, 2003). Thus, the first onset of most mental-health problems is likely to occur prior to or during an individual's undergraduate college career (Beiser et al., 1993; Eisenberg et al., 2007b; Kessler, Berglund, et al., 2005; Kitzrow, 2003; Mowbray et al., 2006). Owing to this untimely overlap, the onset of mental-health problems is likely to disrupt, postpone, or even prevent postsecondary education (Bellamy & Mowbray, 1998; Kessler, Foster, Saunders, & Stang, 1995).

Mental-Health Problems in Higher Education

A significant number of students on college and university campuses are experiencing mental-health problems. The National Center of Education Statistics (NCES) reported that during the 2008-2009 academic year, approximately 707,000 students with disabilities were enrolled in postsecondary and higher-education institutions, 76% of whom reported having depression, anxiety, or posttraumatic stress disorder (PTSD; as cited in Raue & Lewis, 2011). During the same academic year, the American College Health Association conducted a National College Health Assessment (ACHA-NCHA) in which more than one in three undergraduate students indicated feeling so depressed that they had difficulty functioning, and almost one in 10 had seriously considered suicide in the year prior to the survey (ACHA-NCHA, 2009). Several years later, the same survey was distributed to 108 institutions with responses from 93,034 students. The results yielded an increase in both statistics, with 34.5% of students indicating they felt so depressed they had difficulty functioning in the year prior to the survey, and 8.9% had seriously considered suicide (ACHA-NCHA, 2016).

Overall, suicide is the 10th-leading cause of death in the U.S. and the second-leading cause of death for individuals aged 15 to 24 years (Drapeau & McIntosh, 2015). This statistic is of utmost importance when considering that the onset of mental-health problems occurs within this age range, further corresponding with the time at which individuals are considering and attending postsecondary institutions. According to the National Survey of Counseling Center Directors at 275 institutions, 94% of directors reported an increase in the number of students presenting to campus counseling centers with severe mental-health problems. Specifically, directors reported 52% of students experience severe psychological problems, which is up from 44% in 2013 (Gallagher, 2014). In institutions with more than 15,000 students, 59% have severe difficulties; 50% of those students are successfully treated, and 9% are so severely impaired they are unable to remain in school (Gallagher, 2014). This being said, a large number of students who attend academic institutions either enter postsecondary education with a mental-health problem or have their first experience with a mental-health problem during their academic careers.

Not only are students experiencing mental-health problems, but these experiences are negatively impacting their academic performance. Roughly 20 years ago, a nationally representative sample of 8,098 respondents aged 15 to 54 years were surveyed by the National Comorbidity Survey, which indicated that individuals with early-onset mental-health problems are significantly less likely to attend college, and those who do attend are more likely to withdraw as compared to individuals who did not experience early-onset mental-health problems (Kessler et al., 1995). Research has also found that 86% of students with a mental-health problem drop out of college prior to graduation, a number

that is twice as high as the general dropout rate, which is estimated between 30% and 40% (Astin & Oseguera, 2005; Kessler et al., 1995; Porter, 1990). Attempts of individuals to return to school after having overcome their mental-health problem(s) or having learned to manage them are often unsuccessful (Anthony & Unger, 1991; Cook & Solomon, 1993). In 1995, research indicated that roughly 4.29 million (2.4%) individuals in the U.S. would have graduated from college had they not been suffering from psychiatric disabilities (Kessler et al., 1995). A more recent study found that 64% of students who are no longer attending college indicated that they withdrew as the result of a mental-health-related reason (Gruttadaro & Crudo, 2012). Postsecondary education is viewed as a critical factor in improving employment opportunities, yet disruption because of a mental-health problem can further lead young adults down a path of educational underachievement, underemployment, and even unemployment (Becker, Martin, Wajeeh, Ward, & Shern, 2002; Unger, Pardee, & Shafer, 2000). College and university campuses have the potential to help students access available services, ultimately making it more likely that students with mental-health problems will remain in school and be successful.

The impact mental-health problems may have on an individual's postsecondary education is clear; however, identifying what specifically impacts student success is important. The ACHA-NCHA (2016) surveyed 108 undergraduate and graduate programs across the U.S. regarding a variety of concerns related to the academic and personal experiences of students. Within the 12 months prior to the survey, several factors were found to have impacted academic performance. These factors were defined as receiving a lower grade on an exam or project; receiving a lower grade in a course; receiving an incomplete or dropping the course; or experiencing a significant disruption

in thesis, dissertation, research, or practicum work. The factors that impacted students the most were stress (30.0%), anxiety (21.9%), sleep difficulties (20.0%), cold/flu/sore throat (14.6%), work (13.9%), and depression (13.8%).

Based on these statistics, a significant number of students on college and university campuses are impacted by their experience of mental-health problems. Often, this impact manifests in academic difficulties that ultimately have the potential to affect students' overall academic success. Despite the negative impact mental-health problems may have on academic success, supports are available on college and university campuses that have the potential to greatly improve academic success. One support that is of significance for students with mental-health problems is the presence of counseling centers on college and university campuses. This particular support, however, is outside the scope of the current research. Other supports on campus outside of counseling centers also provide support for students with mental-health problems. These supports will be the focus of the current research.

Supports on Campus

Given the potentially negative impact mental-health problems have on students on college and university campuses, ways in which higher education institutions can create an environment of success must be identified. Over the years, several supports have been enacted to decrease discrimination and increase support for students with mental-health problems and other disabilities. Discrimination against individuals with disabilities was addressed by Section 504 of the Rehabilitation Act of 1973, which required colleges and universities to provide reasonable accommodations to qualified students with disabilities to ensure they would have access to the same opportunities as those accessed by

individuals without disabilities (Hartley, 2013; Mowbray et al., 2006). In 1975, the passage of the Individuals with Disabilities Education Act (IDEA) protected individuals based on their disabilities from discrimination and ensured that supports were provided to students in postsecondary institutions (Wolf, 2001). Fifteen years later, the Americans with Disabilities Act (ADA) of 1990 was introduced to protect individuals who have disabilities from discrimination on the basis of their disabilities (Feldblum, Barry, & Benfer, 2008; Kiuhara & Huefner, 2008). Ultimately, this protective statute provides students who identify as having a disability with the ability to receive reasonable accommodations in order to ensure equal opportunity within the education system (Wolf, 2001). Under the ADA, university administrators are legally required to provide reasonable accommodations for students who disclose they have a disability and require accommodations (Kiuhara & Huefner, 2008). More recently, the ADA Amendments Act of 2008 was passed in order to address the limitations of the ADA, namely the definition of disability, which had originally been interpreted in a way that was preventing individuals from being regarded as having a disability (Feldblum et al., 2008).

In theory, the ADA provides significant support for students with mental-health problems on college and university campuses, specifically for those who are struggling academically as a result of their mental-health problem(s). In order to access these services, however, students are legally required to disclose their mental-health problem to the overseeing office or individual (Mowbray et al., 2006). Often, students do not disclose their mental-health problem and fail to seek help from college and university counseling centers because of stigma, discrimination, and/or embarrassment (Megivern, 2002; Mowbray et al., 2006). Given that students with mental-health problems are

increasingly attending postsecondary education, as well as that the majority of students with mental-health problems fail to seek support on campus, a better understanding of the barriers that impede students' decisions to seek help on college and university campuses is crucial.

Some research has focused on help-seeking behaviors of college students; however, the majority of this research explores help-seeking as it relates to college counseling centers (e.g., Gallagher, 2014). Research within the general population indicates a median delay of 11 years between the onset of mental-health problems and when individuals seek help (Kessler, Demler, et al., 2005; Wang et al., 2005). Given that the onset of mental-health problems tends to overlap with traditional college years (Beiser et al., 1993; Eisenberg, Gollust, Golberstein, & Hefner, 2007b; Kessler, Berglund, et al., 2005; Kitzrow, 2003; Mowbray et al., 2006), as well as that the delay in seeking services is 11 years, students may not be accessing the services needed to support their academic success. Of importance, then, is the identification of potential barriers that may prevent students from accessing these services and seeking support for their mental-health problems.

Research has explored help-seeking behavior among college and university students in order to determine whether or not students are accessing the services and supports available to them. Apparently, a large gap exists between students who need services and those who are actually accessing them on college and university campuses. In a survey of 765 college students living with mental-health problems, 62% of students knew how to access accommodations for their mental-health problem(s), but only 43% actually accessed them (Gruttadaro & Crudo, 2012). More than 45% of students who

stopped attending college as the result of a mental-health problem(s) did not receive accommodations, and 50% of these students did not access mental-health services and supports. Those students who failed to access accommodations and mental-health-related services (e.g., counseling) on campus provided several reasons for choosing not to access supports. Among the top five reasons for not accessing services is the fear of stigma (Gruttadaro & Crudo, 2012), which continues to be a barrier despite movements toward the destigmatization of mental-health problems.

A variety of barriers are likely to be the reasons students fail to seek help and support for their mental-health problem(s) on college and university campuses. For the general population, financial constraints are one of the most prominent barriers to seeking treatment (Eisenberg, Golberstein, & Gollust, 2007a; Kessler et al., 2001; Sturm & Sherbourne, 2001). The barriers for students on college and university campuses, however, appear to be somewhat different. Research on help-seeking behaviors among college and university students indicates substantial unmet needs, as well as several barriers to use of counseling services and other supports on campus (Furr, Westefeld, McConnell, & Jenkins, 2001; Hyun, Quinn, Madon, & Lustig, 2006). Some of the barriers preventing students from seeking counseling services include financial constraints, stigma associated with mental-health problems, the lack of availability of services, concerns about privacy, lack of health insurance, and lack of time (Eisenberg et al., 2007a; Givens & Tija, 2002; Megivern et al., 2003; Mowbray et al., 2006; Tija, Givens, & Shea, 2005). Of these barriers, two of the most commonly discussed within the literature are the availability of campus counseling services and the perceived stigma of mental-health problems.

Considering the high rates of mental-health problems among college students, as well as the numerous supports available to students, help-seeking behavior on college and university campuses must be considered. As mentioned previously, a significant gap seems to exist between the onset of mental-health problems and access to supports. Given this delay, as well as the typical age of onset for mental-health problems overlapping with traditional college years, identifying ways in which to increase support on college and university campuses is of utmost importance. Apparently, the most common barriers for students on college and university campuses are the availability of counseling services and fear of stigma. In order to access certain supports on college and university campuses, students are required to disclose their mental-health problem(s). This decision of whether or not to disclose one's mental-health problem is greatly impacted by barriers, including the fear of stigma. A better understanding of the decision-making process for students, as well as of the factors that may impact their decision of whether or not to disclose their mental-health problem and ultimately access services available to them on campus, is therefore important.

Self-Disclosure

Over the years, the definition of self-disclosure has undergone several iterations. One of the earliest definitions was the "act of making yourself manifest, showing yourself so others can perceive you" (Jourard, 1971b, p. 19). This definition includes the assumption that disclosure encompasses verbal and nonverbal ways individuals may express and share information about themselves to others (Chaudoir & Fisher, 2010). In general, one can argue that all forms of verbal and nonverbal communication may reveal information about an individual, thus indicating that any act of communication may be

considered self-disclosure (Greene, Derlega, & Mathews, 2006). Nonverbal communication may occur as a result of an individual's presentation by way of tattoos, jewelry, clothing, or even laughing and smiling. These involuntary disclosures, however, are significantly different from what Jourard (1971a) described as "willful disclosures," in which the "aim is to let someone know, without a doubt, what one feels, thinks, etc" (p.16-17). Therefore, self-disclosure is typically defined as an interaction between two individuals in which one deliberately divulges something personal to another (Derlega, Metts, Petronio, & Margulis, 1993; Greene et al., 2006). Individuals may disclose facts about themselves, their opinions and attitudes, or information about their emotions (Omarzu, 2000). For the purposes of the current study, self-disclosure will be defined as a willful, verbal communication from one individual to another.

Research has, over the years, explored ways in which this disclosure of personal information impacts the individual disclosing. Jourard (1971b) viewed disclosure as an indication of psychological adjustment, proposing that those who tended to choose not to disclose would be more likely to experience mental and physical illnesses (Omarzu, 2000). In this view, choosing not to disclose personal information, such as a mental-health problem, could negatively impact an individual's overall mental health. The act of revealing personal information about oneself to another is considered central to creating close relationships, as well as to maintaining psychological well-being (Altman & Taylor, 1973; Jourard, 1964, 1971b). Self-disclosure further plays an integral role in the kinds of relationships that form between individuals (Greene et al., 2006; Harvey & Omarzu, 1997).

Positive Effects of Disclosure

From a psychological perspective, the research has suggested that disclosure has a variety of positive effects on individuals. Research has indicated that coming out about one's mental-health problem is associated with decreased negative effects of self-stigmatization, thereby further encouraging individuals to move toward achieving life goals (Corrigan et al., 2010; Corrigan & Rao, 2012). Disclosure also has an impact on the intimacy of relationships, in that receiving disclosure creates an obligation to return the favor and ultimately increases overall liking for the discloser (Omarzu, 2000). Researchers posit that disclosure is rewarding to receive and appears to create positive feelings about the individual who discloses (Omarzu, 2000). Further, research suggests that revealing a personal secret, especially one that is connected to identity, removes the stress that results from having to keep this information hidden (Corrigan, 2005b; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001). This reduction in stress can result in the formation of better friendships (Corrigan, 2005b; Beals & Peplau, 2001; Beals, Peplau, & Gable, 2009), as well as in improved job satisfaction (Corrigan, 2005b; Day & Schoenrade, 2006). Individuals who disclose also report experiencing increased support from their families (Corrigan, 2005b; Kadushin, 2000). Beyond the positive individual effects of disclosure are also benefits to the group as a whole. The more individuals come out and disclose, the more likely stigma within society will begin to decrease (Corrigan, 2005b).

Beals et al. (2009) conducted a study with 84 individuals who identified as lesbian or gay and aimed to determine why past research has found that disclosure of one's sexual orientation is beneficial. While several constructs were explored within the study,

the one of significant importance to the current research is that of disclosure and well-being. Participants were asked to keep an event diary of experiences in which they had the opportunity to disclose their sexual orientation throughout each day (Beals et al., 2009). Results indicated that participants reported significantly greater self-esteem, positive affect, and satisfaction with life on days when they chose to disclose compared to days when they had the opportunity to do so but instead chose to conceal their sexual orientation (Beals et al., 2009). Yet another study was conducted to explore the association between emotional disclosure and its impact on subjective well-being in day-to-day life in individuals with no recent history of a major stressor (Saxena & Mehrotra, 2010). The sample consisted of 209 participants who denied the presence of a major life stressor in the recent past. Results indicated that lower affect intensity, higher emotional clarity, lower trait rumination, higher perceived support, and higher emotional disclosure predicted higher subjective well-being. While both studies presented here highlight potential benefits of disclosure, the potential negative effects of disclosure must also be explored.

Negative Effects of Disclosure

While disclosure can be associated with positive outcomes, some negative side effects to sharing personal information with others may also result. Revealing a painful or embarrassing secret may elicit anxiety and/or rejection from the listener, thereby leading to isolation and feelings of low self-worth on part of the discloser. Thus, four risk factors of disclosure have been identified: rejection by the listener, loss of control or self-efficacy, reduction of autonomy and personal integrity, and possibly hurting or embarrassing the listener (Baxter & Montgomery, 1996). Yet another risk of disclosure

is creating a self-fulfilling prophecy for the listener. An inability to articulate one's thoughts clearly has the potential to create distorted impressions for the listener, thereby causing the listener to form stigmatizing opinions based on inaccurate information (Kelly & McKillop, 1996). Considering the stigmatization of mental-health problems, the general public might avoid the individual who discloses their mental-health problem and offer social disapproval. As a result the self-esteem of the disclosing individual may be impacted negatively (Corrigan, 2005b). Further, individuals who are open about their mental-health problems have been found to be far less likely to obtain and/or maintain employment because of the stigma of mental-health problems.

