EMERGING ADULTS DELAY MENTAL ILLNESS TREATMENT: ANOTHER
MANIFESTATION OF EXPERIENTIAL AVOIDANCE?

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Emerging adulthood is a term coined to recognize 18 to 25 year-olds who engage in self-exploration while not yet fully identifying as adults. Many emerging adult college students experience stress, anxiety, and depression. Although many colleges provide affordable and available mental health resources for students, many students who need help appear to not utilize these services. Gaining greater understanding of underlying processes that influence psychological treatment-seeking behavior is imperative. The current study sought to explore the role experiential avoidance (EA) plays as a treatment-seeking barrier in the context of emerging adulthood. Undergraduate students completed online measures of emerging adulthood dimensions, psychological symptoms, EA, self-stigma of, perceived public stigma of, intentions to, and attitudes and beliefs towards seeking treatment, treatment seeking behavior, and a demographics questionnaire. Binomial hierarchical logistic regressions and correlational analyses examined the relationship of EA and treatment-seeking behaviors, accounting for known barriers and emerging adult characteristics. After controlling for demographic variables, results indicated that EA was significantly positively correlated with self-stigma \( r = .187, p < .001 \), perceived public stigma \( r = .178, p < .001 \), intentions \( r = .207, p < .001 \), psychological symptoms \( r = .713, p < .001 \), and attitudes and beliefs \( r = .009, p = .003 \). These and other findings are discussed further, along with the study limitations and implications, as well as possible future directions for work in this area.
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INTRODUCTION

Previous research demonstrates that delayed treatment of mental illness is a significant contributor to exacerbated maladaptive psychological outcomes (Wang, et al., 2005, 2007). Although researchers have identified barriers to seeking treatment for mental illness, none have investigated the role experiential avoidance (EA) plays in delayed treatment seeking for mental illness on a college campus in the context of emerging adulthood. Understanding the underlying processes that contribute to delays in seeking, or failure in seeking, treatment not only will benefit emerging adult college students, but also inform interventions and guide future research.

Emerging Adulthood

In the mid 1990s, Jeffrey Arnett conducted studies demonstrating how conceptualizations of adulthood have changed (Arnett, 1997). He found that defining features of adulthood in American society involved accepting responsibility for one’s self, engaging in independent decision making, and being financially independent (Arnett, 1997, 1998, 2003; Greene Wheatley, & Aldava, 1992). Arnett ultimately identified five features that characterize the culturally based developmental period he termed emerging adulthood (Arnett 1997, 1998, & 2000). Emerging adulthood, characterized by identity exploration, instability, self-focus, feeling-in-between, and having possibilities, applies to many individuals aged 18 to 25 years-old (Arnett, 2004).

Identity exploration. Individuals in the emerging adult developmental period are focused on discovering who they are, identifying who they would like to be, and assessing their interests and options primarily related to meaningful relationships, education, and life-fulfilling careers (Arnett, 2004; Mayseless & Keren, 2014). Three identified forms of exploration include exploration in breadth (e.g., actively trying out many identities), exploration in depth (e.g.,
evaluating presently maintained commitments), and ruminative exploration (e.g., maladaptive exploring; Luyckx, Goossens, Soenens, & Beyers, 2006; Luyckx, et al., 2008). Luyckx and colleagues (2008) found that exploration in breadth and in depth were uniquely related to higher levels of self-reflection, whereas ruminative exploration was uniquely related to higher levels of self-rumination. Furthermore, exploration in breadth and exploration in depth have been found to be positively associated with higher self-esteem (Luyckx et al., 2008). Ruminative exploration, however, has been found to positively associate with low self-esteem, anxiety symptoms, and depressive symptoms (Luyckx et al., 2008; Luyckx, Klimstra, Duriez, Van Petegem, & Beyers, 2013). Although many emerging adults reap informative life experiences through exploration, some emerging adults experience difficulties in this self-understanding process.

*Instability.* Arnett (2004) proposes that some emerging adults experience unstable lifestyles due to the nature of exploring various interests. In their search for self-conceptualization, many emerging adults experience changes in residences, educational tracks, and jobs leading to unstructured and unpredictable lifestyles (Arnett, 2000, 2004; Krahn, Howard, & Galambos, 2015). Instability, that accompanies these frequent changes, is significantly negatively associated with life satisfaction (Reifman, Arnett, & Colwell, 2007). Furthermore, emerging adults’ perceived instability has been found to be negatively associated with community integration and self-esteem, and positively associated with depressive symptoms and job exhaustion (Luyckx, De Witte, & Goossens, 2011). Instability is also observable in emerging adult relationships (Arnett, 2000), such as breaking up and reconciling with romantic partners and having sex with previous partners (Halpern-Meekin, Manning, Giordano, & Longmore, 2013). Additionally, Bowers, Segrin, & Joyce (2015) demonstrated that
instability was significantly positively associated with sexual risk taking behaviors. Even in the midst of this instability emerging adults are choosing to experience life and to obtain what they want in their futures as they develop themselves as individuals (Arnett, 2015).

