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SELF-STIGMA AND HELP-SEEKING IN FIRST GENERATION STUDENTS: THE MODERATING ROLE OF EMPOWERMENT

D'Andra P. Johnson

SELF-STIGMA AND HELP-SEEKING IN FIRST GENERATION STUDENTS:

THE MODERATING ROLE OF EMPOWERMENT

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A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Science

in

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————————————————

by

D'Andra P. Johnson

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ABSTRACT

Self-stigma of help-seeking (SSOHS) is a significant barrier for individuals that perceive a need to rely on mental health services for personal and emotional difficulties. SSOHS refers to the internalization of negative messages regarding help-seeking. Although help-seeking is primarily viewed as an adaptive coping mechanism, many individuals from underrepresented groups view it as a failure and threat to their identity, decreasing the likelihood that members of these groups would rely on help-seeking. Furthermore, many individuals from underrepresented groups are pressured to value independence, which can decrease their reliance on support seeking and increase the likelihood of health and educational disparities in the U.S. First-generation college students (FGCS) continue to represent a minority of college students in the U.S. but are being admitted into 4-year universities at higher rates than previously was the case. They also encounter a larger number of stigma-related barriers thought to interfere with their abilities to succeed in college. As a result, FGCS will report higher psychological distress than their later-generation peers. Simultaneously, they evidence lower mental health service use. Stigma barriers are well-researched in conjunction with help-seeking; however, there is less information available on facilitative factors that weaken this relationship. Thus, researchers in this study will examine the role of empowerment on the relationship between SSOHS and help-seeking attitudes. Participants will include first-generation college students attending a minority and FGCS serving institution. FGCS are

defined as students that have parents, or guardians, that did not obtain a postsecondary degree. Participants completed the study online through the SONA Research Management Database. Pearson product-moment correlations were conducted to determine whether self-stigma of help-seeking was significantly correlated with help-seeking attitudes Additionally, relationships between other variables of interest were explored. A moderation analysis using PROCESS in SPSS was used to examine the role of empowerment on the relationship between SSOHS and help-seeking attitudes. It was hypothesized that empowerment would significantly moderate the relationship between SSOHS and help-seeking attitudes. Results did not support the hypothesis. Specifically, empowerment did not moderate the relationship between SSOHS and help-seeking attitudes. Findings highlighted the need to examine the effects of empowerment-based stigma reduction programs that target help-seeking in college students. Additionally, results highlighted the need to study facilitative factors and barriers to help-seeking in college students.

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CHAPTER ONE:

INTRODUCTION

According to the U.S Department of Education, first-generation college students (FGCS) experience educational disparities in academic performance, major declaration, degree attainment compared to later generation college students (NCES, 2005). In addition to academic challenges, FGCS must adjust to a college environment, which can negatively impact their well-being (Jenkins, Belanger, Connally, Boals, & Duron, 2013). FGCS are defined as students that, in two parent households, have two parents or guardians that did not obtain a postsecondary degree and in a single parent household, have a single parent or guardian that did not obtain a postsecondary degree (Peralta & Klonowski, 2007). The classification of students as first-generation college students has caused debate amongst scholars regarding the impact of this designation on the student (Peralta & Klonowski, 2007). While some scholars argue that classifying students as first-generation perpetuates class differences that can exist between FGCS and their families, as their social mobility increases; others note the benefits of highlighting first-generation backgrounds (Stephens Hamedani, and Destin, 2014; Wildhagen, 2015), Specifically, Stephens et al. (2014) observed improved academic and mental health outcomes in association with first-generation student status. Regardless of the debate sparked by the term, first-generation disparities persist in education and well-being between FGCS and their later-generation peers (Stephens, Markus, Fryberg, Johnson & Covarrubias,

2012).). Furthermore, college students and staff have endorsed perceived and real differences between FGCS and their later generation peers, which influence the first-generation college student experience (Wildhagen, 2015).

FGCS have been found to differ from later generation students with respect to college preparedness, the college admission processes they undergo, and adjustment to college campuses, which impact FGCS' experience (Wildhagen, 2015). In an interview of academic staff in a selective college, staff stated that students reporting first-generation status are treated differently because of their perceived lack of preparedness and lack of resources that requires lenient judgement criteria and specialized support (e.g. supportive programming) (Wildhagen, 2015). Furthermore, Wildhagen (2015) stated that while some FGCS expressed satisfaction with their university experience, others had difficulty adjusting to their new environment and felt the need to distance themselves from their families to succeed. Although some FGCS are empowered by academic institution's efforts to meet FGCS' unique needs, other FGCS feel pressure to assimilate, ignoring the unique needs posed by their varying identities (e.g. racial/ethnic minority status). This experience of FGCS in postsecondary institutions and their needs have gained more attention because of their increased admittance into four-year universities and lower success rates compared to later generation students (Stephens, Markus, Fryberg, Johnson & Covarrubias, 2012).

In the 2015-16 academic school year, 56% of the students admitted into U.S colleges were first-generation college students; however, these students held lower 6-year graduation rates than their later generation counterparts (NASPA, 2019). Moreover, in general, FGCS make up the minority of all college students in the U.S. Additionally, even as first-generation students have, at times, become the majority of matriculated college students, they continue to experience educational difficulties, such as greater stigma related to their abilities to succeed in college, and lower college completion rates than their counterparts (Stephens et al., 2014).

First-generation college students also come from diverse backgrounds, and are often influenced by their intersecting, and oftentimes, minority identities (Wildhagen, 2015). For instance, in 2012, the largest number of first-generation college students were White (49%), followed by Black or African American (14%), Hispanic/Latino (27%), Asian (5%), and other (5%) (Redford, Mulvaney-Hoyer, & Ralph, 2017). Furthermore, a larger number of FGCS report coming from lower income households than higher income households (Redford, Mulvaney-Hoyer, & Ralph, 2017). Given the preponderance of FGCS that come from lower income households, it is not surprising that FGCS that have reported leaving their postsecondary institution prior to graduation listed many financially-based reasons behind their decision to leave college, including financial difficulties, changes in family status, and conflict with home demands (Redford, Mulvaney-Hoyer, & Ralph, 2017). The diverse backgrounds of FGCS contribute

to the cultural mismatch that often exists between FGCS values and the culture of a college campus (Wildhagen, 2015).

A large number of first-generation college students experience a cultural mismatch between their upbringings and the environment of a U.S. college campus. For example, many first-generation students are socialized to be interdependent due to a variety of factors associated with their first-generation status (e.g. cultural socialization, economic difficulties and lower quality grade schools; Stephens et al., 2012). As a result of these social and economic difficulties, FGCS must rely on resources within their high schools and families to succeed. FGCS socialization contradicts the value placed on independence in many college campuses and causes increased distress as students grapple with the pressure to become more independent (Stephens et al., 2012). The cultural mismatch and pressure to succeed on U.S college campuses creates additional distress related to academic achievement and mental well-being.

College student mental health is a growing problem in the U.S (Eisenberg, Hunt, & Speer, 2013). According to the American College Health Association (ACHA, 2011), the number of students reporting mental health problems on U.S. college campuses is increasing, resulting in an increased demand for psychological services and staffing (Bushong, 2009). Furthermore, student identities, such as race/ethnicity, sex, religious background, and socioeconomic status are all significantly related to experiencing mental health problems (Eisenberg et al., 2013). Eisenberg, Hunt, Speer, and Zivin (2011) reported that

among 26 universities within the United States, 32% of student participants reported mental health problems. However, only 36% of these students utilized treatment, of any kind, in the previous year. Although there is an increased need for mental health services on college campuses, a large number of students do not seek treatment (Hunt & Eisenberg, 2009). This trend is especially prevalent amongst first-generation college students (Garriott, Raque-Bogdan, Ziemer, & Utley, 2017).

First-generation college students report higher levels of psychological distress compared to their later-generation counterparts; however, are less likely to use services on college campuses, including counseling services (Garriott et al., 2017; Lundberg, Schreiner, Hovaguimian, & Slavin-Miller, 2007; Stebleton, Soria, & Huesman, 2014;). Postsecondary institutions have the ability to address the diverse needs of students in one setting (e.g. mental health, academic, and medical supports) (Hunt & Eisenberg, 2010). Additionally, a growing body of literature is demonstrating the necessity to focus on needs of students belonging to minority groups, including first-generation students (Becker, Schelbe, Romano, & Spinelli, 2017; Castillo & Schwartz, 2013; Lundberg et al., 2007). College students are often viewed as a privileged population, but they experience psychological distress at the same rate as their non-student peers (Hunt & Eisenberg, 2010). Additionally, first-generation college students experience unique stressors compared to their later-generation peers, which puts them at risk, psychologically and academically (Eisenberg et al., 2013; Martinez, Sher,

Krull, & Wood, 2009). For instance, psychological distress hindered academic performance and predicted dropout in first-generation students, but not their later-generation peers (Martinez et al., 2009). Although researchers have recorded the challenges of FGCS, a paucity of information on predictors of help seeking remain among this group. However, one of the most cited barriers in FGCS help-seeking is stigma, or an undesirable, or discrediting characteristic that causes an individual to be rejected (Goffman, 1963). Furthermore, self-stigma, or the internalization of negative attitudes toward a perceived undesirable personal attribute, has been cited as a significant deterrent to help seeking (Becker et al., 2017; Garriott et al., 2017; Hunt & Eisenberg, 2010).