Disclosure Decision Making

Models of disclosure have been explored over the years, each with varying perspectives on the process by which individuals reach a decision of whether or not to disclose personal information. Although the amount of research on self-disclosure has been significant, little research has focused on factors that impact the decision to disclose one's mental-health problem and the process by which individuals arrive at that decision. The decision, in part, has been said to depend on the perception of relative benefits and costs to the individual disclosing the information, as well as to the individual receiving it (Greene et al., 2006; Kelly, 2002; Omarzu, 2000). Further, the decision to disclose may be encouraged or influenced by the actions of other individuals, as well as of the individual who is disclosing (Omarzu, 2000). Despite insignificant research on the decision to disclose mental-health problems, one model has been proposed that identifies a process by which individuals decide whether or not to disclose personal information.

This model provides a framework that helps to better understand disclosure of personal information, such as mental-health problems.

The disclosure decision-making model (DDM) proposes a decision-making process that has the potential of leading to a variety of different types and levels of disclosure (Omarzu, 2000). The model assumes that individuals manage their disclosures strategically in order to control their social environment, as well as to achieve social and personal goals (Omarzu, 2000). Individuals often enter a situation with a specific goal or social reward that may be achieved through disclosure. Specific goals of students with mental-health problems on college and university campuses may include identifying and/or increasing support and accessing academic accommodations. In a college environment, cues likely are present when entering situations that may indicate that academic accommodations may be helpful for students with mental-health problems and have the potential to aid in their academic success. By choosing disclosure as the means of achieving this goal, students may move forward in their process of succeeding academically. Other behavioral means of achieving this goal are available, however, if disclosure no longer appears to be the most conducive method of achieving the identified goal (Omarzu, 2000). The DDM takes into consideration that disclosure is not always the appropriate strategy to achieve a desired goal, a decision that is accounted for at each stage of the decision-making process. Overall, the model provides a framework for determining whether or not disclosure is the appropriate strategy for students to achieve their desired goal.

The DDM ultimately provides an outline of a decision-making process that individuals engage in prior to disclosure. In general, the model identifies pertinent

variables and makes predictions about the impact these variables will have on the breadth, depth, and duration of self-disclosure. Disclosure breadth is defined by the number of topics included in a disclosure, duration is defined as the amount of disclosure that occurs, and depth is defined as the level of intimacy of the disclosure (Omarzu, 2000). The DDM breaks down the decision-making process into three separate stages, each of which provides an option of whether or not to disclose based on an evaluation of several factors. These factors ultimately impact the nature of the disclosure, the amount of information that is disclosed, and the level of intimacy of the disclosure.

The decision to disclose begins within a particular social context in which specific disclosure goals are made salient. Individuals bring their own set of goals into all situations (Omarzu, 2000); for example, students may enter all social situations with the goal of forming friendships and increasing intimacy. Individuals who wish to achieve intimacy and develop close personal relationships will bring this goal with them into all situations they enter. Similarly, individuals with mental-health problems who desire support may bring this goal with them whenever they enter a situation where support may be available. The DDM proposes that the decision to disclose is activated by an increase in the accessibility of several social rewards, including social approval, intimacy, relief of distress, social control, and identity clarification (Omarzu, 2000). Each of these social rewards may promote disclosure among individuals with mental-health problems in order to increase overall support on campus. College and university campuses have the potential to increase disclosure in order to help individuals gain support by ensuring that these social rewards are salient and available to students. Having these goals present in any given situation, however, does not necessarily set the stage for disclosure to occur.

In the first stage of the DDM, individuals enter a situation in which a specific disclosure goal is made salient and accessible. Individuals may enter situations with several disclosure goals in mind; however, certain cues within a situation may make one goal more salient than the others (Omarzu, 2000). Students who are interested in seeking accommodations on their college or university campus may take into consideration a variety of cues within the context of where they may disclose their mental-health problem(s). Cues within the context of seeking accommodations may include the environment within the office of accommodations, attitudes of individuals within the office with regard to mental-health problems, the overall campus climate regarding mental-health problems, and a host of other factors. If students experience negative attitudes and perceptions on campus with regard to mental-health problems, they may be less likely to disclose their mental-health problem(s), regardless of their need for accommodations and/or support on campus. On the other hand, if students perceive situational cues as supportive of mental-health problems, they will be more likely to move forward in the decision-making process.

Once a goal for disclosure has been identified, students must then explore strategies to achieve this goal. The second stage of the DDM involves the decisions of whether or not disclosure is the appropriate strategy and of to whom an individual should disclose (Omarzu, 2000). Ultimately, individuals can engage in a variety of strategies to achieve a specific goal. In certain situations, disclosure may be the most conducive strategy; however, other situations may offer different opportunities to achieve a goal (Omarzu, 2000). Students who wish to receive academic accommodations or support on campus may not necessarily need to disclose their mental-health problem in order to

achieve these goals. Simply attending student groups on campus related to mental-health problems may create a sense of support without necessarily having to disclose a mental-health problem. Once individuals identify disclosure as the appropriate strategy to achieve their goals, they then need to identify a target person to whom they will disclose. Choosing a target person will be impacted by circumstances, situational cues, and the nature of the particular goal (Omarzu, 2000). If students on college or university campuses perceive an unwelcoming environment or experience stigma related to mental-health problems, they may have difficulty identifying an appropriate target person on campus.

Often, students may receive support for their mental-health problem(s) in several spaces on college and university campuses. If students are seeking accommodations in an office on campus that provides this service, they may be able to identify a variety of individuals within that office as potential target persons for disclosure. Evidence shows that when faced with more than one possible target person, individuals discriminate about when and to whom they will disclose their mental-health problem(s). Individuals often observe potential target persons' reactions to others' disclosures prior to making a decision as to whom they will disclose (Kelly & McKillop, 1996; Omarzu, 2000). Students not only may witness other disclosures on campus first hand, but also may hear other students' experiences with disclosure of mental-health problems. Depending on the overall outcome of the disclosures on campus, students may use this information in their own decision-making process. If students observe other disclosures of mental-health problems on campus that are responded to negatively, those students will likely not choose disclosure as the appropriate strategy to achieve their goal. In situations where

students observe positive experiences of disclosure on campus, the likelihood of disclosure may increase.

Selecting a strategy for disclosure and identifying an appropriate target person are believed to be concurrent and mutually influential within the decision-making process (Omarzu, 2000). Whether selecting a strategy or identifying a target person happens first depends on the individual, as well as on the situation. Students on campus may first identify the need for accommodations as a result of experiencing academic difficulties related to their mental-health problem(s). Once this goal is identified, students may then work on determining where they need to go in order to achieve this goal, at which point they then begin to determine a disclosure strategy. On the other hand, students may have already selected a disclosure strategy prior to identifying a particular target person. Overall, the selection of a disclosure strategy and a disclosure target person sets up the conditions within which students will make the decision about what and how to disclose (Omarzu, 2000).

In the final stage of the decision-making process, students decide what they will disclose in terms of how much information they will share, how intimate the information will be, and how broadly they will disclose (Omarzu, 2000). This part of the decision is ultimately impacted by the individual's overall perception of the situation and of the person to whom they will be disclosing; in essence, the third stage of the decision-making process is impacted and determined by the first two stages. The final deciding factor impacting disclosure is the assessment of the subjective utility of potential reward for disclosure, as well as of the subjective risk (Omarzu, 2000).

Three elements may impact the subjective utility of disclosure: individual differences of disclosers, situational cues, and characteristics of the identified target person (Omarzu, 2000). Individual differences of disclosures ultimately impact the perceived importance of certain goals to the individual. As mentioned previously, individuals bring goals into every situation they enter. Some students with mental-health problems on college and university campuses may always bring the need for support into situations, whereas others may bring the need for accommodations. Cues within the immediate situation will also have an impact on the utility of disclosure. If a situation feels welcoming and supportive regarding mental-health problems, the utility of disclosure likely will be perceived as high. The final factor impacting subjective utility of disclosure is the characteristics of the target person. According to the DDM, the attractiveness, comparative power, and ability to grant tangible benefits should impact an individual's decision to disclose. If students have identified a target person whom they perceive as being supportive or if they have previously witnessed the target person supporting their goal with other students, students may be more likely to identify disclosure as an appropriate strategy to achieve their goal. The DDM further proposes that the subjective utility of possible reward often leads to more strategic disclosures, in that individuals are increasingly more focused on achieving their identified goals (Omarzu, 2000). Overall, the benefits of disclosure are increased by the differences in perception of disclosers, situational cues that shed light on the availability of disclosure rewards, and the characteristics of the target person to whom individuals wish to disclose (Omarzu, 2000).

At the same time that individuals are assessing the possible utility of their disclosure, they are also evaluating the risks. Disclosure risks include, but are not limited to, social rejection, betrayal, and the possibility of causing discomfort for the listener (Omarzu, 2000). While the subjective utility of disclosure impacts the breadth and duration of disclosures, subjective risk has the potential to impact the depth of disclosure. The DDM hypothesizes that with increased risk, individuals will be more cautious about their decision to disclose (Omarzu, 2000). The subjective utility of disclosure may be high; however, if individuals perceive any level of risk with disclosure, the emotional intensity of the content of the disclosure will decrease. For example, students who wish to disclose their mental-health problem(s) on their college or university campus with the goal of receiving academic accommodations, increasing social support, or relieving distress may perceive high levels of subjective utility in achieving their goals based on the assessment of the situation, as well as on the characteristics of the target person. If at any point during the decision-making process students identify potential risk (e.g., increased stigma, social avoidance) they likely will disclose less information or no information at all. In situations where individuals perceive high utility and high risk, disclosure decisions will feel distressing. Under these conditions, individuals will desire to achieve their goals, but will also fear the likelihood of rejection. This experience may cause individuals to use strategies other than disclosure to achieve their goals.

While this model has yet to be tested empirically, it presents an important foundation for better understanding the process by which individuals decide to disclose personal information. This model further provides a framework for understanding disclosure as it relates to mental-health problems on college and university campuses for

the current study. As students progress through the decision-making process regarding whether or not to disclose their mental-health problem(s) on their college or university campus, a variety of factors have the potential of impacting their decision. At each stage of the decision-making process, such factors as the stigma of mental-health problems, the overall environment of the college or university campus, and the perceived level of support from individuals on campus have the potential of benefiting or preventing students' decisions to disclose. If students perceive stigma with regard to mental-health problems on their college or university campus, their decision-making process may be greatly impacted at each stage. Further, if students feel a lack of social support both on and off campus, they may be unable to identify a potential target person for disclosure on campus and may also feel unsupported in their decision-making process. For this reason, these factors will be focused on in exploring their relationship with the decision of whether or not to disclose a mental-health problem on a college or university campus.

Stigma of Mental-Health Problems

In order to better understand the impact of stigma on individuals with mental-health problems, one should explore the historical implications of stigma and how it has been defined over the years. Throughout early literature, stigma was defined as a deeply discrediting attribute that reduces individuals from whole people to tainted and discounted ones (Goffman, 1963; Link & Phelan, 2001). This definition has undergone changes over the years, with stigma now being represented by stereotypes, prejudice, and discrimination (Corrigan, 2005a). Several components further conceptualize stigma and the process by which individuals experience it. Initially, individuals distinguish and label differences between humans. These labeled individuals are then linked to undesirable

characteristics, or negative stereotypes, by way of cultural beliefs. A separation then occurs by placing labeled individuals into distinct and separate categories. At this point, labeled individuals experience a loss of status and face discrimination. Ultimately, stigmatization is contingent upon social, economical, and political power that allows the creation of distinct labels, constructions of stereotypes, and identification of differences among others (Link & Phelan, 2001). Often, individuals with mental-health problems are challenged by the stereotypes and prejudices that are the result of a misconception about mental-health problems (Corrigan & Watson, 2002a).

Mental-health problems are often associated with cognitive, interpersonal, and self-care deficits that ultimately feed the negative stereotypes and prejudices of society. A variety of biological ramifications associated with certain mental-health problems can also negatively impact the quality of life of individuals diagnosed and living with a mental-health problem (Corrigan, 1998). Research has found that society's negative reaction to mental-health problems has an equally harmful impact on an individual's ability to successfully achieve life goals (Corrigan, 1998). Experiences of 1,301 individuals with mental-health problems were explored in a nationwide survey related to stigma and discrimination. Individuals with mental-health problems reported that experiences with the stigmatization of mental-health problems caused them to feel discouraged and hurt and to experience lowered self-esteem (Wahl, 1999). Further, 70% of these individuals reported that others treated them as less competent after their mental-health problem was disclosed, and 60% reported being rejected or avoided (Wahl, 1999). In turn, the majority of respondents (74%) indicated that they avoided disclosing their mental-health problem(s) outside of their immediate family as a result of their negative

experiences with disclosure (Wahl, 1999). This statistic is critical when considering the disclosure decision-making process and potential barriers preventing individuals from disclosing their mental-health problem(s). These negative experiences with disclosure may create a variety of barriers at each stage of the decision-making process, ultimately impacting students' decisions to disclose.

In general, stigma can impact individuals by way of public stigma and/or self-stigma. Public stigma shapes the views of a population as a whole; it includes the reactions of the general population to individuals with mental-health problems (Corrigan, Kerr, & Knudsen, 2005; Corrigan, Powell, & Rusch, 2012b; Corrigan & Watson, 2002a). This form of stigma has been impacted by media representations of mental-health problems, from which three misconceptions have been identified: individuals with mental-health problems are dangerous, unpredictable, and should be feared; they perceive the world in a childlike manner; and/or they are rebellious, free spirits in need of cultivation (Corrigan, 1998; Corrigan & Watson, 2002a). A study conducted with more than 2,000 individuals revealed three common themes within Western attitudes toward mental-health problems. These themes confirmed the common misconceptions discussed earlier and included fear and exclusion, benevolence, and authoritarianism (Brockington, Hall, Levings, & Murphy, 1993).

In yet another study, 1,737 individuals were surveyed regarding enduring themes of individuals with mental-health problems, such as being dangerous, being unpredictable, being difficult to talk with, having only themselves to blame, being unable to pull themselves together, having a poor outcome, and responding poorly to treatment (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Seventy percent of respondents

reported viewing individuals with schizophrenia as dangerous to others, and 80% viewed them as unpredictable. Further, roughly 62% of respondents indicated that individuals with severe depression would be hard to talk to, 23% believed they would not eventually recover, and 23% believed they would be dangerous to others (Crisp et al., 2000). The behavioral impact resulting from these stigmatizing attitudes is social avoidance, in that individuals with mental-health problems are less likely than those without mental-health problems to be hired, are less likely to obtain a lease for an apartment, are less likely to be invited to social events, and are less likely to disclose their mental-health problem(s) to others (Bordieri & Drehmer, 1986; Corrigan, 2005a; Corrigan & Watson, 2002a; Couture & Penn, 2003; Link, 1982; Wahl, 1999).

The result of internalizing the stereotypes and prejudices of the larger society is known as self-stigma. Researchers have explored the process by which stigma impacts individuals and have found that self-stigma is composed of four constructs: awareness, agreement, application, and hurting oneself (Corrigan, 2005a). These constructs make up a four-stage model of self-stigma such that individuals must first be aware of the stereotypes of mental-health problems, they in turn must agree with the stereotypes, and, as a result of applying these stereotypes to themselves, they must suffer decreased self-efficacy and self-esteem (Corrigan, 2005a; Corrigan & Watson, 2002b). The harmful effects of self-stigma are believed to occur once an individual has internalized the stereotypes (Corrigan et al., 2012a). Further, self-stigma in general has been found to affect individuals with mental-health problems, individuals who identify within the Queer community, and those with unexplained pain (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). Living in a society that endorses stigmatizing beliefs greatly

influences how people view themselves with regard to stigmatizing identities (Corrigan & Watson, 2002b).