**Self-focus.** Taking responsibility for identifying one’s desires and making them happen inherently includes focusing on one’s self (Arnett, 2004). Self-focus promotes emerging adults' self-sufficiency through knowledge and abilities development, as they prepare for life as adults (Arnett, 2015). Emerging adults, especially in college, are able to be self-focused due to typically being responsible for themselves by putting off having children and getting married (Arnett, 2014; Mitchell & Syed, 2015). Reifman, Arnett, and Colwell (2007) found that emerging adult individuals who have never been married scored lower on being other-focused (e.g., committing to and/or being responsible for others) than individuals who were engaged or married. Some research findings suggest trends of increased narcissism in emerging adults (see Twenge, 2013); however, other researchers have questioned these claims (see Arnett, 2013 for review). Although many emerging adults are in the process of determining their desires to live meaningfully and independently, they still do not fully meet society’s markers of adulthood (e.g., financial independence).

**Feeling in-between.** Emerging adults express sentiments of identifying as adults in some aspects, yet do not experience all of the responsibilities and expectations deemed characteristic of adulthood (Arnett, 2000; 2004). As mentioned previously, both financial independence and independent decision-making are markers of adulthood. Many emerging adults in college, a setting promoting autonomy, rely on their parents for financial support (Padilla-Walker, Nelson, & Carroll, 2012) and help in decision-making (Carlson, 2014). Unsurprisingly, Zorotovich (2014) found that emerging adult college students reported feeling in-between more so than their
non-college attending peers. Further, living with one’s parents likely prolongs emerging adults feeling in-between (Kins & Beyers, 2010). Although they have the freedom to make their own choices and act on them, many 18 to 25 year-olds, especially in college, do not fully identify as adults and thus experience a feeling of being in-between adolescence and adulthood.

*Possibilities.* Emerging adult individuals, especially in western cultures, tend to positively perceive the world as full of opportunities to be explored and utilized to fulfill personal high hopes and dreams (Arnett, 2004; Chang & Asakawa, 2003). Arnett (2004) proposed that the optimism accompanying this belief is a result of having not yet experienced the realities that life brings. This optimism, peaking among 18 to 23-year-olds, decreases as emerging adults age and acquire more life experiences (Reifman, Colwell, & Arnett, 2007). Although various individuals experience emerging adulthood differently (Arnett, 2000), most individuals identify as adults by the time they reach 30 years-old (Arnett, 2001; Arnett, & Schwab, 2014).

**Emerging Adults Attending College**

Consistent with findings that college graduates have greater financial and career opportunities than their high school graduate only peers (see Pascarella & Terenzini, 2005 for review), many emerging adults view attaining more educational training after high school as important for future financial and career opportunities (Clark University Poll of Emerging Adults, 2015). The Bureau of Labor Statistics (2014) reported that 68.4% of high school graduates directly transitioned to college, with two-thirds of these students attending four-year colleges. The college setting is typically associated with self-discovery such that over the course of one semester emerging adult students changed at least one worldview after experiencing a significant life event (Gutierrez & Park, 2015).
Attending college permits young individuals to embrace and experience their emerging adulthood (Arnett, 2015). Moving to college, to different dorm rooms, and to apartments are among the many changes of residence emerging adults will likely experience. Moving or transitioning to college may involve a physical separation from one’s parents and/or support system (Larose & Boivin, 1998). Many emerging adults thus find themselves with less parental supervision and more personal freedom (Fromme, Corbin, & Kruse, 2008). This unsupervised time permits emerging adults to make independent decisions, which may come in many forms such as engaging in risky behaviors (Fromme, Corbin, & Kruse, 2008), joining or leading student-lead organizations, or volunteering (Foubert & Grainger, 2006; Arnett, 2007).

Due to the many available options catering to various interests, emerging adult students’ college experience can appear vastly different. Nelson and Padilla-Walker (2013) identified three groups of emerging adult college students (well adjusted, externalizing, & poorly adjusted) based on differences in beliefs/attitudes, attributes, and behaviors. The well adjusted group (64% of the sample, \( n = 310 \)) consisted of individuals with the highest levels of religious faith and internalized values, and lowest levels of drinking, drug use, violent video game use, number of sexual partners, and pornography use. The externalizing group (28% of the sample; \( n = 134 \)) consisted of individuals whose levels of depression and self-worth did not differ from those in the well adjusted group, but who did have higher levels of drinking, drug use, violent video game use, number of sexual partners, and pornography use. The poorly adjusted group (8% of the sample; \( n = 39 \)) consisted of individuals who had the lowest levels of self-worth and the highest levels of depression and anxiety as well as the highest levels of drinking, drug use, and number of sexual partners. Furthermore, the well-adjusted group’s levels of anxiety, although lower than
the poorly adjusted group’s levels, were higher than the externalizing group’s levels of anxiety (Nelson & Padilla-Walker, 2013).