Defining Stigma

Broadly speaking, stigma refers to a relationship between devalued characteristics and stereotypes (Link & Phelan, 2001). Goffman (1963) wrote one of the earliest works dedicated to explicitly defining stigma, which is known as a deviation from the societal norm. Stigma can also be broadly categorized into perceivable or hidden differences. Within these categories are the three types of stigma proposed by Goffman (1963), including abominations of the body or physical stigma, blemishes of individual character or character stigma, and tribal or group stigma. Abominations of the body include physical or observable differences. For example, an individual that has a physical impairment might be perceived as less capable (Goffman, 1963). Blemishes of the character refers to internal traits that are not readily observed by others; however, the blemish is

perceived by the stigmatized as abnormal. For example, an individual that suffers from a mental illness might not have physical manifestations of the illness, but believe that their illness is a devalued attribute, causing negative feelings about self (Goffman, 1963). Finally, tribal or group stigma refers to the stigma attached to an individual due to their group identification (e.g. race) (Goffman, 1963). These devalued characteristics have been studied in relation to mental illness, poverty, sexuality, suicide attempts, and more (Becker & Arnold, 1986).

Subsequently, Becker and Arnold (1986) defined stigma as a social and cultural construct. Specifically, stigma beliefs can be traced back to the society in which an individual lives and the cultural group to which they belong (Becker & Arnold, 1986). For example, gay men in the U.S are a historically marginalized group within various communities including the African American community (Lapinksy, Braz, & Maloney, 2010). Derogatory terminology such as "down low" has been used to typify gay men in the African American community that hide their sexuality due to their fear of being rejected (Lapinsky et al., 2010). The stigma related to being a gay man in America is pervasive in this country. In another example of stigma in the U.S, White American women were more likely to rate larger women lower on attractiveness than their African American counterparts (Hebl & Heatherton, 1998). The difference in these ratings has been attributed to differences in sociocultural beliefs regarding body size.

In 2001, Link and Phelan, informed by Goffman's (1963) work, conceptualized stigma as a response to the inconsistent definitions that exist

within stigma literature, impacting the way that it is studied and understood (Becker & Arnold, 1986). Link and Phelan (2001) outlined stigmatization as a process, including recognizing and labeling differences, linking differences to negative stereotypes, separation of "us" from "them," status loss, and finally rejection or disapproval by society. First, an individual must label the perceived differences between their group and the outgroup. Labeling, for instance, is observed when individuals are classified into different groups based on race, such as Black and White (Link & Phelan, 2001). Next, an individual links the differences to negative attitudes or stereotypes. For example, individuals with Leprosy, a disease that often causes physical deformities, are visibly different from those without the disease. Therefore, individuals without the disease are inclined to believe misconceptions regarding leprosy (e.g. it is incurable and there is no treatment), significantly changing their interactions with individuals with leprosy (Luka, 2010). As a result, individuals with leprosy in affected areas, such as South Sudan, undergo a detrimental separation between themselves and others without the disease due to its outward effect. Moreover, individuals experience status loss within their communities, and internalize negative messages regarding leprosy, causing them to hide that they have the disease, increasing the spread (Luka, 2010).

The recognition and grouping of individuals based on differences create negative attitudes and beliefs that are not only learned and practiced by non-stigmatized individuals, but internalized and practiced by individuals belonging to

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stigmatized groups (Link & Phelan, 2001; Becker & Arnold, 1986). Inherent in stigma, is the fear of being perceived by others as different or abnormal. Additionally, stigmatized individuals might hold the same negative beliefs regarding the devalued attribute they possess (Goffman, 1963). In literature, negative perception of characteristics held by others and the internalization of stigma beliefs about self are studied used separately (Corrigan, 2004; Vogel, Wade, & Haake, 2006).

Public Stigma

Vogel, Bitman, Hammer, and Wade (2013) distinguishes between two types of stigma, public and self-stigma. The first and most recognized type of stigma is public stigma (Vogel et al., 2013). Public stigma refers to societal perceptions of a socially unacceptable characteristic, learned through social and cultural groups (Vogel et al., 2006; Becker & Arnold, 1986). Public stigma can give rise to discrimination against others with the unaccepted characteristic (Corrigan, 2004). Furthermore, endorsing the negative beliefs can cause one to conceal their own stigmatized identity (e.g. mental illness) (Corrgian, 2004). In a study conducted by Eisma (2018), participants were presented with vignettes, which required them to assess characteristics of individuals experiencing grief, with and without a mental disorder. Individuals in the vignette with a mental disorder were appraised more negatively than their counterparts with no mental illness (Eisma, 2018). Participant responses reflect their negative perceptions of mental illness, which has been widely regarded as negative or taboo in the U.S.

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Similar to public stigma, self-stigma are beliefs that an individual learns through social and cultural groups; however, the beliefs are later internalized due to their possession of the negatively perceived characteristic.

<u>Self-Stigma</u>

Theories on the development of self-stigma (e.g. Vogel & Wester, 2003; Corrigan & Rao, 2012), conceptualize the process as becoming aware of, accepting, and applying stigmatized beliefs to oneself. This process, referred to as the Stage Model of Self-Stigma, proposed by Corrigan and Rao (2012), leads to internalized negative attitudes such as "I am weak." Consequences of these attitudes include decreases in self-esteem, empowerment, and self-efficacy (Corrigan & Rao, 2006). Subsequently, an individual is likely to react to self-stigma by avoiding help seeking to protect their self-esteem and sense of self-efficacy (Vogel et al., 2006; Corrigan & Rao, 2012).

Despite attempts to protect the self, self-stigma often leads to a reduction in self-worth due to the negative perception of themselves, or the trait they possess (Vogel et al., 2013). Self-stigma is commonly studied in relation to mental health service utilization and mental illness (Corrigan, 2004; Vogel et al., 2013). It is also a noted barrier toward help-seeking for several groups, including men, women, racial/ethnic minorities, and the military population and their families (Andresen & Blais, 2011; Becker & Arnold, 1986). The process of self-stigma is the result of public stigma, or the negative beliefs held by larger groups or society (Vogel et al., 2013). To illustrate, in Vogel and colleagues' (2013)

longitudinal study, college students experiencing public stigma were more likely to develop self-stigma over a three-month period. Although the concepts of public and self-stigma are interconnected, there is data solidifying them as independent constructs (Vogel et al., 2013). Additionally, there is a distinction made between types of self-stigma, specifically, self-stigma of help-seeking (SSOHS) and self-stigma of mental illness (SSOMI) (Tucker, Hammer, Vogel, & Maier, 2013).

<u>Stigma and Mental Illness</u>

Self-stigma of mental illness is a result of the public stigma of mental illness (Corrigan & Watson, 2002). Specifically, as individuals that endorse public stigma of mental illness perpetuate negative attitudes toward individuals living with a psychological condition (e.g. people with mental illnesses are dangerous), individuals that have internalized these attitudes experience self-stigma of mental illness (Corrigan & Watson, 2002). An individual suffering from mental illness and endorsing negative beliefs about the illness can experience harmful personal and social consequences, such as decreased self-esteem, decreased self-efficacy, avoidance of activities, and shame (Corrigan & Watson, 2002; Corrigan, Watson, & Barr, 2006). Self-stigma has also impacted the experience of comorbid depressive symptoms and rehabilitation for individuals with post-traumatic stress disorder, bipolar disorder, and schizophrenia (Bonfils et al., 2018; Karidi et al., 2015). Namely, when participants with bipolar disorder and schizophrenia were compared on self-stigma, both groups held stigmatizing attitudes, while

participants with schizophrenia held more intense negative attitudes that impacted their social functioning (Karidi et al., 2015).

Other consequences of SSOMI include, the decreased willingness to seek assistance for mental health problems and decreases in social behaviors (Corrigan et al., 2006). The social impact of stigma and decreased help-seeking behaviors continue to be an issue today in the general population, regardless of mental health diagnosis, in the general population, college population, and first-generation college student sub-group (Garriott et al., 2017; Hunt & Eisenberg, 2010).