Several expressions of self-stigma may include feeling shame and guilt, limiting social interactions, and being reluctant to seek and engage in rightful life opportunities (Kranke et al., 2010). Those who are targets of stigma are often secretive about their identity in order to avoid negative social and emotional consequences (Corrigan, 2005b). Individuals with mental-health problems tend to experience decreased self-esteem, decreased self-efficacy, and increased depression (Corrigan & Watson, 2002a; Link & Phelan, 2001; Manos, Rusch, Kanter, & Clifford, 2009). Further, individuals who experience mental-health problems often constrict their social networks in anticipation of rejection, thereby leading to isolation (Watson, Corrigan, Larson, & Sells, 2007). This social avoidance is often used as an attempt to hide a stigmatized identity. Individuals engage in avoidance also in order to escape having to deal with concealing a stigma (Corrigan & Matthews, 2003).

Stigma is present in most aspects of everyday life, including social networks, the workplace, and educational settings. Based on the research presented, stigma clearly has the potential to negatively impact the well-being of individuals with mental-health problem(s). Stigma also has the potential to impact the decision-making process at each stage. Consequently, one must understand the ways in which stigma may be present on college and university campuses. By understanding the components that create stigma, as well as the process by which it impacts individuals with mental-health problems, institutions of higher education may have the ability to prevent stigma from negatively impacting students' decisions to disclose their mental-health problems on campus.

Campus Climate

Given the impact stigma has on individuals with mental-health problems, exploring the environment at college and university campuses with regard to perceptions of mental-health problems is of utmost importance. Campus climate research has proliferated over the past several decades as a result of a need to understand and improve the campus climate at colleges and universities for students, staff, and faculty. Almost 3 decades ago, the Carnegie Foundation for the Advancement of Teaching indicated that college and university communities should strive to be purposeful, open, just, disciplined, caring, and celebrative. More specifically, it suggested that college and university campuses needed to provide a climate within which faculty and students collaborate to strengthen teaching and learning; a climate in which freedom of expression is uncompromisingly protected and civility is powerfully affirmed; a climate in which dignity is honored and diversity pursued; and a climate in which the well-being of each individual is supported (Boyer, 1990; as cited in Rankin & Reason, 2008). Around the same time, the Association of American Colleges and Universities (AAC&U, 1995) proposed that colleges and universities ought to commit to the creation of environments in which students are treated equally (Rankin & Reason, 2008). The question then is, what steps need to be taken in order to cultivate such an environment on college and university campuses given the already negative stigmatizing views of mental-health problems in the greater society?

Since these suggestions, more and more attention has been turned to the overall climate on college and university campuses. In order to fully understand campus climate and the research presented, one must define the construct of campus climate and the

constituents of which it is composed. The term *climate* has, over the years, referred to how individuals perceive their environments (Lewin, Lippitt, & White, 1939; Reid & Radhakrishnan, 2003). Campus climate has also been defined as students' perceptions with regard to their experiences, both in and out of the classroom (Woodard & Sims, 2000). This definition has expanded to include the perceptions, attitudes, and expectations of students, which have continued to be an important addition in the understanding of college and university climate (Cress, 2002). For the purposes of this paper, a more inclusive definition of campus climate will be used that combines the various iterations of campus climate definitions over the years. Therefore, campus climate will be defined as students' perceptions of acceptance and inclusion on campus with regard to a mental-health problem.

Students' perceptions of their campus climates have the potential to influence both developmental and learning outcomes (Reason & Rankin, 2006). The majority of campus climate research has focused on racial and ethnic minority student experiences (e.g., Ancis, Sedlacek, & Mohr, 2000; Harper & Hurtado, 2007; Hughes, Anderson, Cannon, Perez, & Moore, 1998; Hurtado, 1992; Hurtado, Carter, & Spuler, 1996; Reid & Radhakrishnan, 2003). Initial climate assessments revealed results that fell in line with the historical exclusion of minority groups, in that racial and ethnic minorities were found to perceive their campus climates as less accepting and significantly more racist in comparison to the perceptions of Caucasian students (Rankin & Reason, 2005). Statistically significant relationships have been found between perceptions of racism on campus and students' commitment to academics, the commitment of the institution, and persistence in pursuing education among 1,454 college students (Cabrera, Nora,

Terenzini, Pascarella, & Hagedorn, 1999). Students who perceived their campus climates as racist experienced negative impacts on their academic experiences and their intellectual development (Cabrera et al., 1999; Rankin, 2006). Despite this population existing outside the scope of the current study, exploring the impact of campus climate on minority students may shed light on experiences of students with mental-health problems.

One population that has been the focus of campus climate research in the past is individuals with concealable stigmatized identities. Concealable stigmatized identities have been defined as identities that are not readily visible and that are socially devalued. Examples of these types of identities are mental-health problems, experiences of abuse or assault, an HIV-positive diagnosis, sexual orientation, and gender identity (Chaudoir & Fisher, 2010; Pachankis, 2007; Quinn & Chaudoir, 2009; Quinn & Earnshaw, 2013). While significant differences exist in terms of the individual experiences of concealable stigmatized identities, important similarities provide the ability to explore campus climate as it relates to mental-health problems. Sexual minorities are one student population that has been the focus of campus climate research in the past, and continues to be the focus moving forward. Prior research suggests that individuals who identify as lesbian, gay, bisexual, transgender, questioning, intersex, and asexual, for example, experience their first exposure to the Queer community in college (Waldo, 1998). This suggestion falls in line with the typical age of onset of mental-health problems being between the ages of 14 and 24 years, an age range that overlaps with traditional college years (Collins & Mowbray, 2005; Hunt & Eisenberg, 2010; Kessler, Berglund, et al., 2005; Kessler, Chui, et al., 2005; Mowbray et al., 2006).

College is often a place for individuals to develop their own identities, to engage in self-exploration, and to experience significant personal growth (Evans, 2001). Despite the college years being a time of exploration for students, college and university campuses have had incidents of heterosexism, homophobia, and discrimination (D'Augelli, 1992; Waldo, 1998). Owing to these experiences of discrimination, harassment, and fear, the campus climate for Queer students may not meet their needs for truly exploring their identity (Brown, Clarke, Gortmaker, & Robinson-Keilig, 2004; Evans, 2001; Rankin, 2003; Waldo, 1998). Some research has focused on the perceptions of the campus climate for Queer-identified individuals, in which the campus climate has been rated lower when compared to ratings of students who do not identify as Queer (Brown et al., 2004; Rankin, 2005; Waldo, 1998). In a national survey of 14 college and university campuses, roughly 36% of Queer students experienced harassment within the year prior to the survey (Rankin, 2005). A study conducted on a large campus found that 77% of Queer-identified undergraduate students reported having been verbally harassed, 27% had been threatened with physical violence, and 3% had been physically attacked (D'Augelli, 1992).

While differences clearly exist between individuals who identify within the Queer community and individuals with mental-health problems, one overarching similarity allows for the exploration of similar experiences on college and university campuses. Individuals with concealable stigmatized identities are often faced with the decision of whether or not to disclose their identity to others. Owing to a dearth of research on campus climate with regard to mental-health problems, the research presented on individuals within the Queer community sheds some light on the potential experiences

students with mental-health problems may face on college and university campuses. By understanding the process of stigma and the way in which it impacts individuals with mental-health problems, as well as understanding the experience of individuals with concealable stigmatized identities on campus, one can understand how students with mental-health problems may experience the environment on their college or university campus.

After understanding the way in which campus climate may impact students' experiences on campus, one may also realize that the overall environment on campuses could impact students' decisions to disclose their mental-health problems. When considering the DDM and the different stages students progress through when making their decisions to disclose, campus climate may impact the decision-making process at every stage. The stage at which campus climate may have the most significant impact is the second stage, in which students are identifying an appropriate target person to whom to disclose their mental-health problem(s). If students perceive the environment on campus as unwelcoming to individuals with mental-health problems, they likely will be unable to identify an individual with whom or an office on campus where they feel disclosure will be warmly received. Another variable, however, that may counterbalance this negative impact of campus climate is the perception of social support in students' lives. If students perceive that they have adequate social support, they may feel supported enough to disclose their mental-health problem on campus despite the potentially unwelcoming environment.

Social Support and Mental-Health Problems

Past researchers have suggested that "our sense of well-being is sustained by membership in primary groups, and that without any primary group affiliations we would become despairing … Withdrawing from primary contacts would be seen as dangerous to an individual's cognitive and emotional states" (Weiss, 1974, p. 18). The association between greater perceived social support and improved physical- and mental-health outcomes has received considerable attention in health psychology (e.g., Sarason, Sarason, & Gurung, 2001; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Social support has been defined as the emotional and practical help from family, friends, counselors, and teachers that enhances and helps protect individuals from stress and can further aid in coping (Sigelman & Rider, 2006). Social support has further been viewed as a psychosocial coping resource that lessens the negative effects of stress and positively impacts self-esteem and self-efficacy (Hefner & Eisenberg, 2009; Thoit, 1995). Because the stigmatization of mental-health problems has been said to impact an individual's self-esteem and self-efficacy (Corrigan & Watson, 2002b), social support has the potential to decrease the negative impact of stigma on individuals with mental-health problems.

Social support has been said to be a goal of stigma management in that individuals base their decisions to disclose their identities on whether or not they can maximize their available social support (Beals et al., 2009). Research suggests that individuals with mental-health problems are less likely to disclose if they anticipate others will devalue them (Savin-Williams, 1996). Research on individuals within the Queer community who reported low levels of social support experienced higher levels of depression and lower self-esteem when compared with those who had higher levels of

social support (Vincke & Bolton, 1994). Conversely, several studies provide evidence for the benefits social support may have for individuals with concealable stigmatized identities. Beals et al. (2009) examined factors that impact the relationship between self-disclosure of one's Queer identity and psychological well-being. Of the factors examined, perceived social support was found to be the most significant predictor of well-being. Further, self-disclosure was found to be strongly correlated with the perception of social support (Beals et al., 2009). Results also indicated that perceived social support was also a marginally significant mediator of disclosure and self-esteem (Beals et al., 2009). In other words, self-disclosure about one's Queer identity has been associated with greater perceived social support, and increased social support has also been associated with greater psychological well-being (Greene et al., 2006). These studies, among others, have established that perceived social support is an important mediator between disclosure and well-being among individuals with concealable stigmatized identities.

While social support is composed of objective elements, such as the frequency of contact with others, the perception of social support, or the belief that one has available support, is the most protective against distress or depression (Turner & Brown, 2010). Perceived social support, which has also been referred to as emotional support, is defined as the subjective belief that one belongs to a caring social network (Lakey & Scoboria, 2005; Turner & Brown, 2010). Much of the research suggesting a significant relationship between social support and psychological well-being focuses on the construct of perceived social support (Berkman & Glass, 2000; House, 1981; House, Umberson, & Landis, 1988; Lin, Ye, & Ensel, 1999; Thoit, 1995; Turner & Brown, 2010). Not only

are perceptions of social support more important than actual support, but receiving actual support promotes psychological adjustment through the perception of the availability of support (Turner & Brown, 2010; Wethington & Kessler, 1986). In essence, social support may be effective only to the extent that it is perceived to exist (House, 1981; Turner & Brown, 2010).

Research on the impact of social support and mental-health problems among college students is sparse; however, one study was conducted that explored this particular population. A survey conducted at a large university explored perceived social support among students and the relationship with mental-health problems (Hefner & Eisenberg, 2009). In a sample of 1,378 college students, of those who screened positive for a mental-health problem, 31% who reported having low levels of social support screened positive for depression compared to 16% who reported medium levels of social support and 5% who reported high levels of social support (Hefner & Eisenberg, 2009). In general, results indicated that perceived quality of support was strongly associated with lower likelihood of depression, anxiety, suicidality, and eating disorders (Hefner & Eisenberg, 2009). While to our knowledge this is the only study that has explored social support and mental-health problems of college students, these results coupled with those among individuals with concealable stigmatized identities provide evidence that social support may have a positive impact on the well-being of individuals with mental-health problems.

Given the potential of social support to improve the well-being of individuals with concealable stigmatized identities, specifically mental-health problems, further exploration of how perceived social support may impact this population within college

and university settings is important. When looking at the process by which individuals make decisions to disclose their mental-health problems, one might conclude that perception of social support can impact this decision at every stage. As mentioned previously, individuals with mental-health problems may be less likely to disclose their mental-health status if they believe others will devalue them (Savin-Williams, 1996). If students perceive high levels of social support, they may quickly move through each stage of the decision-making process. If students perceive lower levels of social support, however, the decision-making process may be halted or take a significantly longer amount of time. Given the evidence indicating the impact perceived social support has on the decision to disclose, as well as on overall well-being, the current study further assumes that the greater the perception of social support, the more likely individuals will disclose their mental-health problem(s) on their college or university campuses.

Summary

Mental-health problems continue to increase within the general population, as well as within student populations. The onset of mental-health problems is estimated to occur between the ages of 15 and 24 years, an age range that has the likelihood to overlap with traditional college years (Collins & Mowbray, 2005; Hunt & Eisenberg, 2010; Kessler, Berglund, et al., 2005; Kessler, Chui, et al., 2005; Mowbray et al., 2006). Owing to this potential overlap, exploring experiences of students with mental-health problems on college and university campuses is important.

In the last 3 decades, college and university campuses have been charged with the responsibility of creating environments in which students are treated equally and offered equal opportunities. With the passing of certain protective statutes, individuals with

concealable stigmatized identities may experience an increase in support. In order to benefit from these protective statutes, however, individuals with mental-health problems are required to disclose their mental-health problem(s) in order to receive reasonable accommodations. Research has found that while students have been aware of these accommodations on campus, they often do not request them for fear of stigma, among other barriers (Gruttadaro & Crudo, 2012). Given the potential benefits accommodations may have for students with mental-health problems, efforts need to be made in order to better understand factors that impact students' decisions to disclose their mental-health problems on college and university campuses.

Of significant interest for the current study is the fact that students are legally required to disclose their mental-health problems in order to receive accommodations on campus. Little known research has explored the disclosure process for individuals with mental-health problems, and more specifically within a student population. Several models have been proposed, however, that provide a framework for a disclosure decision-making process. One model in particular proposes a three-stage decision-making process in which individuals assess the costs and benefits of disclosure. The DDM posits that individuals strategically assess their environments in order to determine whether or not disclosure is the most feasible means of achieving certain goals (Omarzu, 2000). This assessment occurs in a series of stages, each of which provides an opportunity for students to assess different aspects of their environments that may promote or hinder their decisions to disclose their mental-health problem(s) on campus.

A variety of factors may impact students' decisions to disclose their mental-health problem(s); however, for the purpose of the current study, three specific factors will be

examined regarding their relationship to the disclosure of mental-health problems. The factors examined include the stigma of mental-health problems, the overall campus climate with regard to mental-health problems, and perceived social support. Each of these factors has the potential to impact the decision-making process at each stage. Students with mental-health problems are faced with the decision of whether or not to disclose their mental-health problem(s) on campus in order to access services available to them. If students identify disclosure as the necessary means of achieving a particular goal on campus, such as accessing academic accommodations, they begin at that point to progress through the stages of the decision-making model. Given that the research indicates that students tend to choose not to disclose their mental-health problems for fear of stigma, among other factors (Gruttadaro & Crudo, 2012), identifying the other factors that may be related to the decision of whether or not to disclose one's mental-health problem is important.