As indicated, some emerging adults struggle while attending college (Brock, 2010). Individuals who perceive themselves as not having a balanced life endorse decreased well-being and health (Gröpel & Kuhl, 2009). Carlson (2014) found that when experiencing difficulties in balancing work and social lives, relationships, finances, academics and career concerns, emerging adult college students sought advice from their parents. Similarly, out of a sample of 204 incoming freshman, 53% expected to seek parental assistance to solve personal problems (Kenyon & Koerner, 2009). Given that taking responsibility for one’s self and making decisions independently from parents are two of the identifiers of adulthood, individuals might be prolonging their emerging adulthood in how they respond to uncertain and potentially distressing situations.

Emerging Adult College Students’ Mental Health

For many emerging adults, aspects of attending college such as academic performance, pressure to succeed, and post-graduation plans are associated with greater endorsements of experiencing stress, anxiety, and depression (Beiter et al., 2015). In the Spring semester of 2014, the American College Health Association’s National College Health Assessment II (ACHA – NCHA II) assessed 66,887 undergraduate students from 140 institutions across the nation. They found that within the previous year, 53.8% self-reported “more than average” to “tremendous” levels of stress, 54.7% felt overwhelming anxiety, 33.2% felt so depressed that it was difficult to function, and 8.6% reported experiencing both depression and anxiety. Additionally, anxiety, depression, and stress were reported as the most prevalent concerns presenting across clients as
identified by clinicians on college campuses in the United States (Center for Collegiate Mental Health, 2015).

Although difficult life experiences are associated with psychological distress (Jackson & Finney, 2002), how an individual responds to those difficult life experiences is important. As mentioned earlier, ruminative exploration, unlike the other two forms of exploring adult options, is associated with lower self-esteem and higher levels of anxiety and depression (Luyckx et al., 2008). Further, Mahmoud, Staten, Hall, & Lennie (2012) found that maladaptive coping positively predicted stress, anxiety, and depression. Some individuals likely respond to stress, anxiety, and depression in a maladaptive manner, such as engaging in experiential avoidance (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Perhaps, how an individual responds to the experience of private events (e.g., thoughts, feelings, & bodily sensations) associated with stress, anxiety, and depression likely contributes to whether or not individuals seek treatment for psychological struggles. According to the aforementioned 2014 ACHA – NCHA II report, only 36% (n = 8,093) of the 22,206 undergraduate students who felt so depressed that it was difficult to function were diagnosed with or treated by a professional for depression. Additionally, only 26% (n = 9,564) of the 36,587 undergraduates who felt overwhelming anxiety were diagnosed with or treated by a professional for anxiety. Based on these statistics, there are many emerging adult college students who would likely benefit from seeking treatment, but have not sought professional help.

**Modes of Help-Seeking**

Individuals can seek help from both formal and informal help-seeking sources when experiencing psychological struggles (Rickwood & Thomas, 2012). According to Rickwood & Thomas (2012), formal help-seeking involves seeking assistance from professionals able to
provide pertinent advice, support, and/or treatment, whereas informal help-seeking involves seeking assistance from an individual’s social support system. An individual’s psychological outcome will, therefore, likely depend upon from whether and how an individual chooses to seek help.

_Treatment-seeking_. Formal help-seeking can be further understood in terms of the type of professional’s help being sought. For example, within the context of a college campus, one student may seek help from a professor or academic advisor, whereas another student may seek help from psychological services provided on campus. Although both students sought help from formal sources, the latter student was, more specifically, seeking treatment. Therefore, treatment seeking is defined as seeking help from providers of specific health services (Rickwood & Thomas, 2012). According to Rickwood, Deane, & Wilson (2007) treatment is associated with reduced long-term impacts of psychological symptoms and acts as a protective factor against the development of exacerbated symptoms. This is important for emerging adults attending college, because low psychological symptoms and high subjective well-being have been associated with greater academic success (Antaramian, 2015). Additionally, treatment has been associated with improvements in workforce productivity due to decreased psychological symptoms and decreased absences from work (see Wang, Simon, & Kessler, 2003 for review.) Therefore, psychological treatment is not only effective for the individual (Minami et al., 2009), but also cost effective for society (Wang, et al., 2003).