Stigma and Help-Seeking

Vogel, Wade, & Haake, (2006) define self-stigma of help seeking (SSOHS) as the endorsing of negative beliefs regarding an individual that seeks psychological services, which results in a decreased sense of self-efficacy. Self-stigma is one of the most prominent barriers to help seeking identifies in the FGCS help-seeking literature (Garriott et al., 2017; Gulliver, Griffiths, & Christensen, 2010). For example, Garriott et al., 2017, found that self-stigma regarding seeking counseling services was more impactful for FGCS than their counterparts. Help-seeking avoidance is also seen in individuals undergoing severe crises, such as suicidal ideation (Wilson & Deane, 2012). Despite its significance in barrier research, SSOHS is understudied, while self-stigma of mental illness (SSOMI) is more often examined in relation to help-seeking intentions (Tucker et al., 2016). Just as public attitudes can have a harmful

impact on society, self-stigma of help-seeking can fuel negative reactions toward seeking assistance and thwart efforts toward recovery (Vogel et al., 2006; Luka, 2010). Furthermore, individuals that are affected by stigma risk nondisclosure of mental health concerns, which can contribute to the increase in severity of mental health concerns (Hunt & Eisenberg, 2010; Eisenberg et al., 2009). The construct, self-stigma of help-seeking, has been consistently linked to a decrease in help seeking behaviors for individuals with and without a mental illness (Bonfils et al., 2018; Eisenberg et al., 2009). While SSOHS can be detrimental to an individual's well-being, researchers have conceptualized the avoidance of mental health treatment as a method of protecting oneself from the negative effects of stigma (Miller & Kaiser, 2001).

Coping with Self-Stigma

According to Lazarus and Folkman (1984), when individuals perceive a threat, it is accompanied by appraisal stages. First, primary appraisal is the recognition of the threat. Secondary appraisal is defined as the decision regarding the ability to cope with the stressor (Lazarus & Folkman, 1984). If an individual decides that they have the resources to cope, they enact a series of cognitive and behavioral strategies to deal with the demands posed by the stressor (Lazarus & Folkman, 1984). Miller and Kaiser (2001) encouraged researchers to view stigma as a stressor, which is followed by this appraisal process. Unlike temporary stressors, stigma-related stress has the potential for chronic and long-lasting effects due to pervasiveness. For example, gay men

might experience continued stress related to their treatment in society and internalized negative messages, which prevent them from sharing their distress with others (Lapinsky et al., 2010).

Link, Mirotznik, and Cullen (1991) investigated the usefulness of coping orientations among Black American mental health consumers with high levels of self-stigma. All coping preferences (i.e. withdrawal, secrecy, and disclosure), resulted in increased perceived discrimination and devaluation as well as increased distress. Furthermore, this sample identified stigma as a primary reason for psychological treatment attrition and avoidance. Additional studies have identified self-stigma as the reason for the underutilization of mental health services (e.g. Gulliver et al., 2010). Help seeking avoidance and withdrawal are common methods of coping with SSOHS; however, these methods are also associated with harmful outcomes (e.g. increased distress) (Link et al, 1991; Gulliver et al., 2010). The relationship between emotion focused coping strategies (e.g. withdrawal and avoidance) and psychological distress, indicate a poor fit between the stressor and utilized coping strategy (Miller & Kaiser, 2001). In order to change the maladaptive coping strategies applied to self-stigma, an individual must possess the belief in their ability to alter their coping strategies (Chesney et al., 2006).

However, not all individuals that encounter stigma react similarly (Miller & Kaiser, 2001). For example, some individuals are seemingly unaffected by stigma (Miller & Kaiser, 2001; Corrigan & Watson, 2002). One of the

explanations for this observation is that some individuals do not perceive the stigma as a threat to themselves; specifically, the stressor does not exceed their ability to implement coping resources (Lazarus & Folkman, 1984; Miller & Kaiser, 2001). Furthermore, individuals that do not respond to stigma in the expected pattern feel more equipped to respond to the stressor when it is encountered (Miller & Kaiser, 2010). Researchers that have attempted to increase resilience to stigma-related stressors relied on an empowerment framework (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012).

Stigma Reduction

As previously stated, college campuses offer faculty and staff opportunities to address a wide range of social, academic, and health related concerns for students (Hunt & Eisenberg, 2010). Moreover, primary, secondary, and tertiary prevention efforts to address growing mental health demands and underutilization of services can be employed on college campuses. Mittal et al., 2012 conducted a literature review of self-stigma reduction strategies, but most of the self-stigma reduction strategies targeted SSOMI. The disorders that were targeted included schizophrenia, and related psychotic disorders, and depression (Mittal et al., 2012). The primary methods of stigma reduction interventions included psychoeducation (Mittal et al., 2012), third-wave behavior therapies (e.g. acceptance and commitment therapy) (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008), and multimodal interventions (e.g. psychoeducation and behavior therapy techniques) (Mittal et al., 2012). However, research efforts have not

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yielded studies that have focused exclusively on stigma of help-seeking, which is

conceptually distinct from self-stigma of mental illness (Talebi, Matheson, &

Anisman, 2016). Moreover, existing stigma reduction programs have yielded

mixed success. Two primary strategies have been used to achieve stigma

reduction, including altering stigma beliefs and empowerment (Mittal et al., 2012).

Self-Stigma and Empowerment

Corrigan and Watson (2002) examined the paradox of self-stigma,

specifically, that some individuals do not exhibit the same deleterious effects of

self-stigma (i.e. decreased self-esteem and self-efficacy) as others. It is apparent

that some individuals are unaffected by stigma, while others are motivated to

overcome stigma beliefs (Corrigan & Watson, 2002). Specifically, some

individuals might become acclimated to the effects of stigma within their

environment or alternatively might become motivated to challenge the stigma

beliefs (Corrigan & Watson, 2002). These unexpected reactions to self-stigma

are often seen in person(s) of color and other minority groups (Corrigan &

Watson, 2002; Hoelter, 1983). Most of the literature examining the effects of

resilience on stigma conceptualize it as a method of coping, or overcoming the

negative consequences (e.g. avoidance); however, some researchers have

suggested empowerment as a means of overcoming the harmful effects of

stigma (Corrigan & Watson, 2002).

This inconsistency of reactions to stigma is thought to be the result of

empowerment (Corrigan, 2002). Empowerment is defined as perceived mastery,

control, collaboration, and equity within the environment (Clark & Krupa, 2002; Zimmerman & Rappaport, 1988). Self-efficacy, locus of control, self-esteem and other constructs that mediate the effects of self-stigma exist on a spectrum of empowerment and have been conceptualized as parts of this broad construct (Zimmerman & Rappaport, 1988). Empowerment is conceptualized as the opposite of self-stigma, with an inverse relationship existing between the constructs (Brohan et al., 2010; Corrigan & Watson, 2002). Corrigan and Watson (2002), found that individuals provided with opportunities to increase their personal power through collaboration and community opportunities had improved mental health recovery goals (Corrigan & Watson, 2002). Furthermore, Evans, Pelletier, and Szkola (2018), found that education was the primary mode of empowering individuals that were incarcerated, increasing motivation to change, and decreasing self-stigma. This inverse relationship between self-stigma and empowerment highlights the benefit of utilizing empowerment frameworks to decrease stigma (Mittal et al., 2012).

<div align="center">Attitudes Toward Help-Seeking</div>

Vogel and Wester's (2003) examination of the theory of reasoned action, proposed by Ajzen and Fishbein (1980), revealed that the primary determinant to seeking mental health treatment is the attitude that an individual possesses about counseling (Vogel & Wester, 2003). Moreover, individuals that possess stigmatized beliefs about help seeking will likely have negative reactions to help seeking and be less likely to seek help (Vogel & Wester, 2003). Shih (2004)

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called attention to the lack of literature on empowering individuals to overcome stigma instead of coping with it (e.g. avoidance). Although eliminating stigma is an important task, it is a larger scale and long-term goal that cannot be achieved quickly. Literature has shown that individuals can persist despite stigma or are unaffected by it (Corrigan & Watson, 2002). Consequently, it is important to identify factors that strengthen resilience and increasing the likelihood of help-seeking regardless of the stigmatized beliefs.

Purpose of the Study

This study examined the effect of self-stigma of help seeking on first-generation college students' attitudes toward seeking help. Additionally, empowerment was examined as a moderator in this study. Attitudes toward help-seeking is one of the primary determinants of actual help-seeking behaviors (Vogel & Wester, 2003). As a result, attitudes toward help-seeking are examined as a possible point of intervention for increasing actual help-seeking behaviors in FGCS. Most importantly, this study was conducted using an entirely FGCS, and largely minority sample. The students that participated in this study also attend an institution that is comprised largely of first-generation college students (81% of the total population) and over 60% of the students are belonging to a racial or ethnic minority group ("Our Student Population," 2019). The existing research on FGCS is comprised, largely, of White identified students (Garriott et al., 2017; Stebleton et al., 2014).

The purpose of this study was to examine the role of empowerment on the relationship between SSOHS and help-seeking attitudes. Specifically, this study examined empowerment as a moderator on the relationship between SSOHS and help-seeking attitudes in FGCS. It was hypothesized that empowerment would significantly moderate the relationship between help-seeking attitudes and SSOHS in first-generation college students.

CHAPTER TWO:

METHODS

Participants

Participants were recruited from a minority and FGCS serving institution through the SONA Research Management Database (N = 112). All participants were 18 years or older (M = 24.7, SD = 6.03) and identified as a first-generation college student. First-generation college students were defined as students that, in two parent households, have two parents or guardians that did not obtain a postsecondary degree and in a single parent household, have a single parent or guardian that did not obtain a postsecondary degree (Peralta & Klonowski, 2007). One hundred fifty students signed up to participate in the study. The response rate for the study was 88% with 132 participants completing the study. Of the 132 completed responses, 112, or 84% of participants qualified as a first-generation college student, which is representative of the first-generation student population at the studied institution. The 20 participants that did not meet inclusion criteria were excluded from the analysis. Six men and 106 women completed the survey.