Chapter 3: Hypotheses

The current study intended to evaluate which variables would be predictive of disclosure and/or concealment of mental-health problems on college and university campuses within the U.S. More specifically, it was originally hypothesized that gender, previous experiences with disclosure, campus climate, perceived stigma, perceived social support, and self-compassion would be predictive of students' decisions to disclose and/or conceal their mental-health problems outside of the counseling center on their college or university campus. However, because of problems with data collection, these original hypotheses could not be examined. Given these limitations, the hypotheses were revised to address the following research questions:

Research Question: Does a relationship exist between students' overall perceptions of the college or university mental-health climate, perception of stigma, and the level of perceived social support, and their decision to disclose their mental-health problem(s) on campus outside of college/university counseling centers?

Ancillary Questions:

1. What are the rates at which students are disclosing their mental-health problems on campus?
2. What are the rates at which students are accessing services on campus?
3. What are the reasons students choose not to disclose?
4. What helps students to make the decision to disclose?
5. How can college/university campuses aid in this decision?
6. What problems/benefits did students experience after disclosing?

Chapter 4: Methodology

Design

The present study employed a cross-sectional correlational design based on data collected from undergraduate and graduate college students across the United States (U.S.). A web-based survey was created in order to gather information about students' experiences with disclosure and/or concealment of mental-health problems on college and university campuses. The overall survey contained several sections: a demographic questionnaire; a survey on disclosure and concealment experiences of study participants; questions about campus mental-health climate; a coming out about mental illness scale; a perceived social support scale; and a self-stigma scale.

Participants

The participants in this survey included undergraduate and graduate students from colleges and universities across the U.S. The students self-selected into the survey by clicking an embedded link within an e-mail invitation as well as through invitations posted on social media sites. A total of 223 survey responses were received; however, owing to missing data from respondents not completing the full survey, not all of these responses were used.

Inclusion Criteria

Respondents were screened for eligibility for the study based on the following criteria that study participants self-reported: (a) They must have been enrolled as a student at the time of completion of the study; (b) They must have identified as either having a current mental-health problem(s) or having had a mental-health problem in the previous year. This criterion was operationalized in two ways: respondents reported they

had been diagnosed with a mental-health problem based on *DSM-IV-TR* criteria by any medical professional (e.g., primary-care physician, psychiatrist, psychologist) and/or reported that they were self-diagnosed with a mental-health problem (definition: the person must, to their best knowledge, have had a diagnosable mental-health problem, such as anxiety or dysthymia, that had affected the way they thought, felt, and behaved); (c) They must have been at least 18 years of age; (d) They must have been fluent in English; (e) Their experiences of disclosure or concealment must have occurred within a college or university setting; and (f) They must have been enrolled at a college in the U.S.

Exclusion Criteria

Respondents were excluded from the study if they met any of the following criteria: (a) They identified as being faculty, staff, or administration; (b) They did not identify as having a current mental-health problem or as having had a mental-health problem in the past year; (c) They were younger than 18 years of age; (d) They did not speak fluent English; (e) Their experiences of disclosure or concealment occurred prior to attending a college or university; or (f) They were not enrolled at a college in the U.S.

Recruitment

Recruitment of participants began in February 2015 and was open to all students at all colleges and universities in the U.S. A variety of recruitment methods were employed. Schools were contacted and asked if they would be willing to send out e-mail announcements to all current students with an invitation to the survey. An invitation for participation was posted on personal Facebook pages with a request for individuals to forward the survey to anyone they believed would be eligible and interested in participating in the study. This snowball method of recruitment was used in that

individuals were asked to pass on the link with the description of the study to other college students whom they knew and who may have fit the inclusion criteria.

Measures

Demographic Questionnaire

Participants were asked background information that allowed the researcher to adequately describe the sample. Participants were asked about such items as their age, college or university major, degree program, gender identity, race/ethnic background, and medically diagnosed and/or self-diagnosed mental-health problems. The demographic questionnaire can be found in Appendix A.

Campus Climate Mental-Health Survey

This survey consisted of five questions created by Susan Rankin, PhD, of Rankin Associates, that were developed and used in her campus climate assessment research across numerous college and university campuses in the U.S. (Rankin & Reason, 2008). The original survey created by Dr. Rankin contained questions focused on the perception of students with regard to the openness of college and university campuses toward students with disabilities. For the purposes of the current study, the questions were geared toward understanding the perceptions of students with regard to the openness of college and university campuses toward mental-health problems (e.g., “The overall campus climate at my college/university is positive for people with mental health problems.”). The questions used a 5-point Likert-type scale (1 = *Strongly Disagree*; 5 = *Strongly Agree*). No measures of validity are available for this survey because the questions were reworded to reflect the topic of the current study.

Disclosure Experiences Survey

This survey was specifically developed for this study and asked about students' experiences (both positive and negative) with disclosure of their mental-health problem(s) on their college and/or university campuses. It further asked about perceived and experienced benefits to disclosure (e.g., "How would you characterize the benefits of your disclosure?"), as well as about participants' experiences of problems when disclosing their mental-health problem(s) (e.g., "Do you believe you encountered any of the following problems when disclosing your mental health problem(s)? Check all that apply."). Some of the questions used a 7-point Likert-type scale (1 = *Very Negative;* 7 = *Very Positive*), whereas other questions provided an array of options from which to choose, as well as a place to fill in a response that was not listed. The survey further inquired as to whether or not students requested accommodations (e.g., "Have you ever requested accommodations, related to your mental health problem, at your college or university campus? Includes any requests both formal and informal."), and to whom students disclosed their mental-health problem(s) (e.g., "If so, to whom have you disclosed your mental health problem(s) on your college/university campus? Check more than one if applicable."), as well as a variety of other questions regarding their experience of disclosure on their college/university campus. No psychometric data are available on this survey because it was created for the current study. A copy of this survey can be found in Appendix B.

Concealment Experiences Survey

This survey was also developed for the current study and asked about students' experiences with concealment of their mental-health problem(s) on their college and/or

university campuses. Students were asked questions regarding how often they concealed their mental-health problem (e.g., "How often have you concealed your mental health problem(s) from this/these individual(s) on your college/university campus?"), for what reasons they chose to conceal their mental-health problem(s), (e.g., "For what reason did you choose to conceal your mental health problem(s) from this/these individuals on your college/university campus? Check more than one if applicable."), as well as a variety of other questions pertaining to their overall experiences of concealment. Some questions in the survey used a Likert-type scale, whereas others provided an array of choices, as well as spaces to fill in responses. A copy of this survey can be found in Appendix C.

Coming Out with Mental Illness Scale (COMIS; Corrigan et al., 2009)

The Coming Out with Mental Illness Scale (COMIS) is a 21-item questionnaire that assesses the coming out of individuals about their mental-health problems. It was created based on the similarities observed between members of sexual-minority populations and individuals with mental-health problems. Corrigan et al. (2009) conducted interviews with gay men and lesbians about staying in the closet and coming out, which enhanced the content validity of the measure. The interviews yielded 30 themes that were then categorized into 13 conceptual frameworks. Further, one conceptual framework was found to represent the cost-benefits for perceptions about coming out versus those related to staying in the closet (Corrigan et al., 2010).

Based on the findings from the interviews, the COMIS was created with 21 items. Of the 21 items, seven represent the benefits of coming out of the closet with mental-health problems (e.g., "I came out of the closet because I was comfortable with myself"), and 14 represent the benefits of staying in the closet (e.g., "In the past I stayed

in the closet to avoid harming my self-identity"). Participants responded to these items on a 7-point Likert scale (1 = *Strongly Disagree;* 7 = *Strongly Agree*). The COMIS begins with a question requiring a yes or no answer (e.g., "Are you out about your mental illness? In other words, have you decided to tell most of your family, friends, and acquaintances that you have a mental illness? Have you decided not to hide it?"). Participants who answered "yes" were administered those items focusing on why the individuals were out and why they were in the closet in the past. Those who answered "no" were given items regarding why they preferred to stay in the closet and why they might come out in the future (Corrigan et al., 2010). Factor scores for the measure were obtained by adding up the items that load into each factor (e.g., Benefits of being out: sum of Items 1-7; Reasons for staying in: sum of Items 8-21), with scores ranging from 21 to 147 (Corrigan et al., 2010). No psychometric data have been found regarding the validity and reliability of this scale.

Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) is a 12-item self-report questionnaire designed to measure perceived social support from family, friends, and significant others (Zimet, Dahlem, Zimet, & Farley, 1988). Respondents use a 7-point Likert-type scale (1 = *Very Strongly Disagree*; 7 = *Very Strongly Agree*) for each item on the measure. Example items include "My family really tries to help me," "I have friends with whom I can share my joys and sorrows," and "There is a special person in my life who cares about my feelings." In the original study, the MSPSS was administered to university undergraduates and demonstrated good internal reliability with coefficient alphas for the subscales ranging from .85 to .91, and the scale as a whole had

a coefficient alpha of .88 (Zimet et al., 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). With regard to validity, studies show that the subscales and the scale as a whole had good construct validity when compared to Depression and Anxiety subscales of the Hopkins Symptoms Checklist (HSCL; Zimet et al., 1988). Overall, the MSPSS appears to be a reliable and valid measure.

Self-Stigma of Mental Illness Scale – Short Form (SSMIS-SF, Corrigan, 2012)

The Self-Stigma of Mental Illness Scale – Short Form (SSMIS-SF) is a 20-item questionnaire that was constructed from the original 40-item Self-Stigma of Mental Illness Scale (SSMIS). The SSMIS-SF omitted half of the original questions in order to decrease the length of administration time, as well as to make the measure less offensive. Corrigan et al. (2012a) found that participants were choosing not to complete the SSMIS because of its harsh tone. The SSMIS contained 10 stereotypes about mental illness, five of which were determined to be the least offensive and thus were selected for the short form (i.e., persons with mental illness are unpredictable, will not recover or get better, are dangerous, are to blame for their problems, and are unable to take care of themselves; Corrigan et al., 2012a). For these reasons, the SSMIS-SF was chosen for the current study.

The measure is divided into four subscales derived from the four constructs used to define self-stigma (Corrigan et al., 2012a). The subscales include awareness (e.g., “I think the public believes most persons with mental illness are to blame for their problems.”), agreement (e.g., “I think most persons with mental illness are unpredictable.”), application (e.g., “Because I have a mental illness I will not recover or get better.”), and harm to self-esteem (e.g., “I currently respect myself less because I am

dangerous."). Each subscale contains five items to which individuals respond using a 9-point Likert agreement scale (1 = *I Strongly Disagree*; 9 = *I Strongly Agree*). Scale scores for the SSMIS-SF are derived by summing the five items within each subscale in which the lowest possible score is 5, and the highest possible score on each of the four subscales is 45 (Corrigan et al., 2012a).

Corrigan et al. (2012a) reviewed three previous studies that used the SSMIS-SF with regard to its validity and reliability. They found that the internal consistency for the four SSMIS-SF subscales yielded alphas ranging from 0.65 to 0.87, with the exception of one subscale that yielded an alpha of .22 in one of the studies (Corrigan et al., 2006).

Qualitative Open-Ended Questions

The last items presented to individuals completing the disclosure and/or concealment experiences surveys were three open-ended questions. Individuals were asked about what aided their decision to disclose and/or conceal their mental-health problem(s) ("What helps you to decide whether or not to disclose your mental health problem(s)?"), as well as about their thoughts as to how their college and/or university could aid in this decision-making process ("What could your college/university do to help you feel more comfortable with reaching a decision whether or not to disclose about your mental health problem(s)?"). The three different open-ended questions can be found in Appendix D.

Procedure

The Disclosure and Concealment Experiences Survey was constructed within a research lab focusing on self-disclosure of mental-health problems among mental-health professionals. This questionnaire asked respondents for information as to whether or not

a disclosure had occurred in the 6 months prior to the survey. The research lab met once every 2 weeks, beginning in 2014, with the goal of creating a survey to assess the experiences of mental-health professionals working with individuals with mental-health problems. This research group aided the principal investigator in the construction of the survey for the current study in order to assess self-disclosure and/or concealment of mental-health problems among students at college and university settings across the U.S. The Disclosure and Concealment Experiences Survey was constructed by using previously created self-disclosure surveys and reworded items to better reflect the population of the current study. Previous research on self-disclosure of mental-health problems among students on college and university campuses was also referenced during the construction of the survey. The research group helped in the construction of the demographic questionnaire by determining information that would be necessary to better understand factors that may contribute to disclosure or concealment of mental-health problems.

The Disclosure and Concealment Experiences Survey was an anonymous Internet survey conducted using Survey Monkey, a web-based survey engine. Recruitment for the study occurred using a variety of methods. Campus-wide e-mails encouraging students to participate in the study were sent out at the researcher's college. The link to the survey was posted on a social-media website (i.e., Facebook) and was shared through various different educational networks. The survey was accessible to students across the U.S. for 15 months starting in February 2015 and ending in May 2016. The cover page of the survey informed students about the purpose of the study, as well as about inclusion criteria to determine eligibility for participation. Students were

required to acknowledge that they met criteria for inclusion in the study in order to move forward to the actual survey. Students were informed that participation in the study was voluntary and that they had the option to withdraw at any time. They were further informed that all surveys would be de-identified to ensure confidentiality and anonymity.

Chapter 5: Results

The purpose of the current study was to determine whether or not a relationship existed between campus climate, stigma of mental-health problems, perceived social support, and students' decisions to disclose their mental-health problem(s) on their college or university campuses. Pearson product-moment correlations were used to explore whether a relationship existed between these variables, and descriptive statistics were used to assess other ancillary questions posed in order to have a better understanding of the sample.

Demographics

A total of 223 surveys were submitted for the current study; however, a significant number of survey respondents did not complete the entire survey. Owing to these missing data, demographic data reported were based on the responses received for each of the demographic questions, with valid percentages reported owing to the calculation without the inclusion of the missing data. Of those who responded (N = 96), 47.9% of respondents were between the ages of 18 and 24 years (n = 46), 38.5% were between the ages of 25 and 31 years (n = 37), and 13.5% were between the ages of 32 and 59 years (n = 31). Approximately 82% (N = 97) of the respondents indicated their biological sex was female (n = 79), 17.5% indicated their biological sex was male (n = 17), and one individual identified as intersex. Further, 19.4% indicated their gender identity was "man" (n = 19), 78.6% indicated their gender identity was "woman" (n = 77), one individual (1%) identified as transgender, and one individual (1%) identified as "gender fluid (both cis and trans)" (N = 98).

With regard to race and/or ethnicity, of those who responded (*N* = 98), one individual (1%) identified as African American, two individuals (2%) identified as Asian American or Pacific Islander, four individuals (4.1%) identified as Hispanic, 84 individuals (85.1%) identified as European American/Caucasian, one individual (1%) identified as Native American, and six individuals (6.1%) identified as "other" and indicated a biracial or multiracial identity. Individuals were also asked what best described their sexual orientation (*N* = 97), with two individuals (2.1%) identifying as Asexual, three (3.1%) identifying as Bisexual, two (2.1%) identifying as Gay, 78 (80.4%) identifying as Heterosexual, seven (7.2%) identifying as Lesbian, and five (5.2%) identifying as Pansexual. A complete breakdown of these demographic characteristics can be found in Table 1.

Religious and Spiritual Affiliation

Religious and spiritual affiliation was presented as an open-ended question, in which respondents were provided space to indicate their specific religious and/or spiritual affiliation. Twenty-six individuals reported no religious or spiritual affiliation, 48 individuals reported a religious affiliation, and 22 individuals reported a spiritual affiliation.