All participants were undergraduate students, with the average years of school completed totaling 3.46 (M= 3.46, SD = 1.13). In terms of ethnicity, 83.9% of participants were Hispanic or Latino. Regarding race, 35.7% participants identified as White (n = 40), 0.9% were African American (n = 1), 6.3% of participants were American Indian or Alaska Native (n = 7), 4.5% of participants

were Asian (n = 5), 13.4% of participants considered themselves mixed race (n = 15), and 39.3% of participants identified with a race that was not listed in the survey (n = 44). All participants were awarded one unit of extra credit assigned to a course of their choice for their participation in the survey. All participants were treated in accordance with the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). This study was approved by the Institutional Review Board at California State University, San Bernardino.

<center>Materials</center>

Demographic Questionnaire. Participants were asked to provide information about their age, race, ethnicity, gender, income, household size, employment status, parental education, and year in school.

Kessler Psychological Distress Scale (K10; Kessler et al., 2002) is a brief 10-item measure of psychological distress that asks participants to rate how often they experience the specific symptoms consistent with depression and anxiety. This measure was reported as showing evidence of good construct and criterion validity using an adult sample in the general population experiencing nonspecific emotional distress, as determined by clinical reappraisal surveys and interviews (Kessler et al., 2002). Participants can rate each response on a 5-point Likert scale from 1 (none of the time) to 5 (all of the time). Statements include, "In the past 4 weeks, about how often did you feel nervous?" and "In the past 4 weeks, about how often did you feel worthless?". The internal consistency for the K10 for this study was (α = .93). Scores under 20 indicate that is

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participant is well. Scores between 20 and 24 are likely indicative of a mild mental disorder. Scores between 25 and 29 are likely indicative of a moderate mental disorder and scores over 30 are likely indicative of a severe mental disorder.

Self-Stigma of Help-seeking (SSOHS; Vogel, Wade, & Haake, 2006) is a brief 10-item measure that assesses a respondent's beliefs regarding seeking psychological help utilizing a Likert scale. This measure displayed good predictive, criterion and construct validity with college students, as demonstrated by positive correlations between total scores on SSOHS and social stigma toward help-seeking and anticipated risks scales. Furthermore, total scores on SSOHS were negatively correlated with intentions to seek counseling, attitudes toward help-seeking, and anticipated benefits. Questions can be rated from 1 (strongly disagree) to 5 (strongly agree). Sample statements include, "my self-esteem would increase if I talked to a therapist" and "I would feel worse about myself if I could not solve my own problems." The internal consistency for the SSOHS for this study was (α = .91). Higher scores represent higher degrees of self-stigma.

Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF; Fischer & Turner, 1970; Elhai, Schweinle, & Anderson, 2008) is a 10-item measure that assesses an individual's positive or negative attitudes toward seeking psychological help from a professional. This measure was validated using an undergraduate college student sample. Results supported

good criterion validity for this scale, as evidenced by a significant, positive correlation with intensity of recent mental health care usage, an action-oriented measure (Elhai et al., 2008). Participants can rate each statement on a scale from 0 (disagreement) to 3 (agreement). Statements include, "I might want to have psychological counseling in the future" and "Personal and emotional troubles, like many things, tend to work out by themselves." The internal consistency for the ATSPPH-SF for this study was (α = .77). Higher scores indicate more favorable attitudes toward help-seeking.

Empowerment Scale (ES; Rogers et al., 1997) is a 28-item measure that assesses an individual's level of empowerment in four domains, including self-efficacy, perceived power, optimism about and control over the future, and community activism, and righteous anger. This measure was developed and tested using a sample of mental health consumers with a reasonably high degree of mental illness and showed some support for convergent and divergent validity, as supported by negative correlations with psychological symptoms and positive correlations between empowerment and quality of life (Rogers et al., 1997). Participants will rate each statement on a 4-point Likert scale ranging from strongly agree to strongly disagree. Statements include "Getting angry about something never helps" and "People are only limited by what they think is possible." The internal consistency for the empowerment scale for this study was (α = .81). Additionally, the internal consistency for the subscales is as follows: self-efficacy (α = .82), perceived power (α = .59), optimism about and control

over the future (α = .45), community activism (α = .59), and righteous anger (α = .64). Higher scores indicate a higher sense of empowerment.

Procedure

This study was conducted online. Participants completed five questionnaires through Qualtrics, an online survey system. First, participants were shown an informed consent and asked to consent to participation in the study. Participants were informed that participation was entirely voluntary. Next, a demographics questionnaire was administered to screen participants out of the study that did not qualify as first-generation college students, were younger than 18 years old, and not enrolled at the university. The next set of questionnaires assessed self-stigma of help-seeking behaviors (SSOSH; Vogel, Wade & Haake, 2006), help seeking attitudes (ATSPPH; Attitudes Toward Seeking Professional Psychological Help, Fischer & Turner, 1970), empowerment (ES; Empowerment Scale, Rogers, Ralph, & Salzer, 2010), and psychological distress (K10; Kessler Psychological Distress Scale, 2001). Once students completed the surveys, they were directed to a screen, which thanked them for their participation, and provided local mental health resources in the rare event that questions from the study caused distress. All data was identified using an assigned number that linked the participant to their Qualtrics responses and SONA profile, which allowed the principal investigator to assign compensation. Participants were manually screened by the principal investigator based on the inclusion criteria. If students did not meet inclusion criteria their data was excluded from the analysis.

Design and Analysis

First, a power analysis was conducted using G*Power (Faul, Erfelder, Bucnhner, & Lang, 2014) to determine an appropriate sample size for a moderation analysis with a moderate effect size. This analysis was likely to have the greatest requirement for power in this study. To achieve a medium effect size, an alpha of .05, and a power level of .95, the results of the analysis suggested a minimum of 89 participants to achieve ample power in this study.

Next, Pearson product-moment correlation were obtained to determine whether self-stigma of help-seeking was significantly correlated with help-seeking attitudes. Next, a moderation analysis was conducted using PROCESS in SPSS to determine if empowerment moderated the relationship between self-stigma and help-seeking. Tests were conducted to ensure assumptions of normality were not violated. Additional correlation analyses were conducted, post hoc, using psychological distress, treatment history, empowerment, self-stigma, and attitudes to better understand the relationships between these variables. The Empowerment Scale subscales were included in correlation and moderation analyses, including self-efficacy, perceived power, optimism and control, community activism, and righteous anger because each factor in this scale has been hypothesized to help individuals overcome the negative impact of stigma (Corrigan & Watson, 2002).

CHAPTER THREE:

RESULTS

Descriptive Statistics for Variables of Interest

With regard to the Kessler Distress Scale (M = 24.09, SD = 8.01), 30.49% (n = 35) of the participants reported a distress score that fell within the well range, 23.3% (n = 26) of students fell within the mild range, 23.3% (n = 26) of students fell within the moderate range, and 22.5% (n = 25) of students fell within the severe range. Furthermore 59.8% (n = 67) of the sample indicated that they never received psychological treatment (M = 2.54; SD = .614). Additionally, more than half of the participants within this study (n = 72) reported being employed. Of the employed participants, most of them (n = 68) reported working over 10 hours every week. Finally, the average household size for all participants was 4.12 (M = 4.12, SD = 1.72) and 83.1% (n = 95) of participants reported a household income of less than $70,000 U.S. dollars.

Pearson Product-Moment Statistics

The results of the Pearson Product Moment Correlations revealed no significant correlation between self-stigma of help-seeking and help-seeking attitudes; however, self-stigma of help-seeking was significantly, positively correlated with psychological distress (r = .198, p < .05). Specifically, as self-stigma of help-seeking scores went up, psychological distress also went up. Self-stigma of help-seeking was not correlated with the Empowerment Scale or its

subscales. Attitudes toward help-seeking were significantly, negatively correlated with empowerment, but not its subscales (r = -.199, p < .05). This result meant that as participants indicated more positive attitudes toward help-seeking, there was a decrease in empowerment. Lastly, the total empowerment scale (r = .246, p < .05) was significantly, positively correlated to psychological distress, meaning as a participant was more empowered, they also indicated higher psychological distress.

The self-efficacy subscale was significantly, positively correlated with psychological distress (r = .516, p < .05), meaning as participants indicated higher distress, they also indicated higher self-reliance. Next, the perceived power subscale was significantly, negatively correlated with psychological distress (r = -.328, p < .05). Namely, if participants indicated high perceived power, they were likely to indicate lower psychological distress. Finally, the optimism and control subscale was significantly positively correlated with psychological distress, meaning that participants indicating high optimism and control, were also more likely to indicate higher psychological distress (r = .341, p < .05). Finally, the righteous anger and community activism scales were not significantly correlated with distress. Although treatment history was not significantly correlated with psychological distress (r = -.183, p <.05), findings suggest it is approaching significance and is negatively related to distress.