Mental-Health Diagnosis

Individuals were further asked about their medically or self-diagnosed mental-health problems (*N* = 89). Three individuals (3.4%) reported a diagnosis of Attention Deficit/Hyperactivity Disorder, one individual (1.1%) reported a diagnosis of Adjustment Disorder, 30 individuals (33.7%) reported a diagnosis of Anxiety Disorder, two individuals (2.2%) reported a diagnosis of Bipolar Disorder, four individuals (4.5%)

Table 1

Demographics of Respondents

Characteristics	*n*	Valid %
Age range		
18 – 24	46	47.9
25 – 31	37	38.5
32 – 38	9	9.4
39 – 45	2	2.1
46 – 52	1	1.0
53 – 59	1	1.0
Sex		
Female	79	81.4
Male	17	17.5
Intersex	1	1.0
Gender identity		
Woman	77	78.6
Man	19	19.4
Transgender	1	1.0
Other (gender fluid – both cis and trans)	1	1.0
Race/ethnicity		
African American	1	1.0
Asian American or Pacific Islander	2	2.0
Hispanic	4	4.1
European America/Caucasian	84	85.7
Native American	1	1.0
Other (biracial/multiracial)	6	6.1
Sexual orientation		
Asexual	2	2.1
Bisexual	3	3.1
Gay	2	2.1
Heterosexual	78	80.4
Lesbian	7	7.2
Pansexual	5	5.2
Religions/spiritual affiliation		
No religious/spiritual affiliation	26	-
Religious affiliation	48	-
Spiritual affiliation	22	-

Note. Religions/spiritual affiliation has no percentages because responses were open-ended in nature.

reported a diagnosis of Borderline or Other Personality Disorder, one individual (1.1%) reported a diagnosis of Cyclothymia, five individuals (5.6%) reported a diagnosis of Dysthymia, five individuals (5.6%) reported a diagnosis of Eating Disorder, two individuals (2.2%) reported a diagnosis of Learning or Communication Disorder, 22 individuals (24.7%) reported a diagnosis of Major Depression, two individuals (2.2%) reported a diagnosis of Schizophrenia, and 12 individuals (13.5%) reported having a diagnosis not listed.

Individuals were further asked how troubled they were currently by their diagnosis, and of those who responded (N = 96), 20.8% reported Not at All (n = 20), 35.4% reported Slightly (n = 34), 35.4% reported Moderately (n = 34), and 8.3% reported Very Much (n = 8). In terms of family acceptance of their mental-health problem(s) (N = 92), 14 individuals (15.2%) indicated Not at All, 19 individuals (20.7%) indicated Somewhat Accepting, 17 individuals (18.5%) indicated Accepting, 12 individuals (13%) indicated Mostly Accepting, and 30 individuals (32.6%) indicated their family was Very Accepting of their mental-health problem(s).

Mental-Health Treatment

When asked if they were currently seeking treatment for their mental-health problem(s) (N = 97), slightly more than half of respondents (52.6%) indicated that they were. Respondents were further asked where they were seeking treatment (N = 54); 20.4% reported seeking counseling on campus (n = 11), 74.1% reported seeking counseling off campus (n = 40), and 5.6% reported seeking counseling both on and off campus (n = 3). Respondents were further asked if they had ever attended outpatient treatment for their mental-health problem(s) (N =95), with 57.9% of respondents

indicating that they had (n = 55). About 70% of respondents (n = 66) reported managing their mental-health problem(s) through means not provided by a psychiatrist or mental-health service provider (N = 95). Respondents were further asked if they had ever been hospitalized for their mental-health problem(s) (N = 97), in which 95.9% of respondents indicated that they had not (n = 93), with 4.1% reporting that they had (n = 4). Roughly 60% of respondents (n = 58) also indicated that they were taking medication for their mental-health problem(s) at the time of the study (N = 97). A breakdown of self- or medically diagnosed mental-health problem(s) and mental-health treatment can be found in Table 2.

Location

Of those who responded as to the area in which they resided (N = 97), 67 individuals (69.1%) resided in the Northeast, 15 individuals (15.5%) resided in the Southeast, three individuals (3.1%) resided in the Midwest, 11 individuals (11.3%) resided in the Northwest, and one individual (1%) resided in the Southwest. Individuals were further asked in what type of area they lived (N = 97), in which 34 individuals (35.1%) reported living in an urban area, 13 individuals (13.4%) reported living in a rural area, and 50 individuals (51.5%) reported living in a suburban area. The location of the college or university respondents currently attended was also asked (N = 97), in which 70 individuals (72.2%) indicated their college/university was located in the Northeast, 15 individuals (15.5%) indicated their college/university was located in the Southeast, one individual (1%) indicated their college/university was located in the Midwest, nine individuals (9.3%) indicated their college/university was located in the Northwest, and two individuals (2.1%) indicated their college/university was located in the Southwest.

Table 2

Mental-Health Diagnoses and Treatment

Characteristics	*n*	Valid %
Self- or medically diagnosed mental health problem(s)		
Attention deficit/hyperactivity disorder	3	3.4
Adjustment disorder	1	1.1
Anxiety disorder	30	33.7
Bipolar disorder	2	2.2
Borderline or other personality disorder	4	4.5
Cyclothymia	1	1.1
Dysthymia	5	5.6
Eating disorder	5	5.6
Learning or communication disorder	2	2.2
Major depression	22	24.7
Schizophrenia	2	2.2
Other	12	13.5
Mental-health treatment		
Currently seeking	51	52.6
On-campus	11	20.4
Off-campus	40	74.1
Both	3	5.6
Outpatient treatment (past)	55	57.9
Outpatient treatment (current)	37	38.1
Medication (current)	39	40.2
Hospitalized (past)	4	4.1
Other treatment (not with psychiatrist/psychologist)	66	69.5

Note. Owing to missing data, *n* values represent subgroups of respondents who responded to survey questions presented.

Respondents were further asked where they lived during the academic year (*N* = 98), with 17 individuals (17.3%) living on campus, 58 individuals (59.2%) living off campus, 15 individuals (15.3%) living at home, and eight individuals (8.2%) living somewhere not listed. In terms of distance from their families (*N* = 97), roughly half of the respondents (49.5%) lived up to 60 miles from their families (*n* = 48), whereas the other half (50.5%) lived more than 60 miles away from their families during the academic year (*n* = 49). Whether or not respondents lived with a roommate was also explored (*N* = 98), with 49 individuals (50%) saying they lived with a roommate, while the other half did not.

Degree Program

Respondents were further asked a series of questions regarding their level of education and the degrees they were currently obtaining. The levels of education respondents were obtaining included the following (*N* = 97): 24 respondents were obtaining their undergraduate degree (24.7%), 21 respondents were obtaining their graduate degree (21.6%), 51 respondents were obtaining their professional degree or beyond (52.6%), and one of the respondents reported obtaining a degree not listed. With regard to the respondents' year in their academic program (*N* = 97), roughly half of the respondents (51.5%) were in their first or second year in their academic program at the time of the study (*n* = 50), with the other half of the respondents in their third year or beyond (*n* = 32). Ninety-two percent of respondents (*n* = 91) indicated being full-time students, whereas only 7.1% indicated being part-time students (*n* = 7). The majority of respondents (63.2%) reported a class size between one and 60 students (*n* = 62), while the rest of the respondents (36.8%) reported class sizes of greater than 60 students (*n* =

36). The campus size (N = 97) ranged between small (fewer than 5,000 students), medium (5,000 to 15,000 students), and large (more than 15,000 students), with 59.8% of respondents indicating a small campus size (n = 58), 30.9% indicating a medium campus size (n = 30), and 9.3% reporting a large campus size (n = 9). Information regarding location of college/university, where students lived on campus, level of education, year in program, class size, and campus size can be found in Table 3.

Of the respondents who indicated they were currently in an undergraduate program (N = 32), four respondents (12.5%) reported having an Undeclared/General Education major, whereas 28 respondents (87.5%) reported having had declared their major at the time of the study. Students who reported their current program was a graduate or professional degree (N = 67) indicated such programs as Psychology, Social Work, Special Education, Physical Therapy, Biomedical Sciences, Medicine, and Public Health. Further, five respondents (5.8%) indicated that they were obtaining their graduate degree at the same institution as their undergraduate degree (N = 86).

Extracurricular Activities

Respondents were asked if they partook in any extracurricular activities while obtaining their degree (N = 98), with 42.9% of individuals indicating that they were involved in activities on campus (n = 42). Some of the extracurricular activities reported by respondents included Greek life, sports teams, and campus clubs. Respondents were also asked whether or not they were currently working (N = 98), with 57.1% indicating that they were working while obtaining their degree (n = 56). Of those who indicated they were working (N = 56), 39.3% reported working on campus, whereas 60.7% indicated having jobs off campus (n = 34). In order to better understand exposure

Table 3

College/University of Respondents

Characteristics	*n*	%
College/university location		
Northeast	70	72.2
Southeast	15	15.5
Midwest	1	1.0
Northwest	9	9.3
Southwest	2	2.1
Live during academic year		
On campus	17	17.3
Off campus	58	59.2
Home	15	15.3
Other	8	8.2
Level of education		
Undergraduate degree	24	24.7
Graduate degree	21	21.6
Professional degree or beyond	51	52.6
Other	1	1.0
Year in program		
First year	27	27.8
Second year	23	23.7
Third year	15	15.5
Fourth year	21	21.6
Fifth year	9	9.3
Sixth year and beyond	2	2.1
Class size		
1 – 10 students	2	2.0
11 – 30 students	46	46.9
31 – 60 students	14	14.3
61 – 90 students	8	8.2
91 – 120 students	4	4.1
>120 students	24	24.5
Campus size		
<5,000 students	58	59.8
5,000 – 15,000 students	30	30.9
>15,000 students	9	9.3

Note. Owing to missing data, *n* values represent subgroups of respondents who responded to survey questions presented.

students may have had to self-disclosure, respondents were asked whether or not they had ever taken a class or been involved in a research group in which the topic of self-disclosure was addressed (N = 97), with 70.1% of individuals reporting they had not (n = 68). They were further asked whether or not they had ever had an opportunity to self-disclose in a class or research group (N = 97), with 63.9% of individuals indicating they had not had this opportunity in their program(s) (n = 62). Respondents were also asked if an Active Minds chapter was at their college or university (N = 97), with only 10.3% of respondents indicating that there was (n = 10), and 72.2% reporting they did not know (n = 70).

Family

Information regarding respondent's family included number of siblings (N = 97), with the majority of respondents (83.4%) indicating having one to three siblings (n = 81). Respondents were further asked if any mental-health problems existed in their families while growing up (N = 97), in which 76.3% of individuals indicated mental-health problems did exist within their families (n = 74). Of those who indicated specific family members (N = 78), a little more than half of respondents (57.7%) indicated one of their parents experienced mental-health problems (n = 45). Roughly 63% further reported that their family was accepting of the individual with the mental-health problem(s) (n = 83).

Disclosure of Mental-Health Problems on Campus

Of those who indicated whether or not they disclosed their mental-health problem on their college/university campuses (N = 111), 83 respondents (74.8%) reported having disclosed their mental-health problem on their college or university campuses within the prior 6 months, 75 of whom (33.6%) disclosed this information to a classmate.

Benefits of Disclosure

Survey respondents were asked to reflect on their experiences of disclosure, specifically focusing on benefits they may have experienced after disclosing their mental-health problem(s). Of those respondents who indicated they experienced benefits, 51 indicated that they were able to get support through conversations with classmates/advisors/professors; 45 indicated that the individual they disclosed to revealed that he or she also had a personal experience with a mental-health problem; 19 indicated that they were able to receive classroom accommodations; 45 experienced normalizing or increased feelings of personal authenticity; 21 indicated they were able to advocate and address possible stigma on college and university campuses; 14 indicated that they did not experience any benefits from disclosing. Respondents were also provided an option to report other benefits that were not listed in the survey. Thirteen respondents identified other benefits, including “I became closer with my friend and my professor/mentor”; “I gave information about myself that gave them a better understanding of my personal challenges”; and “I was released from the stress of worrying about what people might think/needing to find ways to hide this fact about myself.”

Problems with Disclosure

Respondents were also provided with the option to identify problems they experienced when disclosing their mental-health problem(s) on their college or university campuses. Responses indicated the following problems: one individual was asked to leave the program; 13 individuals indicated that the person they disclosed to then avoided them, did not talk to them, or otherwise treated them differently; 19 individuals indicated that they had to educate the person they disclosed to about mental-health problems; 12

individuals indicated that they were asked for more information that they did not want to disclose; 12 individuals indicated that the information they disclosed was then revealed to others without their consent; 13 individuals indicated that they experienced general miscommunication or lack of communication; and 59 individuals reported experiencing no problems from disclosing. Further, respondents were provided the option of reporting problems not listed in the survey. Eight respondents reported other problems they experienced, including the following: "General discomfort while disclosing" and "Asked if I could handle my position."

Accommodations

Information regarding accommodations used on campus was also collected. Respondents were asked if they had ever requested accommodations (N = 107), to which 26.2% indicated that they had (n = 28), and 73.8% of respondents indicated that they had never requested accommodations related to their mental-health problem(s) (n = 79). Those who indicated they had not requested accommodations indicated the following reasons: 39 respondents (17.5%) indicated they did not need accommodations; eight respondents (3.6%) indicated they were unaware that accommodations were available; two respondents (<1%) indicated they could not acquire the necessary documentation for accommodations; eight respondents (3.6%) indicated they could not decide what accommodations would be appropriate; nine respondents (4%) indicated they did not request accommodations because of the possibility of negative consequences of requesting accommodations; and nine respondents (4%) indicated that they felt their mental-health problem(s) was not other people's business. Respondents were further provided with a space to report reasons for not requesting accommodations that were not

listed in the survey. Of those who chose to report other reasons (n = 4), the following reasons were included: “embarrassed to ask for them”; “I don’t want academic accommodations, I want to be on the same level as my classmates”; and “I have a desire to prove to myself that I can still be successful without accommodations.”

Concealment of Mental-Health Problems on Campus

Respondents were also provided an opportunity to answer questions regarding a concealment experience of their mental-health problem(s) over the course of the prior 6 months. Of those who responded (N = 98), 66 individuals (67.3%) indicated that they had concealed their mental-health problem(s) in the prior 6 months, 20 individuals (20.4%) had not concealed their mental-health problem(s), and 12 individuals chose not to complete the concealment section of the survey. When asked if respondents regretted their decisions to conceal their mental-health problem(s) (N = 61), eight individuals (13.1%) indicated that they did regret their decisions, whereas the other 53 (86.9%) did not regret their decisions. When asked if respondents believed that concealing their mental-health problem(s) was the right decision (N = 62), a little more than half of respondents (53.3%) indicated “sometimes” (n = 33), and 29.0% of respondents reported “seldom or rarely” (n = 18).

Respondents were further asked if they felt as though people treated them differently when they knew they had a mental-health problem(s) or had received mental-health services. Of those who responded (N = 60), the majority of the respondents indicated “seldom or rarely” (63.3%), followed by “sometimes” (33.3%).

Pearson Correlations

Pearson product-moment correlations were calculated to examine associations between disclosure of mental-health problems on campus, overall campus climate, perceived social support, stigma of mental-health problems, and coming out about one's mental-health problem. (See Table 4 for correlational findings.) Owing to conducting a large number of correlations in exploring the relationships between several variables in the study, the risk of making a Type I error increased. In order to compensate for this potential error, a Bonferroni Correction was calculated as a means of adjusting the original alpha level of .05 to a more stringent level. This correction is defined by dividing the original alpha level by the number of statistical tests conducted. In doing so, .05 was divided by 8, which yielded a new, more stringent alpha level of .006. This new corrected alpha level was then used as the criterion for determining whether a relationship between two variables was or was not significant.