Moderation Analysis

      A moderation analysis was conducted using PROCESS in SPSS. It was hypothesized that self-stigma (M = 26.95, SD = 3.95) and attitudes toward help-seeking (M = 14.85, SD = 3.08) would be moderated by empowerment (M = 59.82, SD = 6.62) in first-generation college students. Results of the moderation analysis were not significant (R = .224, R^2 = .050, F(3, 108) = 1.91, 95% [-.115, .179], p > .05). Furthermore, SSOHS initially accounted for 5% of the variance in help-seeking attitudes; however, when empowerment was added into the model, explained variance decreased (R^2 = .050, $R^2 change$ = .008, F(1, 108) = .849, 95% [-.012, .032], p > .05). Additional moderation analyses were run on the Empowerment Scale subscales (i.e. self-efficacy, perceived power, optimism and control, righteous anger, and community activism), post hoc. None of the subscales moderated the relationship between self-stigma of help-seeking and help-seeking attitudes. Assumptions of normality were met.

CHAPTER FOUR:

DISCUSSION

The purpose of this study was to identify variables that have the potential to weaken the relationship between self-stigma of help-seeking and help-seeking attitudes in a first-generation college student sample. Self-stigma of help-seeking has been linked to unfavorable attitudes toward help-seeking in many underrepresented groups, including FGCS (Garriott et al., 2017). It was hypothesized that empowerment would significantly moderate the relationship between SSOHS and help-seeking attitudes. The results of the study did not provide support for the hypotheses. More specifically, the relationship between self-stigma of help-seeking and help-seeking attitudes was not moderated by empowerment. Furthermore, this finding was attributed to the paradox of self-stigma, proposed by Corrigan and Watson (2002).

Additionally, post hoc moderation analyses revealed that the empowerment subscales did not moderate the relationship between self-stigma and attitudes toward help-seeking. A Pearson Product-Moment Correlation analysis also revealed no significant relationship between SSOHS and attitudes toward help-seeking. Post hoc correlation analyses were run to better explain the relationship between empowerment, stigma, psychological distress, actual treatment history, and attitudes toward help-seeking. The analyses revealed that as psychological distress increased, so did self-stigma of help seeking and a sense of empowerment, including the self-efficacy, and optimism and control

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subscales. Conversely, as psychological distress increased, perceived power was likely to decrease. Moreover, although psychological distress was not significantly correlated with help-seeking behaviors, the findings suggest that this relationship is approaching significance, as it may be that participants were less likely to report seeking psychological treatment despite endorsing distress. Finally, as individuals reported more favorable attitudes toward help-seeking, they also reported lower scores on empowerment.

Implications

The results of this study did not support the hypothesis. Specifically, self-stigma of help-seeking did not significantly predict help-seeking attitudes. Furthermore, empowerment did not moderate the relationship between self-stigma of help-seeking and help-seeking attitudes. The additional correlation analyses revealed no significant relationship between self-stigma and attitudes toward help-seeking. Although these results did not provide support for the hypotheses, findings potentially provide support for the paradox of self-stigma. This theory, proposed by Corrigan and Watson (2002), is influenced by research on minority groups and stigma. Specifically, Corrigan and Watson (2002) observed three groups of people in literature, including a group that suffers from a loss of self-self-efficacy due to stigma, a group that is motivated by stigma (i.e. righteous anger), and a group that is unaffected by stigma. For example, in Hoelter (1983), groups at higher risk of stigma stressors, such as African Americans, also endorsed higher self-efficacy than their White counterparts.

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Consequently, Corrigan and Watson (2002) proposed that individuals with mental illness might react similarly to other minority groups facing stigma stressors. Specifically, individuals from underrepresented backgrounds, or minority groups might not always lose self-efficacy when encountering stigma beliefs. It is assumed that individuals that do not display the expected pattern of decreased self-efficacy may be influenced by several factors, including their level of group identification and endorsement of stigma beliefs. For example, if an individual reported high group identification and endorse the stigma beliefs, they are likely to react toward stigma with anger. On the contrary, low group identification and endorsement of stigma beliefs is expected to be related to indifference (Corrigan & Watson, 2002). The observations of this paradox in literature suggest that individuals with mental illness and minority groups already cope with stigma in ways that protect or increase their self-efficacy (Corrigan & Watson, 2002).

Participants in this study were members of at least one underrepresented background (i.e. FGCS); however, many of the participants indicated multiple underrepresented identities, including being members of racial or ethnic minority groups, and coming from a low socioeconomic background. The results of this study are, potentially, a display of the paradox of self-stigma. More precisely, this sample of underrepresented participants are reacting in a way that is consistent with previous observations of minority groups, making them less susceptible to some negative effects of stigma (e.g. negative help-seeking attitudes). Implications of these findings suggest the usefulness of further exploring the

effects of righteous anger and group identification on minority groups' self-efficacy, and stigma attitudes. Furthermore, the findings suggest the importance of exploring other types of stigma on help-seeking attitudes.

Although the moderation analyses did not support the hypotheses, consistent with literature on FGCS, most participants in this sample reported psychological distress, but denied seeking mental health services currently, as well as in the past (Garriott et al., 2017). Furthermore, self-stigma was positively correlated with distress. These results indicate a potential negative effect of self-stigma of help-seeking. Namely, increased psychological distress can result from a high degree of stigma beliefs. Although the correlation between distress and help-seeking was not significant in this study, the results of the analysis was approaching significance in a negative direction. The behavioral questions, assessing for help-seeking action (i.e. yes, I am receiving treatment, no, not at the moment, and no, I have never received treatment), resulted in over half (58%) of the sample denying ever receiving psychological treatment. As suggested in literature, it is possible that the multitude of stressors that a first-generation college student encounter, such as racial or ethnic group stigma, the FGCS label, and academic performance, can exacerbate their distress as they attempt to refute the stereotypes attached to these groups (Becker et al., 2014). Furthermore, they might be less likely to seek help because they view it as a threat to their identity, leading to an increased use of avoidance coping strategies (e.g. help-seeking avoidance and negative attitudes) (Link et al., 1991).

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Moreover, as stated by Wildhagen (2015), the term first-generation might have negative impacts on the FGCS experience, contributing to the stress posed by the college environment. Implications of these findings suggest the importance of examining the impact of SSOHS on psychological distress as it relates to intersectionality.

The final set of analyses, using empowerment, yielded unexpected results. Specifically, empowerment was positively correlated with distress, and negatively correlated with attitudes toward help-seeking. Further analyses using empowerment subscales, revealed relationships between self-efficacy, power, optimism and control, and anger. Empowerment is a construct, often defined using several components, such behavioral, intrapersonal, and interactional traits (Back & Keys, 2019; Zimmerman, 1995). Intrapersonal traits refer to an individual's feelings about themselves (e.g. self-efficacy and self-esteem) (Zimmerman, 1995). Interactional traits refer to the sociopolitical and community understanding an individual has, while behavioral components refer to the actions someone takes (Zimmerman, 1995). Within the empowerment measure used for this study, several factors, developed by mental health service users have potential to be classified into these three groups (Back & Keys, 2019). For example, the self-efficacy subscale asks several questions that imply action (e.g. I generally accomplish what I set out to do) (Rogers et al., 1997). Additionally, in the optimism and control subscale, questions suggest action is important (e.g. very often a problem can be solved by taking action). These measures were

positively correlated with distress, meaning as self-efficacy and optimism and control increased, so did distress. In Back and Keys (2019), they state that many racial/ethnic minority students take on extra responsibilities during their college experience, which can also serve as an indicator of empowerment. Furthermore, over half of the college students in this sample (63%), reported having a job, with most participants working over 10 hours per week. It is probable that FGCS or racial or ethnic minority college students have learned to cope with their unique stressor, during college, which is indicative of empowerment. However, their increased distress could be influenced by the pressure to succeed and maintain independence in a college environment (Stephens et al., 2012). As a result, it is likely that FGCS have found ways to persist during college, despite holding stigma beliefs, but not without experiencing distress.

Conversely, the perceived power subscale was negatively related to psychological distress. Specifically, as perceived power increased, psychological distress decreased. The subscales items for power (e.g. usually, I feel alone), which dealt largely with perception, had the potential to decrease the pressure that is placed on students to perform (Back and Keys, 2019). Additionally, this finding provides additional support for the paradox of self-stigma, suggesting that when participants perceive themselves as powerful, it can be beneficial to overcoming challenges (Corrigan & Watson, 2002). Furthermore, participants might be protected from the negative effects of stigma when they feel powerful.