Caveat

The procedure in this study was designed to allow the participants to choose which items to answer. In this manner, subjects were in no way forced to answer questions they chose not to answer for whatever reason. While this procedure allowed participants freedom of choice in this regard, it created a major limitation. The possibility existed that different subgroups of subjects answered different questions, thereby undermining comparability across the items and variables being studied. To consider this issue, a number of analyses were conducted to examine the differential demographic characteristics of participants across the variables of interest. In SPSS, the investigator selected those participants who answered a question and compared them to

Table 4

Summary of Pearson Correlations

Variable	1	2	3	4	5	6	7	8
1. Disclosure	–	.144	.059	.115	-.026	.006	.370	.006
2. Campus Climate	.144	–	.362*	.046	.042	-.222	.490*	-.222
3. Social Support	.059	.362*	–	-.183	-.056	-.150	.229	-.150
4. Stigma	.115	.046	-.183	–	-.097	.336	-.018	.336
5. Coming Out Current	-.026	.042	-.056	-.097	–	.[c]	.[c]	.[c]
6. Coming Out Past	.006	-.222	-.150	.336	.[c]	–	-.275	1.000
7. Coming Out Future	.370	.490*	.229	-.018	.[c]	-.275	–	-.275
8. Coming Out Staying Current	.006	-.222	-.150	.336	.[c]	1.000	-.275	–

Note. *. Correlation is significant at the 0.006 level (1-tailed); c. Cannot be computed because at least one of the variables is constant.

participants who did not answer this same question on a number of demographic characteristics. These analyses repeatedly confirmed that there were different subgroups of subjects who did answer versus did not answer several questions. These findings underscore that generalizations based on the entire sample are severely limited, and the findings appear to represent different subgroups across the variables and questions answered. The findings reported as follows should be cautiously interpreted with this caveat in mind.

Campus Climate and Overall Campus Respect

A Pearson correlation was conducted in order to determine the relationship between the overall perception of campus climate and the overall respect students perceived their campuses or universities had with regard to mental-health problems. A positive, large, and significant correlation was found between campus climate and overall campus respect, $r(215) = .860$, $p < .000$, indicating that a significant correlation existed between overall perception of campus climate with regard to mental-health problems and the overall perception of respect with regard to mental-health problems on college and university campuses. The coefficient of determination reveals that about 74% of the variability regarding the perception of respect for mental-health problems is attributable to differences in perception of campus climate.

Campus Climate Correlations

Overall Campus Climate and Regret

A Pearson correlation was conducted in order to determine the relationship between the overall perceptions of campus climate and whether or not students regretted their decisions to disclose their mental-health problems. A weak, positive correlation was

found between these two variables, $r(101) = .314$, $p < .001$. These results indicate that as the overall perception of campus climate increases (is more positive), the less likely students will regret having disclosed their mental-health problems to others on their campus. Further, roughly 9.8% of the variability with regret is associated with differences in the perception of campus climate.

Overall Campus Climate and Perceived Social Support

A Pearson correlation was also conducted to determine the relationship between students' overall perceptions of campus climate and their experience of perceived social support. A weak, positive correlation was found between these two variables, $r(102) = .362$, $p < .000$, indicating that as students' perceptions of the campus climate increase and are more positive, students are more likely to perceive positive social support among family, friends, and significant others. Further, 13.1% of the variability with perceived social support is associated with differences in students' perceptions of campus climate.

Overall Campus Climate and Coming Out in the Future

Another Pearson correlation was conducted in order to determine the relationship between students' overall perceptions of campus climate and whether or not they will "come out" about or disclose their mental-health problem(s) in the future. A moderate, positive correlation was found between these two variables, $r(49) = .490$, $p < .000$. This finding indicates that the more positively students view their campus climate with regard to mental-health problem(s), the more likely they will choose to disclose their mental-health problem(s) in the future.

Stigma Correlations

Stigma and Perceived Social Support

A Pearson correlation was conducted to determine the relationship between stigma and perceived social support. A very weak, negative, nonsignificant relationship was found between perception of stigma and perceived social support, $r(94) = -.183$, $p < .05$, indicating that as the perception of stigma increases, the less likely students will have higher perceptions of social support. The coefficient of determination indicates that 3.3% of the variability in perception of social support can be accounted for by students' perceptions of stigma.

Stigma and Coming Out

Another Pearson correlation was conducted in order to examine the relationship between stigma and students' decisions to come out about their mental-health problem on their college or university campuses. A weak, positive correlation was found between stigma and students' decisions to stay in the closet about their mental-health problem(s) in the past, $r(44) = .336$, $p < .05$. While this finding is not significant, it may suggest that as the perception of stigma increases, so does the likelihood that students concealed their mental-health problem(s) in the past. The coefficient of determination indicates that 11.3% of the variability in students' decisions to stay in the closet about their mental-health problem(s) in the past can be attributed to their overall perception of stigma. A weak, positive, nonsignificant correlation also was found between stigma and students' current decisions to stay in the closet about their mental-health problem(s), $r(44) = .336$, $p < .05$. This finding indicates that as perceptions of stigma increase, so does the likelihood that students will choose to remain in the closet and not disclose their mental-

health problem(s). Further, 11.3% of the variability in students' decisions to not disclose their mental-health problem(s) can be attributed to their perceptions of stigma.

Disclosure Correlation

A Pearson correlation was conducted in order to determine whether or not any relationships exist between disclosure of mental-health problem(s) on college/university campuses in the prior 6 months and the following variables: campus climate, perceived social support, perceived stigma, and the decision of whether or not to come out about one's mental-health problem(s). A weak, positive relationship was found between disclosure of mental-health problem(s) and the decision to come out about one's mental-health problem(s) in the future, r (32) = .370, $p < .05$. This relationship indicates that disclosing one's mental-health problem(s) currently is positively associated with one's decision to disclose one's mental-health problem(s) in the future. The coefficient of determination indicates that 13.7% of the variability in the decision to disclose one's mental-health problem(s) in the future can be accounted for by having already disclosed one's mental-health problem(s) in the present.

Qualitative Open-Ended Questions

Respondents were also asked what helps them to decide whether or not to disclose their mental-health problem(s) and were provided with a space in which to type their responses. Of the 63 respondents who provided open-ended responses, 15 (23.1%) indicated that being able to "trust" the person they are disclosing to impacted their decisions to disclose their mental-health problem(s). Further, another 17 (26.2%) respondents indicated that level of comfort, how well they knew the individual, and the closeness of the relationship as important factors in determining whether or not they

would disclose their mental-health problem(s). Overall, 38 (58.5%) of the 63 respondents indicated that their decision to disclose was determined by the person to whom they were disclosing.

Respondents were further asked what helps them to decide whether or not to conceal their mental-health problem(s) and were provided with a space in which to provide written comments. Of the 38 responses provided, 12 (31.6%) respondents endorsed the relationship with the other person, including level of trust, as important in determining whether or not they would conceal their mental-health problem(s). Some respondents indicated that concern with professors' potential reactions was a barrier to disclosing. Other themes that emerged included perceived stigma, the climate of the classroom and/or campus, and potential negative consequences of disclosing (i.e., negatively affecting education).

Another open-ended question was provided for respondents who chose to answer the disclosure section, the concealment section, or both. This question asked respondents what their college or university could do to help them feel more comfortable reaching a decision of whether or not to disclose and/or conceal their mental-health problem(s). A total of 92 open-ended responses to this particular question were given across both surveys. One of the most common themes across the responses was providing education and increasing awareness on campus with regard to mental-health problems. Respondents also indicated that creating space on campus for more open conversations and dialogue about mental-health problem(s), whether within the classroom with professors or on the campus as a whole, would be helpful. Responses also indicated that having support groups on campus where disclosure is welcomed would be extremely

beneficial. Normalizing of experiences was endorsed, with respondents indicating a desire to have their experiences normalized to feel more comfortable opening up to staff, faculty, and other students. Overall campus climate and a welcoming environment were also reported as important factors in feeling better able to reach a decision of whether or not to disclose and/or conceal mental-health problem(s).

Chapter 6: Discussion

The current study explored the relationship between the overall campus climate with regard to mental-health problems, students' perceived social support, students' perception of stigma, and students' decision to disclose their mental-health problems on campus outside of campus counseling centers. Contrary to expectations, relationships were not found between perceived stigma, perceived social support, campus climate, and disclosure. Disclosure of mental-health problems did, however, have a weak, positive relationship with students' decisions to come out about their mental-health problem in the future. Campus climate, on the other hand, yielded several significant relationships within the current study. Campus climate had a large, positive relationship with the perception of campus respect with regard to mental-health problems, as well as a weak, positive relationship between campus climate and students' perception of social support. Further, a moderate, positive relationship was found between campus climate and students' decisions to come out about their mental-health problem in the future, as well as a weak, positive relationship between campus climate and students' experiences of regret regarding their decisions to disclose their mental-health problems on campus. Finally, stigma yielded several nonsignificant results in that a weak, positive relationship was found between perceived stigma and students' decisions to stay in the closet in the past, as well as a weak, positive relationship between perceived stigma and students' decisions to stay in the closet currently. These results should be considered with caution because of issues with survey construction that will be explored later in this section.

Several ancillary questions provided some descriptive statistics regarding the experiences of students on campus. These questions examined the rates at which students

are disclosing their mental-health problems on campus; the rates at which students are accessing services on campus; the reasons students choose not to disclose their mental-health problem(s); what helps students make the decision to disclose; how college and university campuses can aid in the decision-making process; and the problems and/or benefits students experienced after disclosing their mental-health problem(s) on campus. Rates of students accessing services, such as accommodations, within the current study were similar to those seen in other studies in that the majority of students indicated not accessing accommodations for a variety of reasons. Further, respondents identified a variety of benefits of disclosure, including experiencing normalization, access to social support, and access to accommodations that were in line with findings from prior studies.

Disclosure of Mental-Health Problems

The decision to disclose mental-health problems has not been readily explored in research to date; however, this topic is extremely relevant when considering mental-health problems and college/university campuses. According to the Americans with Disabilities Act (ADA) of 1990, students are required to disclose their mental-health problem(s) to the overseeing office in order to receive reasonable accommodations. This need to disclose presents an interesting dilemma for students, especially given the tendency of individuals to conceal their mental-health problems because of their stigmatized nature. Therefore, disclosure may be something that occurs more on an individual basis for support from staff, faculty, and classmates rather than for the purposes of receiving academic accommodations. One finding of the current study that is of significance was a positive relationship between students' decisions to disclose their mental-health problem(s) at the present time and the likelihood that they would disclose

their mental-health problem(s) in the future. While what specifically impacts this relationship is unknown, a look at the rest of the data reveals that a variety of factors are likely at play.

The disclosure decision-making model (DDM) outlines the process by which individuals decide whether or not to engage in self-disclosure to achieve a certain social goal. Once students identify disclosure as an appropriate strategy to achieve a desired social goal, they must identify an appropriate target person to whom they will disclose (Omarzu, 2000). As seen in the open-ended responses with regard to what helps students decide whether or not they will disclose their mental-health problem(s), 58.5% indicated that their decisions to disclose were determined by the person to whom they were disclosing and the relationship they had with that person. Further, 31.6% indicated that their decisions of whether or not to conceal their mental-health problem(s) were determined by the relationship with the person, as well as by the level of trust with the person to whom they would have disclosed their mental-health problem(s). In addition, of the respondents who reported having disclosed their mental-health problem(s) on campus, the majority of them disclosed to a classmate. These findings support the importance of identifying an appropriate target person to whom to disclose, ultimately bringing individuals one step closer to disclosing their mental-health problem(s) on campus. While the current study did not explore reasons that students tended to disclose to classmates, this decision possibly is impacted by perceived social support. Prior research has found that social support was strongly associated with a decreased likelihood of depression, anxiety, suicidal ideation, and eating disorder symptoms (Hefner & Eisenberg, 2009). While this research focused on the impact social support has on

mental-health symptoms, it provides support for the potential reasons that students may choose to disclose their mental-health problems to fellow classmates.

Campus Climate

The majority of campus climate research to date has focused on perceptions of students, staff, and faculty with regard to racial and ethnic inclusion (e.g., Ancis et al., 2000; Harper & Hurtado, 2007; Hughes et al., 1998; Hurtado, 1992; Hurtado et al., 1996; Reid & Radhakrishnan, 2003). The current study used the findings from this research, as well as from the research on the experiences on campus for members of sexual minority populations, in order to hypothesize the impact campus climate may have on students' willingness and openness to disclose their mental-health problem(s) on campus. While research is lacking regarding the impact of campus climate and disclosure of concealable or hidden identities, past studies found less-than-favorable perceptions of the campus climate for a subset of this population, namely for students who identify within the Queer community.

In line with this latter finding, results from the current study suggest that the more positive the campus climate is with regard to mental-health problems, the more likely students will choose to disclose their mental-health problem(s) in the future. Further, of the respondents who indicated having disclosed their mental-health problem(s) within the previous 6 months, those who identified having a positive perception of their campus climate were less likely to regret their decisions to disclose their mental-health problem(s) in the past. The open-ended questions on the survey provided significant insight into what helped students reach a decision of whether or not to disclose their mental-health problem(s) on campus. While a variety of different reasons were provided

by respondents, one theme present was the overall campus climate and the welcoming atmosphere on the campus as a whole, as well as in the classroom. This theme supports the finding that campus climate is positively associated with disclosure of mental-health problems, as well as associated with less regret about disclosure. Students may be more inclined to seek help, whether through the campus counseling center, the student accommodations office, or directly from professors, if the environment is perceived as welcoming of students with mental-health problems.

Access to Campus Resources

Previous research has found that despite the increased prevalence of mental-health problems on college and university campuses, a significant number of individuals within the student population have not sought treatment (Hunt & Eisenberg, 2010). Low treatment rates have been found across all mental-health problems, with fewer than half of students diagnosed with mood disorders and fewer than 20% of those diagnosed with anxiety disorders receiving treatment (Blanco et al., 2008; Hunt & Eisenberg, 2010). Research has also found that students are failing to access academic accommodations for their mental-health problems. A survey of college students indicated that although 62% of students knew how to access accommodations, only 43% of them actually did so (Gruttadaro & Crudo, 2012). Results from the current study continue to support these previous findings in that more than 70**%** of respondents indicated never having requested accommodations related to their mental-health problem(s). While a little more than half of the respondents reported not accessing accommodations because they did not need them, the other half identified such reasons as being unaware that accommodations were available to them and fearing negative consequences.

With regard to mental-health treatment, roughly half of the respondents reported receiving treatment at the time of the survey, and approximately 74% reported seeking counseling services off campus. The question remains as to which factors are interfering with students seeking accommodations through their college/university campuses. One of the top-five barriers to not seeking services on college/university campuses has been the fear of stigma (Gruttadaro & Crudo, 2012). Respondents in the current study indicated one of the reasons for not requesting accommodations for their mental-health problem(s) was the possibility of negative consequences. While this finding does not specifically implicate stigma as a negative consequence, a number of respondents identified stigma as a barrier to coming out about their mental-health problem(s) on their college and/or university campuses.

Stigma of Mental-Health Problems

Numerous studies have examined the impact stigma has on individuals with mental-health problems. Prior research has found that stigma has the potential to impact an individual's ability to successfully achieve life goals related to work, independent living, health, and wellness (Corrigan, 1998; Corrigan et al., 2010). Studies have also reported that the stigmatization of mental-health problems has caused feelings of discouragement, pain, and lowered self-esteem (Wahl, 1999). The findings of the current study suggested a weak, positive relationship between stigma and individuals' decisions to come out about their mental-health problem(s) in the past, as well as a weak, positive relationship with their decisions to stay in the closet about their mental-health problem(s) in the present. The results also indicated that as the perception of stigma increases, an individual's perception of social support decreases. This finding is consistent with

findings of other studies, with perceived stigma negatively associated with perceived social support (e.g., Mickelson, 2002).

Limitations of the Current Study

While the current research provides insight into the decision-making process of students on college and university campuses with regard to their mental-health problem(s), several limitations need to be addressed. With regard to the methodology of the current study, a number of factors impact the validity and reliability of the findings. Of significant importance with regard to the limitations of the current study is the overall survey construction. Despite receiving 223 survey responses, a significant number of respondents did not complete the survey in its entirety. The survey included 205 questions, each of which was marked as optional. In theory, making all questions optional provided respondents the option to skip any questions that may have created feelings of discomfort. In order to create randomization in the survey distribution, the measures were counterbalanced, and four separate links were created. In each survey construction, however, the demographic questionnaire was placed at the end, which limited the number of respondents who completed this particular section. This placement of the demographic questionnaire created a significant disconnect across measures in terms of having an understanding of the demographic make-up of the individuals responding to each of the measures within the survey as a whole. In turn, this method created a significant amount of missing data across all measures included with the survey. The internal validity of the survey was significantly impacted, making demographic information of the respondents across all measures impossible to discern.

Yet another limitation with the construction of the survey is the overall length. Given that respondents had to answer 205 questions, the respondents may have experienced response fatigue. A look at response rates across all surveys revealed that the number of responses apparently decreased over the course of the survey as a whole, likely as the result of response fatigue given the number of questions respondents had to answer. Further, the overall survey was composed of several measures that had been used in previous studies and that had been found to be valid and/or reliable, as mentioned in Chapter 4. The Disclosure Experiences Survey and Concealment Experiences Survey, however, were created specifically for the current study and have no measurement of reliability or validity. This lack of psychometric data prevents the ability to state whether or not the findings from these surveys can be generalized across the sample of the study, as well as to the general population. Limitations also exist regarding recruitment for the current study. The majority of the sample was composed of individuals who were between the ages of 18 and 31 years, who identified as European American/Caucasian, who identified as biologically female, and who attended universities in the Northeast. While the study was intended to reach college and university campuses across the United States, distribution was hindered by the location of the investigator.

The topic of the current study lacks significant empirical support. Little to no studies were found that explored the decision-making process of disclosure of mental-health problems in general, as well as within a student population. This lack of empirical support presents a limitation to the current research as a result of the lack of literature to support the findings of the current study. While the findings suggest a variety of barriers

to students who wish to disclose their mental-health problem(s) on college/university campuses, little to no empirical support backs up these findings.

Future Implications

Despite the limitations of the current study, the results provide insight into the process by which students decide whether or not to disclose their mental-health problem(s) on their college/university campuses. One of the most significant findings of the current study is the impact perception of campus climate has on students' decision-making processes. The study found that students who perceive their campus climate more positively regarding mental-health problems were less likely to regret their decisions to disclose their mental-health problem(s) on their college and/or university campuses. Further, students who perceived their campus climate as positive with regard to mental-health problems were more likely to disclose their mental-health problem(s) in the future. This finding highlights the possible relationship between campus climate and the decision to disclose one's mental-health problem. While the majority of the research has explored the negative impact of campus climate on education and success with regard to racial and ethnic minority populations (Ancis et al., 2000; Harper & Hurtado, 2007; Hughes et al., 1998; Hurtado, 1992; Hurtado et al., 1996; Reid & Radhakrishnan, 2003), the current research highlights ways in which campus climate may impact students' abilities to engage in a disclosure decision-making process regarding mental-health problems. Given that 86% of students with mental-health problems have dropped out of college prior to graduation (Astin & Osequera, 2005; Kessler et al., 1995; Porter, 1990), determining whether or not a more positive campus climate with regard to mental-health problems would have made a difference in the experiences of these students is important.

Stigma surrounding mental-health problems is yet another area that was found to be a barrier in the disclosure decision-making process of students within the current study. Research has found that students often conceal their mental-health problems and choose not to seek support on their college and/or university campuses because of stigma associated with mental-health problems, lack of availability of services, and financial constraints (Eisenberg et al., 2007a; Givens & Tija, 2002; Megivern et al., 2003; Mowbray et al., 2006; Tija et al., 2005). Respondents within the current study identified the need for increased awareness of mental-health problems on college and university campuses as a means of fighting the stigma that is present on campuses. This awareness needs to be made not only for students on campus, but also for staff and faculty. Students who are not seeking support on their college or university campuses are likely faced with the need to speak directly with professors about ways in which their mental-health problem(s) are impacting their academic performance. Respondents of the current study identified negative experiences with faculty members discounting their ability to succeed after having disclosed their mental-health problem(s).

One way in which college and university campuses can aid in students' decision-making processes is to host events on campus during which open, candid conversations about mental-health problems are had among students, faculty, and staff. These forums may create an overall sense of understanding and inclusion among individuals on campus. Respondents indicated their desires for more open conversations on campus as a means of not only creating safe spaces where disclosure can occur, but also decreasing the stigma of mental-health problems in general. Such conversations including not only students but also faculty and staff can create an environment in which students feel more

comfortable communicating with staff and faculty about their experiences. The majority of respondents reported disclosing their mental-health problem(s) to fellow classmates and identified that trust, the closeness of the relationship, and how well they know someone were all significant factors in their decision to disclose. By opening the door to self-disclosure from faculty and staff, students may begin to feel more comfortable opening up to more than just classmates on campus. This area should be further explored empirically in order to determine the effectiveness of this form of communication, education, and awareness on college and university campuses.

Support is not just important with regard to spaces where students can talk about their experiences with mental-health problems. The open-ended responses also shed light on the need for increased publicity and advertising of services on campus for students with mental-health problems. Findings from the current study show that the majority of students had not requested accommodations for a variety of reasons, including being unaware that accommodations were available and being unable to acquire the necessary documentation. These findings support previous research in which the majority of students were aware that accommodations were available, but only slightly more than half of them actually accessed them (Gruttadaro & Crudo, 2012). Increasing advertising on campus with regard to options students have in terms of receiving support for their mental-health problems is extremely important. Further, a National Survey of Counseling Center Directors reported that the ratio of counselors to students is 1 counselor to 2,081 students on average (Gallagher, 2014). The findings from the current study indicated that the majority of students were seeking counseling services off campus. Often, students are unaware of the services available at the counseling center

and fail to seek help as a result of this lack of knowledge. Advertising services available to students on campus has the potential for greatly increasing help seeking on campus. Future research should examine the ways in which increased advertising on college and university campuses impacts students' access to resources on campus.

Given the lack of research on the disclosure of mental-health problems on college and university campuses, future research should examine variables that may impact this decision-making process. While the current research appears to support previous findings that students are not accessing services available to them on college and university campuses (Gruttadaro & Crudo, 2012), an exploration of the barriers that prevent students from deciding to disclose their mental-health problem on campus must continue. By increasing understanding of what impedes students' decisions to disclose on campus, colleges and universities can use this information to create a more welcoming and inclusive environment for students with mental-health problems. Owing to the lack of empirical research regarding this topic within the student population, future research should continue to explore the barriers to disclosure in order to foster more supportive environments.

Conclusion

The aim of the current study was to determine whether or not a relationship existed between students' perceptions of the overall campus climate with regard to mental-health problems, their perceptions of stigma, their perceptions of social support, and their decisions to disclose their mental-health problem on their college/university campuses outside of counseling centers. The findings suggest that disclosure of mental-health problems is associated with a positive perception of campus climate, in that the

more positively students perceive the campus climate with regard to mental-health problems, the less likely students will regret their decisions to disclose. Further, a positive perception of campus climate is associated with students' decisions to disclose their mental-health problems in the future. Despite the increased need for support on campuses for students with mental-health problems, the findings of the current study suggest that students are not accessing these supports despite being aware of them. Reasons for the lack of accessing supports on campus included fear of negative consequences. While this finding does not specifically indicate stigma as a negative consequence, stigma was found to negatively impact students' decisions to disclose their mental-health problems in the past, as well as in the present.

While the limitations within the current study make difficult a true examination of the relationship between students' perceptions of the overall campus climate, their perceptions of stigma, their perceptions of perceived social support, and their decisions to disclose their mental-health problems on college/university campuses, the results provide insight into potential barriers students may face on campuses. Although the results of the current study must be taken in light of the limitations, they offer promising support for future research within this particular population. With the increase in students on campus with mental-health problems, identifying ways in which institutions of higher education can provide support for students who are experiencing difficulties on campus is important. Given that disclosure is required for students to receive academic accommodations, identifying ways in which to increase students' likelihood to disclose their mental-health problems on campus is of utmost importance.

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Appendix A

Demographic Questionnaire

What is your age range?

☐18-24

☐25-31

☐32-38

☐39-45

☐46-52

☐53-59

☐60-66

☐67-73

☐74+

What is your assigned birth sex?

☐Male

☐Female

☐Intersex

What is your gender identity?

☐Man

☐Woman

☐Transgender

☐Other (please specify) _____

Racial/Ethnic/Cultural Background?

☐African American

☐Asian American or Pacific Islander

☐Hispanic

☐European American/Caucasian

☐Native American

☐Other: _____

What is your religious/spiritual affiliation? (please identify one and explain your choice)

☐None

☐Religious (please note your religion)

☐Spiritual (please note your spirituality)

What best describes your sexual orientation?

☐Asexual

☐Bisexual

☐Gay

☐Heterosexual

☐Lesbian

☐Queer

☐Questioning

☐Other (please specify) _____

If medically or self-diagnosed, which of the following diagnoses best describes you? We realize you may have received many different diagnoses over time. Please select or specify the diagnosis that you feel best describes your experience.

☐Autism Spectrum Disorder

☐Attention Deficit Hyperactivity Disorder

☐Adjustment Disorder

☐Anxiety Disorder (i.e., PTSD, OCD, or generalized anxiety disorder)

☐Bipolar Disorder

☐Borderline or other Personality Disorder

☐Cyclothymia

☐Dysthymia

☐Eating Disorder

☐Learning or Communication Disorder

☐Major Depression

☐Schizophrenia or other Psychotic Disorder

☐Other: _____

How troubled are you currently by this diagnosis/mental health problem?

☐Not at all ☐Slightly ☐Moderately ☐Very much

Is your family accepting of your mental health problem(s)?

☐Not at all

☐Somewhat Accepting

☐Accepting

☐Mostly Accepting

☐Very Accepting

Where in the U.S. do you reside?

☐Northeast

☐Southeast

☐Midwest

☐Northwest

☐Southwest

In which of the following areas do you live?

☐Urban

☐Rural

☐Suburban

Where in the U.S. is the College or University that you currently attend?

☐Northeast

☐Southeast

☐Midwest

☐Northwest

☐Southwest

Where do you live during the academic year?

☐On Campus (e.g., dorm building)

☐Off Campus (e.g., off campus apartment)

☐Home (with parents/guardians)

☐Other (please specify)

Do you live with a roommate(s)?

☐Yes

☐No

How far away do you live from your family?

☐less than 10 miles

☐< 60 miles

☐< 120 miles

☐< 180 miles

☐>180

What level of education are you currently obtaining?

☐Undergraduate (BS/BA/Associates Degree)

☐Graduate (MS/MA)

☐Professional or beyond (Ph.D., MD, DO, PsyD, etc.)

☐Other (please specify)

What year are you in your program?

☐First Year (e.g., freshman)

☐Second Year

☐Third Year

☐Fourth Year

☐Fifth Year

☐Sixth year and beyond

Are you:

☐Part-time

☐Full-time

What is your class size?

☐1 - 10

☐11 - 30

☐31 - 60

☐61 - 90

☐90 - 120

☐> 120

What is your campus size?

☐Small (< 5,000 students)

☐Medium (5,000 – 15,000 students)

☐Large (> 15,000 students)

What is your academic major? (Undergraduate students ONLY)

☐Undeclared/General Education

☐Other (please specify)

What is your academic program? (Graduate students ONLY)

☐Please Specify.

Did you complete your undergraduate degree at the same place as your graduate degree?

☐Yes

☐No

Are you involved in any extracurricular campus activities (e.g., clubs, sports team, sorority, fraternity, etc.)?

☐Yes

☐No

If yes, please specify what extracurricular activities:

Are you currently working?

☐Yes

☐No

If yes, where?

☐On campus (e.g., work study, GA position, TA position, etc.)

☐Off campus

How many siblings do you have?

☐0

☐1

☐2

☐3

☐4

☐5+

Were there any mental health problems in your family growing up?

☐Yes

☐No

If so, who suffered with a mental problem?

☐Myself

☐Father

☐Mother

☐Brother

☐Sister

☐Grandmother

☐Grandfather

☐Aunt

☐Uncle

☐Cousin

Was your family accepting of the individual with the mental health problem?

☐Yes

☐No

Have you ever taken a class or been involved in a research group in which the topic of self-disclosure was addressed?

☐Yes

☐No

Have you ever taken a class or been involved in a research group in which you had the opportunity to self-disclose?

☐Yes

☐No

To your knowledge, is there an Active Minds chapter at your college or university?

☐Yes

☐No

☐I don’t know

Are you currently seeking treatment for your mental health problem?

☐Yes

☐No

If yes, where?

☐On campus counseling center

☐Off campus site

☐Both (e.g., on campus counselor and off campus psychiatrist)

Have you ever been hospitalized for your mental health problems (e.g. inpatient hospital)?

☐Yes

☐No

Have you EVER attended an outpatient treatment setting for your mental health problem(s) (e.g., individual or group therapy, medication management, etc.)?

☐Yes

☐No

Are you CURRENTLY receiving outpatient mental health services from a mental health service provider (e.g. psychiatrist, psychologist, social worker, etc.)?

☐Yes

☐No

Are you currently taking medication for your mental health problem?

☐Yes

☐No

Do you currently manage your mental health problem(s) through means NOT provided by a psychiatrist or mental health service provider (e.g. meditation, exercise, diet, support group, online support, acupuncture, ect.)?

☐Yes

☐No

Appendix B

Disclosure Experiences Survey

This part of the survey asks you about when you have disclosed your mental health problem(s) to anyone on campus, OR decided not to disclose (concealed) your mental health problem when you had the opportunity to do so. When answering the following questions, please answer for the most salient disclosure and/or concealment of your mental health problem(s) over the past 6 months. In other words, you may only have one concealment experience, you may only have one disclosure experience, you may have both experiences, or you may have neither. For the purposes of this survey, the term "salient" refers to the disclosure/concealment experience that is most memorable (positive OR negative) for you. Please remember to provide responses based on this or these particular experience(s).

If you have had both a disclosure and a concealment experience regarding your mental health problem(s) on your college/university campus, you may respond to both surveys. While we know this may be slightly more time consuming, it would be greatly appreciated as it would add to our findings. If you choose to respond to both, you will be prompted to continue to the subsequent section at the end of the survey.

<u>Disclosure of Mental Health Problems</u>

NOTE: if the only person you have disclosed your mental health problem on campus to is the mental health counselor on campus, please do not use that experience for this disclosure section.

Over the course of the past 6 months, have you experience BOTH a disclosure and a concealment experience of your mental health problem(s) on your college/

☐ Yes

☐ No

For the purposes of this survey, which experience will you be referring to? Remember, you can choose to use both.

☐ Disclosure Experience

☐ Concealment Experience

☐ Both (you will be prompted with a question at the end of the next survey)

Over the course of the past 6 months, have you disclosed your mental health problem(s) to someone on your college/university campus (other than a mental health counselor)?

☐ Yes

☐ No

If so, to whom have you disclosed your mental health problem(s) to on your college/university campus? Check more than one if applicable.

☐ Classmate(s)

☐ Advisor(s)

☐ The Office of Human Resources

☐ The Office of Disability Services

☐ Professor(s)

☐ The Office of Student Affairs

☐ The Diversity Office

☐ Director of specific program

☐ Staff on campus

☐ Other, please specify: _____

How often have you disclosed your mental health problem(s) with this/these individual(s) on your college/university campus?