Finally, attitudes toward help-seeking was negatively associated with empowerment, meaning as participants indicated more favorable attitudes toward help-seeking, they were likely to indicate lower empowerment. As described by Stephens et al. (2012), many college students may feel pressure to succeed independently, due to the individualistic culture of a U.S. college campus. Furthermore, Wildhagen (2015) described the implications of grouping first-generation students together. For example, students in that study stated that they felt pressure to separate themselves from family to succeed in college. As a result, it is possible that the FGCS within this study also feel pressure to uphold ideas of independence that are common within U.S. college campuses. Therefore, if participants report favorable help-seeking attitudes, they are likely to feel less empowered due to a perceived lack of power, self-efficacy, and control. Implications of these findings suggest the importance of exploring the impact that empowerment has on underrepresented groups prior to advocating for programs, empowerment-based programming, due to the potential it has to inadvertently reinforce the pressure of independence.

Limitations

There were several limitations within this study. First, the empowerment measure utilized in this study was developed and validated using mental health service consumers. This scale also grouped constructs, such as self-efficacy and self-esteem, which did not leave room to measure them as separate factors. As a result, this measure might hold less validity within an underrepresented college

student sample. Furthermore, the self-stigma of help-seeking and attitudes toward help-seeking scales, although validated using a college population, failed to validate the measure on FGCS and racial/ethnic minorities, despite the acknowledgement of the centrality of this population within the larger FGCS population. Furthermore, continuing generation students were excluded from this study which did not allow a test of these measures on a comparison group of traditionally represented students. With regard to our FGCS sample, a majority of our sample was female, and Hispanic/Latino. A more diverse sample, with regard to gender identification, race, and ethnicity can be useful. Finally, it is suggested that the measurement of FGCS status be reworded for more inclusivity (e.g. parent or guardian).

Future Research and Intervention Implications

This study was comprised of first-generation college students. Additionally, most students indicated being a racial/ethnic minority group member. Existing research on FGCS tend to focus on their experience at predominantly White universities (e.g. Becker et al., 2017), or universities where FGCS are a minority (e.g. Wildhagen, 2015). Although participants were members of traditionally underrepresented groups, the institution that this study was conducted at is a minority serving institution, and the majority of the students (81%) are FGCS ("Our Student Population," 2019). Although no significant relationship was found between attitudes toward help-seeking and self-stigma, other correlations revealed patterns consistent with existing research (e.g.

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Garriott et al., 2017). For example, our participants reported psychological distress, but were likely to report never seeing a therapist. These findings with a traditionally underrepresented sample, in a minority serving institution suggest the need for future research regarding the culture of U.S. college campuses. More specifically, as Stephens et al. (2012) suggest, U.S. college campuses' emphasis on independence can undermine the values that FGCS place on interdependence. Exploration of the culture of minority serving institutions can provide additional insight into this theory. Furthermore, although the correlation between distress and help-seeking behaviors was not significantly correlated, the results were approaching significance in a negative direction. These findings suggest the need to continue utilizing underrepresented college samples to better understand the influence of stigma. Their high risk of experiencing distress and underutilization of services, even in a setting where they are the majority further support this need. Additionally, to avoid over pathologizing underrepresented groups and better understand the nature of distress, other outcome measures, such as well-being or quality of life, can be used.

This sample of FGCS indicated the presence of stigma beliefs, lowered help-seeking, favorable help-seeking attitudes, and empowerment. The lack of a relationship between help-seeking attitudes and self-stigma suggest that FGCS are persisting despite the presence of stigma stressors (Miller & Kaiser, 2001). It is likely that many FGCS have developed ways of coping with stigma, weakening the relationship between self-stigma and help seeking attitudes, but not without

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distress and the underutilization of mental health care services. These findings can serve as indication of a need to further examine the usefulness of empowerment-based programming on underrepresented groups, prior to advocating for programs that are empowerment based (e.g. Mittal et al., 2012). Colleges and universities can also consider this information when developing programs that address FGCS and racial/ethnic minority student needs.

First-generation college students come from many backgrounds, including low socioeconomic statues, and are often racial or ethnic minorities (Wildhagen, 2015). There has been debate sparked by the term, first-generation, and the implications this term has on individuals grouped into this category (Wildhagen, 2015). However, an increasing number of college students are identifying as first-generation, which can lead to an increased likelihood that colleges and universities will provide them with specialized attention and programming (NASPA, 2019; Wildhagen, 2015). While literature suggests there is a relationship between help-seeking attitudes and self-stigma in first-generation college students, some researchers have observed a paradox (Corrigan & Watson, 2002). Specifically, some underrepresented groups are indifferent or angry toward stigma, protecting their sense of self-efficacy. Despite persisting beyond stigma, this sample continued to display trends of reporting psychological distress and underutilizing services. These findings support the need to focus on first-generation college students, while considering their diverse backgrounds.

Further research should be conducted using stigma, empowerment, and help-seeking attitude scales to validate these measures on underrepresented college students. Additionally, the grouping of underrepresented groups into larger groups, such as FGCS, can take away from their unique needs and backgrounds. This grouping increases the chances that researchers and college staff and faculty will not be given information that accurately reflect the unique needs of all FGCS. Hence, more research with a larger sample of individuals from diverse backgrounds that comprise intersecting identities with FGCS status are critical. For example, the surveys within the study can be expanded for exploration of more inclusive points of intersectionality (e.g. sexuality and gender), which can allow for a more detailed analysis explaining differences between seemingly similar groups (e.g. women or FGCS).

This author also calls for more research that collaborates and collects data with underrepresented samples on college campuses. Lastly, this author calls for the continued examination of the utility of predominantly independence-based and empowerment-based messaging on U.S. college campuses. Many members of underrepresented groups are studied as homogenous populations, allowing researchers and professionals to ignore their unique needs. This paper was an effort to focus on the diverse backgrounds and needs of a FGCS sample. Furthermore, the findings of this study suggest access to mental health care remains an issue for underrepresented groups. Consequently, it is important that

efforts to improve access for minority populations in mental health care attempt

to address systemic as well as individual barriers.

APPENDIX A: INFORMED CONSENT

Self-Stigma and Help-Seeking in First Generation Students: The Moderating Role of Empowerment

You are invited to participate in a research study conducted by D'Andra Johnson, under the supervision of Dr. David V. Chavez, Professor of Psychology at California State University, San Bernardino (CSUSB). This study is designed to examine the relationship between self-stigma and help-seeking attitudes in first-generation college students. You must be 18 years or older to participate in this study. This study has been approved by the Institutional Review Board at CSUSB.

PURPOSE OF THE STUDY

We are examining the relationship between stigma and help-seeking attitudes in first-generation college students. Additionally, we will explore the impact of empowerment on this relationship. This study can be used to inform future research on help-seeking behaviors in first-generation college students and assist in the development of programs targeting stigma and promoting well-being and help-seeking, for first-generation students.

STUDY PROCEDURES

Participation in this study will be completed through the online SONA Research Management System. You will be asked to complete surveys on factors, such as distress, empowerment, stigma, and help-seeking attitudes. All surveys will be administered at one time and take approximately 30 minutes.

INCENTIVE FOR PARTICIPATION

For your completion of each part of the study, you can receive 1 extra credit unit for 30-minute participation in the online study. A participant who provides poor responses, identified by quality control items, will NOT be awarded the incentive for participation. Participation in this study is entirely voluntary. You may revoke your consent to participate at any time.

POTENTIAL RISKS AND DISCOMFORTS

Participation in this study will be associated with minimal risk, as defined by the Institutional Review Board. Participants will be asked to indicate stigma related beliefs, attitudes toward seeking help, empowerment beliefs, and levels of psychological distress. Questions are similar to those asked during routine psychological assessment or health screenings (e.g. "how often did you feel so sad that nothing could cheer you up?"). In the unlikely event that distress is caused by measures in the study, all participants will be provided resources to campus and community mental health clinics.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Benefits of participation include an extra credit incentive worth 1 point for completion of the study. Participants will be awarded 1 extra unit on SONA that can be applied to a course of their choice per instructor approval. Participants will be exposed to questionnaires commonly used in counseling and social psychology research. Participants will also gain familiarity with participating in a counseling related research study. Finally, findings have implications for campus

outreach programs targeting stigma and promoting help-seeking and psychological well-being for underrepresented groups experiencing distress.

CONFIDENTIALITY

You will not be asked to provide identifying information while completing your demographics survey. Your responses will remain confidential and will be stored in an encrypted electronic file. Once the study has been completed, all extra credit assignments will be made through SONA, if applicable. Data from this study will be used for educational purposes in classrooms, workshops, professional presentations or scientific publications. When the results of the research are published or discussed in conferences, no identifiable information will be used. Data from this study can be used in the future for another study.

INVESTIGATOR'S CONTACT INFORMATION

The investigators are available to answer your questions about this study. If any questions arise, you can contact D'Andra Johnson, Department of Psychology, California State University, San Bernardino, SBS 425, 5500 University, Parkway, San Bernardino, CA 92407 or Dr. David V. Chavez, Department of Psychology, California State University, San Bernardino, SBS 527, 5500 University Parkway, San Bernardino, CA 92407, (909) 537-4507.

CONSENT OF RESEARCH PARTICIPANT

If you agree to participate in the study, please select "I am 18 years or older and I have read and understand the consent document and agree to participate in your study" If you do not consent to participate, please select "I am not interested in participating in this study or I am under 18 years old"

- o I am 18 years or older and I have read and understand the consent document and agree to participate in your study
- o I am not interested in participating in this study or I am under 18 years old

APPENDIX B: TABLES

Table 1. *Pearson Product Moment Correlations between self-stigma, help-seeking attitudes, and empowerment* (*N* = 112)

Variable	M	SD	1	2	3	4	5	6	7	8
SSOHS	26.95	3.95	1	.050	.025	.135	-.184	.014	.045	-.073
2. ATSPPH	14.85	3.08		1	-.199*	-.164	-.029	-.081	-.185	-.179
3. Emp	59.82	6.62			1	.797**	.390**	.726**	.791**	.556**
4. Emp – SE[a]	16.63	3.78				1	-.144	.457**	.733**	.188*
5. Emp - P[a]	21.43	2.39					1	.232*	.028	.583**
6. Emp – CA[a]	10.38	1.90						1	.538**	.303**
7. Emp - C&O[a]	8.30	1.56							1	.269**

Variable	M	SD	1	2	3	4	5	6	7	8
8. Emp – RA[a]	9.90	1.55								1

Note. SSOHS = Self-Stigma of Help-Seeking, ATSPPH = Attitudes Toward Seeking Professional Psychological Help, Emp = Empowerment Scale, SE = Self-efficacy, CA = Community Activism, C&O = Control & Optimism, RA = Righteous Anger.
[a] Subscales of the Empowerment Scale.
p < .05 *, *p* <.001 **

Table 2. *Pearson Product Moment Correlations between distress and variables of interest* (*N* = 112)

	Tx Hx	SSOHS	ATSPPH	ES	ES-SE[a]	ES-P[a]	ES-CA[a]	ES-C&O[a]	ES-RA[a]
Distress	-.183	.198**	.099	.246**	.516**	.328**	-.081	.341**	-.125

Note. ES = Empowerment Scale, ATSPPH = Attitudes Toward Seeking Professional Psychological Help, Tx Hx = Treatment History, SE = Self-efficacy, CA = Community Activism, C&O = Control & Optimism, RA = Righteous Anger.
[a] Subscales of the Empowerment Scale.
p < .05 *, *p* <.001 **

APPENDIX C: FIGURES
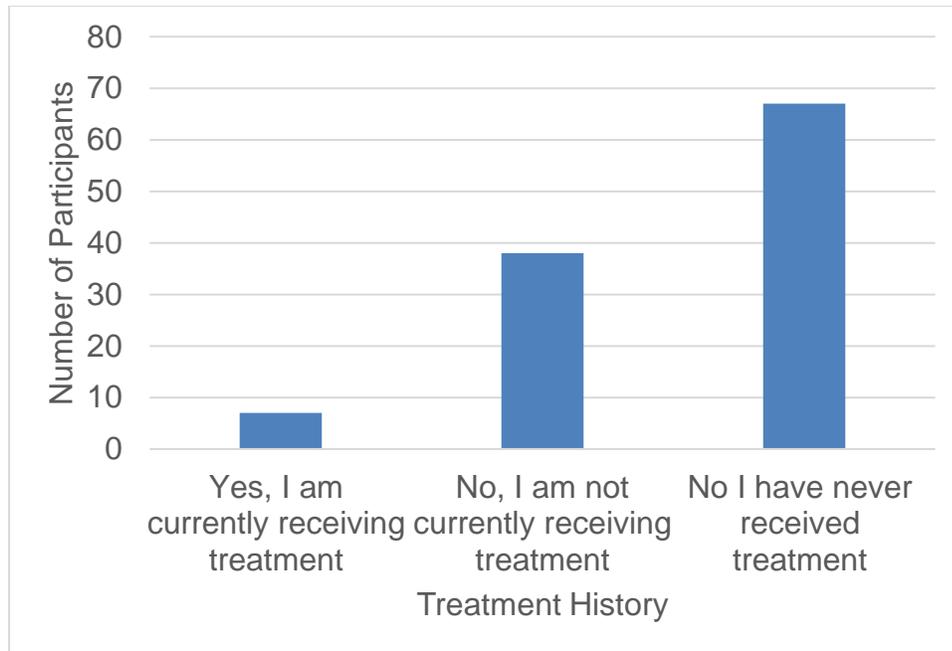
Figure 1. Number of participants that were receiving psychological treatment (i.e. medication or therapy) at the time of the study.
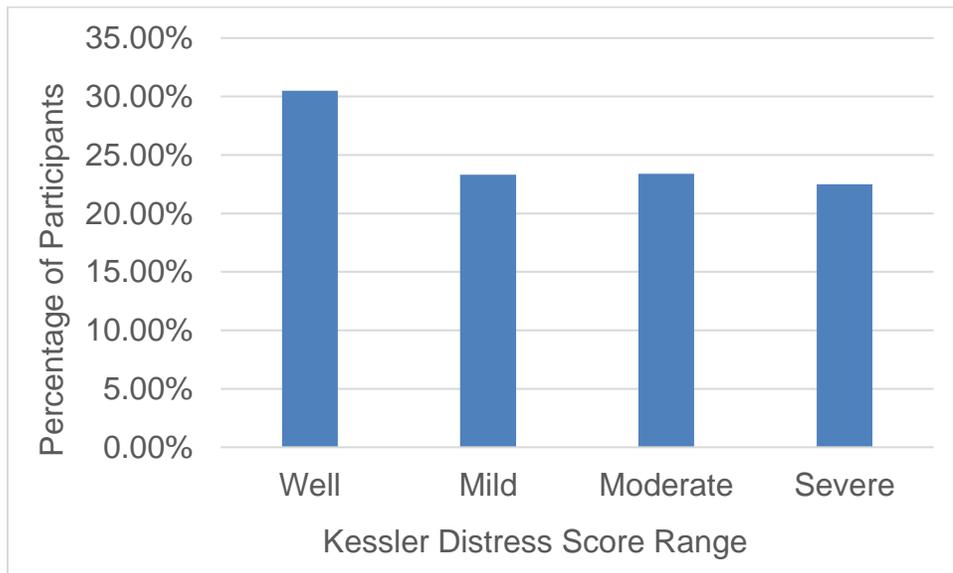
Figure 2. Percentage of participants indicating a score within the well, mild, moderate, and severe ranges on the Kessler Distress Scale.

APPENDIX D: MATERIALS

Demographics Questionnaire:

1. Provide your CSUSB ID number:
_____

2. What year of school are you in?
- o   1st
- o   2nd
- o   3rd
- o   4th
- o   5th +

3.How old are you?
_____

4. Indicate the highest level of school completed by your mother.
- o   Less than High School
- o   Some High School
- o   High School Graduate (GED/Diploma)
- o   Some College (No Degree)
- o   College Graduate (Includes AA)
- o   Graduate School (Includes Masters Degree and Beyond)
- o   Unknown

5. Indicate the highest level of school completed by your father.
- o   Less than High School
- o   Some High School
- o   High School Graduate (GED/Diploma)
- o   Some College (No Degree)
- o   College Graduate (Includes AA)
- o   Graduate School (Includes Masters Degree and Beyond)
- o   Unknown

6. Do you identify as Hispanic or Latino?
- o   Yes
- o   No

7. Choose one or more races that you consider yourself to be:
- ☐   White
- ☐   Black or African American
- ☐   American Indian or Alaska Native
- ☐   Asian
- ☐   Native Hawaiian or Pacific Islander
- ☐   Mixed Race, Please specify:
_____
- ☐   Other, please specify
_____

8. What is your gender?
- o   Male
- o   Female

   o Transgender

   o Non-binary

   o Other, please specify

_____

   o Decline to state

9. Are you employed? If yes, please indicate number of hours you work per week

   o Yes _____

   o No

   o Decline to state

10. What is the current size of your household? (If larger than 8, please fill in the number).

   o 1

   o 2

   o 3

   o 4

   o 5

   o 6

   o 7

   o 8+ _____

11. Information about income is very important to understand. Would you please give your best guess? Please indicate the answer that includes your entire household income in (previous year) before taxes.

   o Less than $10,000

   o $10,000 to $19,999

   o $20,000 to $29,999

   o $30,000 to $39,999

   o $40,000 to $49,999

   o $50,000 to $59,999

   o $60,000 to $69,999

   o $70,000 to $79,999

   o $80,000 to $89,999

   o $90,000 to $99,999

   o $100,000 to $149,999

   o $150,000 or more

12. Are you currently receiving psychological treatment (medication and/or psychotherapy)?

   o Yes, I am currently receiving treatment

   o No, I am not currently receiving treatment

   No, I have never received treatment

Kessler Distress Scale (K-10)

Instructions: These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been:

1 - None of the Time   2 - A little of the time   3 - Some of the time
4 - Most of the time 5 - All of the time

1. During the last 30 days, about how often did you feel tired out for no good reason?   o   o   o   o   o
2. During the last 30 days, about how often did you feel nervous?
o   o   o   o   o
3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down? o   o   o   o   o
4. During the last 30 days, about how often did you feel hopeless?   o
       o   o   o   o   o   o