☐ Hardly Ever

☐ Occasionally

☐ Sometimes

☐ Frequently

☐ Always

How much information regarding your mental health problem(s) have you disclosed with this/these particular individual(s) on your college/university campus?

☐ Very little

☐ Little

☐ A moderate amount

☐ Much

☐ Very much

How intimate/personal was the information you disclosed to this/these individual(s)?

☐ Not very intimate/personal

☐ A little intimate/personal

☐ Moderately intimate/personal

☐ Very intimate/personal

☐ Extremely intimate/personal

How would you characterize the experience of disclosing your mental health problem(s) to this/these individual(s)?

☐ Very negative

☐ Moderately negative

☐ Slightly negative

☐ Neither positive or negative

☐ Slightly positive

☐ Moderately positive

☐ Very positive

☐ N/A

How would you characterize the benefits of your disclosure? Check all that apply.

☐ I was able to get support through conversations with classmates/advisors/professors etc.

☐ The individual I disclosed to revealed that they also had a personal experience with a mental health problem.

☐ I was able to receive classroom accommodations.

☐ I experienced normalizing or increased feelings of personal authenticity (i.e. I do not need to hide or mask part of my identity).

☐ I was able to advocate and address possible stigma on college and university campuses.

☐ I did not experience any benefits from disclosing.

☐ Other, please specify: _____

Do you believe you encountered any of the following problems when disclosing your mental health conditions? Check all that apply.

☐ Asked to leave program

☐ Person I disclosed to then avoided me, did not talk to me, or otherwise treated me differently.

☐ Person I disclosed to had to be educated about mental health problems.

☐ Person I disclosed to asked for more information that I did not want to disclose.

☐ Person I disclosed to then revealed the information to others without my consent.

☐ General miscommunication or lack of communication.

☐ I did not experience any problems from disclosing.

☐ Other, please specify: _____

Do you regret your disclosure?

☐ Yes

☐ No

How familiar are you with accommodations that you may be entitled to under the law (e.g. Americans with Disabilities Act)?

☐ Not at all familiar.

☐ Slightly familiar.

☐ Moderately familiar.

☐ Very familiar.

☐ Extremely familiar.

At your college or university, who/what is responsible for managing student accommodation requests related to disability? Check more than one if applicable.

☐ Office of Disability Services

☐ Student Affairs

☐ Chairperson of specific program

☐ Advisor(s)

☐ Unsure

☐ Other, please specify: _____

Have you ever requested accommodations, related to your psychiatric disability at your college or university campus? Includes any requests both formal and informal.

☐ Yes (skip to question 12)

☐ No

If no, why not? Check more than one if applicable.

☐ I did not need them.

☐ I was unaware that accommodations were available.

☐ I could not locate the office or person to make the request.

☐ I could not acquire necessary documentation.

☐ I could not decide what accommodation would be appropriate.

☐ The possibility of negative consequences of requesting accommodations.

☐ I felt that it was not other people's business.

☐ Other, please specify: _____

If yes, please respond to the following question that asks about specific accommodations you may have requested and/or received. If you have received an accommodation, please indicate how helpful the accommodation is (or was, if you are no longer receiving it). If you did not receive the accommodation please select the N/A option for that row. Please check all that apply.

		How helpful is or was this accommodation			
	Check if you have received this accommodation	Not at all helpful	Somewhat helpful	Very helpful	N/A
Extended time to complete work	Yes/no				
Advanced notice of work assignments	Yes/no				

Adjusted proportion of responsibilities (for example, a reduced case load in exchange for additional service work)	Yes/no				
Modified but not reduced work schedule	Yes/no				
Change of modality for work-related events (for example, conducting an interview via instant-message chat rather than orally)	Yes/no				
Alternative or additional modes of processing information (for example, having a designated note-taker during meetings)	Yes/no				
Alternative or additional work equipment	Yes/no				
Memory cues (for example name tags or written notes)	Yes/no				
Availability of quiet space	Yes/no				
Natural or incandescent lighting instead of fluorescent lighting for work space	Yes/no				
Authorization to bring lamp for light therapy	Yes/no				
Virtual attendance (for example, by Skype) for work-related events such as a conference	Yes/no				

Additional mentoring or feedback sessions to discuss performance at work	Yes/no				
Other, please specify:	Yes/no				

How much do symptoms of your mental health problems currently affect your academic experience?

☐ Not at all.

☐ Seldom.

☐ Some of the time.

☐ Most of the time.

☐ All of the time.

Does medication for your mental health problems cause any side effects that cause barriers to your professional success?

☐ Yes

☐ No

☐ I do not take psychiatric medications

To what extent do side effects from medication for your mental health problems (e.g. restlessness, dry mouth, difficulty concentrating, etc.) negatively impact your educational experience?

☐ Not at all

☐ Slightly

☐ Moderately

☐ Very

☐ Extremely

To what extent have the following people our groups been valuable in providing support for managing your mental health problem(s) at school? (If the people or groups are not actively involved in your life, as well as with your mental health problem(s), please select the "N/A" choice for that row).

		How valuable has this support been:					
	Check all that apply	Not at all	Slightly	Moderately	Very	Extremely	N/A
Family (other than spouse)	Yes/no						
Friends	Yes/no						
Spouse or significant other	Yes/no						
Classmates at your college/university	Yes/no						
Advisor(s) at your college/university	Yes/no						
Professional organization (American Psychological Association; ADA, etc.)	Yes/no						
Colleague(s) NOT at your	Yes/no						

college/university							
Support group (in person)	Yes/no						
Support group (online)	Yes/no						
Crisis hotline or other type of assistance hotline	Yes/no						
Your personal psychologist or psychiatrist	Yes/no						
Your personal mental health providers	Yes/no						
Clergy	Yes/no						
Other (please specify)							

How often do people treat you differently when they know you have a mental health problem or have received mental health services?

☐ Never

☐ Seldom or rarely

☐ Sometimes

☐ Most of the time

As an individual who has received mental health services, do you believe others at your college/university to whom you have disclosed your mental health problem(s)…

	Never	Seldom	Sometimes	Most of the time	Always
… feel or treat you like you are violent or dangerous?					
… feel you are a child or treat you like a child?					
… feel or treat you like you are unpredictable?					
… think that you do not know what is in your own best interests?					
… feel or treat you like you are incapable of doing your job?					
….feel that you cannot really have the problem as you are functioning well in your academic endeavors?					

If you have also had a concealment experience regarding your mental health problem(s) on your college/university campus, are you willing to share your concealment experience? (Note: this may add some time to the survey, but would be greatly appreciated).

☐ Yes

☐ No

☐ I have already taken the concealment experience survey.

Appendix C

Concealment Experiences Survey

This part of the survey asks you about when you have disclosed your mental health problem(s) to anyone on campus, OR decided not to disclose (concealed) your mental health problem(s) when you had the opportunity to do so. When answering the following questions, please answer for the most salient disclosure and/or concealment of your mental health problem(s) over the past 6 months. In other words, you may only have one concealment experience, you may only have one disclosure experience, you may have both experiences, or you may have neither. For the purposes of this survey, the term "salient" refers to the disclosure/concealment experience that is most memorable (positive OR negative) for you. Please remember to provide responses based on this or these particular experience(s).

If you have had both a disclosure and a concealment experience regarding your mental health problem(s) on your college/university campus, you may respond to both surveys. While we know this may be slightly more time consuming, it would be greatly appreciated as it would add to our findings. If you choose to respond to both, you will be prompted to continue to the subsequent section at the end of the survey.

<u>Concealment of Mental Health Problems</u>

NOTE: if the only person you have disclosed your mental health problem on campus to is the mental health counselor on campus, please do not use that experience for this disclosure section.

Over the course of the past 6 months, have you concealed your mental health problem(s) from someone on your college/university campus?

☐ Yes

☐ No

☐ I do not wish to fill out the concealment section

If so, from whom have you concealed your mental health problem(s) on your college/university campus? Check more than one if applicable.

☐ Classmate(s)

☐ Advisor(s)

☐ The Office of Human Resources

☐ The Office of Disability Services

☐ Professor(s)

☐ The Office of Student Affairs

☐ The Diversity Office

☐ Director of specific program

☐ Staff on campus

☐ Other, please specify: _____

How often have you concealed your mental health problem(s) from this/these individual(s) on your college/university campus?

☐ Hardly Ever

☐ Occasionally

☐ Sometimes

☐ Frequently

☐ Always

How much information regarding your mental health problem(s) have you concealed from this/these particular individual(s) on your college/university campus?

☐ Very little

☐ Little

☐ A moderate amount

☐ Much

☐ Very much

How intimate/personal was the information you concealed to this/these individual(s)?

☐ Not very intimate/personal

☐ A little intimate/personal

☐ Moderately intimate/personal

☐ Very intimate/personal

☐ Extremely intimate/personal

How would you characterize the experience of concealing your mental health problem(s) to this/these individual(s)?

☐ Very negative

☐ Moderately negative

☐ Slightly negative

☐ Neither positive or negative

☐ Slightly positive

☐ Moderately positive

☐ Very positive

☐ N/A

For what reason did you choose to conceal your mental health problem(s) from this/these individuals on your college/university campus? Check more than one if applicable.

☐ Concern about being asked to leave the program.

☐ Concern that people may view me and my academic work differently.

☐ Concern that people may avoid me, not talk to me, or treat me differently.

☐ Concern that the information might be revealed to others without my consent.

☐ Feeling that it is not other peoples' business.

☐ Feeling that it is not relevant to my education.

☐ I have had a previous negative experience with disclosure.

☐ I know someone on campus who has had a negative experience with disclosure.

☐ I know someone off campus who has had a negative experience with disclosure.

☐ My culture does not encourage self-disclosure.

☐ Other, please specify: _____

How would you characterize the benefits of your concealment? Please check all that apply.

☐ I was able to avoid discrimination based on my mental health problem(s).

☐ I was able to avoid stigma based on my mental health problem(s).

☐ I felt more comfortable in my classes around my classmates and professors.

☐ I did not experience any benefits from concealing my mental health problem(s).

☐ Other (please specify): _____

How did you feel immediately after concealing your mental health problem from this/these individuals?

☐ I felt relieved.

☐ I felt it was the right decision.

☐ I felt anxious.

☐ I felt it was the wrong decision.

☐ Other (please specify): _____

Do you regret your decision to conceal your mental health problem(s)?

☐ Yes

☐ No

Do you believe concealing your mental health problem(s) from this/these individuals was the appropriate decision?

☐ Most of the time

☐ Sometimes

☐ Seldom or rarely

☐ Never

☐ N/A

Do you conceal your mental health problem due to believing you would be treated differently?

☐ Most of the time

☐ Sometimes

☐ Seldom or rarely

☐ Never

☐ N/A

How familiar are you with accommodations that you may be entitled to under the law (e.g., Americans with Disabilities Act)?

☐ Not at all familiar

☐ Slightly familiar

☐ Moderately familiar

☐ Very familiar

☐ Extremely familiar

At your college or university, who/what is responsible for managing student accommodation requests related to disability? Check more than one if applicable.

☐ Office of Disability Services

☐ Student Affairs

☐ Chairperson of specific program

☐ Advisor(s)

☐ Unsure

☐ Other, please specify: _____

Have you ever requested accommodations, related to your psychiatric disability at your college or university campus? Includes any requests both formal and informal.

☐ Yes (skip to question 12)

☐ No

If no, why not? Check more than one if applicable.

☐ I did not need them.

☐ I was unaware that accommodations were available.

☐ I could not locate the office or person to make the request.

☐ I could not acquire necessary documentation.

☐ I could not decide what accommodation would be appropriate.

☐ The possibility of negative consequences of requesting accommodations.

☐ I felt that it was not other people's business.

☐ Other, please specify: _____

If yes, please respond to the following question that asks about specific accommodations you may have requested and/or received. If you have received an accommodation, please indicate how helpful the accommodation is (or was, if you are no longer receiving it). If you did not receive the accommodation please select the N/A option for that row. Please check all that apply.

		How helpful is or was this accommodation			
	Check if you have received this accommodation	Not at all helpful	Somewhat helpful	Very helpful	N/A
Extended time to complete work	Yes/no				
Advanced notice of work assignments	Yes/no				
Adjusted proportion of responsibilities (for example, a reduced case load in exchange for additional service work)	Yes/no				
Modified but not reduced work schedule	Yes/no				
Change of modality for work-related events (for example, conducting an interview via instant-message chat rather than orally)	Yes/no				
Alternative or additional modes of processing information (for example, having a designated note-taker during meetings)	Yes/no				
Alternative or additional work	Yes/no				

equipment					
Memory cues (for example name tags or written notes)	Yes/no				
Availability of quiet space	Yes/no				
Natural or incandescent lighting instead of fluorescent lighting for work space	Yes/no				
Authorization to bring lamp for light therapy	Yes/no				
Virtual attendance (for example, by Skype) for work-related events such as a conference	Yes/no				
Additional mentoring or feedback sessions to discuss performance at work	Yes/no				
Other, please specify:	Yes/no				

How much do symptoms of your mental health problems currently affect your academic experience?

☐ Not at all.

☐ Seldom.

☐ Some of the time.

☐ Most of the time.

☐ All of the time.

Does medication for your mental health problems cause any side effects that cause barriers to your professional success?

☐ Yes

☐ No

☐ I do not take psychiatric medications

To what extent do side effects from medication for your mental health problems (e.g. restlessness, dry mouth, difficulty concentrating, etc.) negatively impact your educational experience?

☐ Not at all

☐ Slightly

☐ Moderately

☐ Very

☐ Extremely

To what extent have the following people our groups been valuable in providing support for managing your mental health problem(s) at school? (If the people or groups are not actively involved in your life, as well as with your mental health problem(s), please select the "N/A" choice for that row).

		How valuable has this support been:					
	Check all that apply	Not at all	Slightly	Moderately	Very	Extremely	N/A
Family (other than spouse)	Yes/no						
Friends	Yes/no						
Spouse or significant	Yes/no						

other							
Classmates at your college/university	Yes/no						
Advisor(s) at your college/university	Yes/no						
Professional organization (American Psychological Association; ADA, etc.)	Yes/no						
Colleague(s) NOT at your college/university	Yes/no						
Support group (in person)	Yes/no						
Support group (online)	Yes/no						
Crisis hotline or other type of assistance hotline	Yes/no						
Your personal psychologist or psychiatrist	Yes/no						
Your personal	Yes/no						

mental health providers							
Clergy	Yes/no						
Other (please specify)							

How often do people treat you differently when they know you have a mental health problem(s) or have received mental health services?

☐ Never

☐ Seldom or rarely

☐ Sometimes

☐ Most of the time

As an individual who has received mental health services, do you believe others at your college/university to whom you have concealed your mental health problem(s)…

	Never	Seldom	Sometimes	Most of the time	Always
… feel or treat you like you are violent or dangerous?					
… feel you are a child or treat you like a child?					
… feel or treat you like you are unpredictable?					
… think that you do					

not know what is in your own best interests?					
… feel or treat you like you are incapable of doing your job?					
….feel that you cannot really have the problem as you are functioning well in your academic endeavors?					

If you have also had a disclosure experience regarding your mental health problem(s) on your college/university campus, are you willing to share your disclosure experience? (Note: this may add some time to the survey but would be greatly appreciated).

☐ Yes

☐ No

☐ I have already taken the disclosure experience survey

Appendix D

Open-Ended Responses

1. **What could your college/university do to make you feel more comfortable in reaching a decision whether to disclose or conceal your mental health problem(s)?**

2. **What helps you to decide whether or not to disclose your mental health problem(s)?**

3. **What helps you to decide whether or not to conceal your mental health problem(s)?**