5. During the last 30 days, about how often did you feel restless or fidgety?
       o   o   o   o   o
6. During the last 30 days, about how often did you feel so restless you could not sit still?   o   o   o   o   o
7. During the last 30 days, about how often did you feel depressed?
o   o   o   o   o
8. During the last 30 days, about how often did you feel that everything was an effort?   o   o   o   o   o
9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up? o   o   o   o   o
10. During the last 30 days, about how often did you feel worthless?
o   o   o   o   o

Self-Stigma of Help-Seeking (SSOHS)

Instructions: Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

1 - Strongly Disagree   2- Disagree   3 - Agree & Disagree Equally
4 - Agree   5 - Strongly Agree

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

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

o   o   o   o   o

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

o   o   o   o   o

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

o   o   o   o   o

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

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

o   o   o   o   o

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

o   o   o   o   o

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

o   o   o   o   o

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

o   o   o   o   o

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

o   o   o   o   o

Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF)

Instructions: Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

0 - Disagree 1 - Partly disagree   2 - Partly agree   3 - Agree

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

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

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

o   o   o   o

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

o   o   o   o

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

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

o   o   o   o

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

o   o   o   o

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

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

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

Empowerment Scale (ES)

Rogers, E.S., Ralph, R.O., Salzer, M.S. Validating the empowerment scale with a multisite sample of consumers of mental health services. *Psychiatric Services. 2010, 61*, 933–936. https://doi.org/10.1176/ps.2010.61.9.933

Instructions: Below are several statements relating to one's perspective on life and with having to make decisions. Please circle the number above the response that is closest to how you feel about the statement. Indicate how you feel now. First impressions are usually best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answers reflect your true feelings.

1 - Strongly Agree   2 - Agree   3 - Disagree 4 - Strongly Disagree

1. I can pretty much determine what will happen in my life.

o   o   o   o

2. People are only limited by what they think is possible.

o   o   o   o

3. People have more power if they join together as a group.

o   o   o   o

4. Getting angry about something never helps.

o   o   o   o

5. I have a positive attitude toward myself.

o   o   o   o

6. I am usually confident about the decisions I make.

o   o   o   o

7. People have no right to get angry just because they don't like something.

o   o   o   o

8. Most of the misfortunes in my life were due to bad luck.

o   o   o   o

9. I see myself as a capable person.

o   o   o   o

10. Making waves never gets you anywhere.

o   o   o   o

11. People working together can have an effect on their community.

o   o   o   o

12. I am often able to overcome barriers.
o   o   o   o
13. I am generally optimistic about the future.
o   o   o   o
14. When I make plans, I am almost certain to make them work.
o   o   o   o
15. Getting angry about something is often the first step toward changing it.
    o   o   o   o
16. Usually I feel alone.   o   o   o   o
17. Experts are in the best position to decide what people should do or learn.
    o   o   o   o
18. I am able to do things as well as most other people.
o   o   o   o
19. I generally accomplish what I set out to do.
o   o   o   o
20. People should try to live their lives the way they want to.
o   o   o   o

21. You can't fight city hall. o   o   o   o
22. I feel powerless most of the time.
o   o   o   o
23. When I am unsure about something, I usually go along with the rest of the
group.   o   o   o   o
24. I feel I am a person of worth, at least on an equal basis with others.
    o   o   o   o
25. People have the right to make their own decisions, even if they are bad ones.
    o   o   o   o
26. I feel I have a number of good qualities.
o   o   o   o
27. Very often a problem can be solved by taking action.
o   o   o   o
28. Working with others in my community can help to change things for the
better.   o   o   o   o

APPENDIX E: DEBRIEFING INFORMATION

Post Study Resources

Please see the list of community mental health resources below if you are interested in pursuing or learning more about mental health services in your area.

Community Resources: Riverside, San Bernardino and Los Angeles County Counseling and Psychological Services (CAPS)/California State University, San Bernardino

5500 University Parkway San Bernardino, CA 92405 HC-162 909.537.5040

Phoenix Services/County of San Bernardino Department of Behavioral Health

820 E. Gilbert Street San Bernardino, CA 92415 (909) 387-7200

Moreno Valley Clinic

21250 Box Springs Rd., Suite 106 Moreno Valley, CA 92557 (951) 369-8036 M-Th 8am-9pm F 9am-1pm

Riverside Clinic

8172 Magnolia Riverside, CA 92505 (951) 509-8733 Tuesday and Wednesday 12:30pm-9pm

The Community Counseling Center-- Department of Psychology of CSUSB

(909) 537-5569

Counseling Services – Catholic Charities

Visit the Catholic Charities Counseling Services website.

San Bernardino and Riverside Counties 1441 North "D" Street San Bernardino, CA 92405 (909) 763-4970 Fax: (909) 763-4977

Loma Linda University Social Action Community Health System (SACHS)

Visit the SACHS website.

Norton AFB – 1455 East Third Street, San Bernardino, CA 92408 (909) 382-7100

Arrowhead – 1455 East 3rd St, San Bernardino, CA 92405 (909) 381-1663

Frazee – 488 South K Street, San Bernardino, CA 92410 (909) 383-8092

Loma Linda University Department of Psychology – Psychological Services Clinic

Visit the LLU Psychological Service Clinic website. (909) 558-8576 1686 Barton Rd. Redlands, CA 92373

Christian Counseling Services. Visit the Christian Counseling Services website. (909) 793-1078 51 West Olive Avenue Redlands, CA 92373

Bilingual Family Counseling Service, Inc.

Visit the BFCS website. (909) 986-7111 317 West "F" St. Ontario, CA 91762

Clearview Treatment Center (909)798-6200 1902 Orange Tree Lane Suite 200 Redlands, CA 92374

Rim Family Services, Inc. 28545 Highway 18 Skyforest, CA 92385-0578 On Highway 18, 50 yards west of Kuffel Canyon (909) 336-1800

NAMI National's Helpline

1-800-950-NAMI (1-800-950-6264)

Crisis Resources

National Suicide Prevention Hotline Resource: 1-800-273-TALK (8255)

Suicide and Crisis Hotline: (951) 686- 4357

1-888-628-9454 (En Español)

1-800-799-4889 (TTY Service for Deaf & Hard of Hearing)

Dial 211
National hotline run by trained professionals available with comprehensive resources nationally and internationally (including most parts of Canada)
Crisis Text Line: Text HELLO to 741-741
FOR ADDITIONAL RESOURCES UTILIZE THE LINK BELOW:
Los Angeles County: https://www.namiurbanla.org/resources
San Bernardino County: http://wp.sbcounty.gov/dbh/
Riverside County: https://www.rcdmh.org/

APPENDIX F: INSTITUTIONAL REVIEW BOARD APPROVAL

CSUSB Institutional Review Board Approval
January 27, 2020
CSUSB INSTITUTIONAL REVIEW BOARD
Expedited Review
IRB-FY2020-185
Status: Approved
D'Andra Johnson, David Chavez
Department of CSBS - Psychology
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407
Dear D'Andra Johnson, David Chavez:
Your application to use human subjects, titled "Self-Stigma and Help-Seeking Attitudes in First-generation Students: The Moderating Role of Empowerment" has been reviewed and approved by the Institutional Review Board (IRB). The informed consent document you submitted is the official version for your study and cannot be changed without prior IRB approval. A change in your informed consent (no matter how minor the change) requires re-submission of your protocol as amended using the IRB Cayuse system protocol change form. Your IRB proposal (FY2020-185) is approved. You are permitted to collect information from [150] participants for [1 SONA unit] from [CSUSB/SONA]. This approval is valid from [1/27/2020] to [1/26/2021].
Your application is approved for one year from
January 27, 2020 through --.
Please note the Cayuse IRB system will notify you when your protocol is up for renewal and ensure you file it before your protocol study end date.
Your responsibilities as the researcher/investigator reporting to the IRB Committee include the following 4 requirements as mandated by the Code of Federal Regulations 45 CFR 46 listed below. Please note that the protocol change form and renewal form are located on the IRB website under the forms menu. Failure to notify the IRB of the above may result in disciplinary action. You are required to keep copies of the informed consent forms and data for at least three years. You are required to notify the IRB of the following by submitting the appropriate form (modification, unanticipated/adverse event, renewal, study closure) through the online Cayuse IRB Submission System.
1. If you need to make any changes/modifications to your protocol submit a modification form as the IRB must review all changes before implementing in your study to ensure the degree of risk has not changed.
2. If any unanticipated adverse events are experienced by subjects during your research study or project.
3. If your study has not been completed submit a renewal to the IRB.
4. If you are no longer conducting the study or project submit a study closure.
Please ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required. If you have any questions regarding the IRB decision, please contact Dr. Jacob Jones, Assistant Professor of Psychology. Dr. Jones can be reached by email at Jacob.Jones@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.
Best of luck with your research.
Sincerely,
Donna Garcia
Donna Garcia, Ph.D., IRB Chair
CSUSB Institutional Review Board
DG/MG

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