Many universities and colleges offer on-campus psychological services for students to utilize (Reetz, Krylowicz, & Mistler, 2014). On various campuses these affordable and accessible services may include individual counseling, group therapy, and couples counseling (Reetz, et al., 2014). Students aged 18 or older are responsible for their own mental health
treatment. As examples, students are required to provide information regarding presenting problems and must schedule their appointments with the clinician. Although research findings suggest college students’ utilization of on-campus services have been increasing over time, there are many students not seeking help from on-campus mental-health professionals (see Eisenberg, Hunt, & Speer, 2012 for a review).

Delayed/failure to seek treatment. When students do not seek treatment, they are likely either seeking help from non-psychology-specific professionals such as general practitioners, seeking help from informal sources such as friends and family, or trying to cope with their psychological struggles on their own (Rickwood & Thomas, 2012; Eisenberg, Hunt, Speer, & Zivin, 2011). Each of these options likely leads to either delayed treatment, or failure to seek treatment altogether. The course of psychological symptoms varies, as does the degree to which symptoms affect peoples' functioning (Wang, Berglund, Olfson, Pincus, Wells, & Kessler, 2005; Wang et al., 2007). For some people, symptoms simply go away over time, but for others the symptoms get worse. Some people can function with symptoms present, but some people are completely incapacitated. As a result of exacerbated symptoms, delaying treatment or failing to seek treatment is associated with decreased academic success and dropping out of college (Eisenbeg, Golberstein, & Hunt, 2009). Therefore, understanding the barriers associated with emerging adult delayed treatment-seeking behaviors is important for promoting college student success.

Treatment Seeking Barriers

There are many environmental factors that contribute to behavior (e.g., seeking or not seeking treatment). Because individuals can engage in the same behavior for varying reasons, examining the context of the behavior can lead to better understanding the purpose, or function,
that behavior was serving. Previous research has established that various factors, such as stigma, lack of intentions to seek treatment, and negative attitudes and beliefs towards seeking psychological treatment act as barriers to emerging adults seeking treatment for mental health difficulties. Therefore, these barriers should be examined to better understand the purpose that delayed treatment (or failure to seek treatment) serves for emerging adults experiencing psychological difficulties.

*Stigma of seeking treatment.* One of the highly cited barriers to psychological treatment seeking is stigma (Corrigan, 2004). Lannin, Vogel, Brenner, and Tucker (2015) define the stigma of seeking psychological treatment as the “stereotyping, separation, status loss, and discrimination experienced by someone who seeks help, or is considering seeking help, from a mental health professional” (p. 66). Research further identifies a distinction between self-stigma and public stigma in terms of the behavior of seeking treatment for mental health difficulties (Lannin, Vogel, Brenner, & Tucker, 2015). Self-stigma of seeking psychological treatment is conceptualized as perceiving oneself as flawed when seeking treatment, due to perceiving mental health treatment seeking as socially unacceptable (Corrigan, 2004; Vogel, Wade, & Haake, 2006). Self-stigma of seeking treatment has been associated with less positive attitudes towards seeking treatment, less intention to seek treatment, and decreased self-esteem (Vogel et al., 2006). Self-stigma of treatment seeking has been shown to significantly decrease after an individual sought treatment (Vogel et al., 2006; Wade, Post, Cornish, Vogel, & Tucker, 2011).

Self-stigma of treatment seeking has been shown to predict perceived public stigma of treatment seeking among undergraduate students (Lannin et al., 2015). Public stigma associated with seeking psychological treatment is conceptualized as perceiving that an individual who seeks psychological treatment is socially unacceptable (Vogel et al., 2006). Perceived public
stigma of seeking treatment has been demonstrated to predict less emotional openness and less positive attitudes toward help seeking (Komiya, Good, & Sherrod, 2000). Therefore, self-stigma and/or perceived stigma are likely alleviated when emerging adults avoid seeking treatment.

Although similar, stigma of seeking psychological treatment is conceptually and empirically distinct from self-stigma of mental illness (Tucker et al., 2013; Clement et al., 2015). Self-stigma of treatment seeking significantly negatively predicted intentions to seek treatment, whereas self-stigma of mental illness was not significantly related (Tucker et al., 2013; Lannin et al., 2015). Additionally, Vogel, Wade, and Hackler (2007) found that self-stigma of seeking treatment mediated the relationship between public stigma of mental illness and attitudes towards seeking treatment. Consistent with these findings, Tucker (2012) found that self-stigma of seeking treatment was negatively related to treatment seeking, whereas self-stigma of mental illness was not significantly related. The present study therefore focused on stigma of seeking psychological treatment.

**Intentions to seek treatment.** Many help-seeking studies have conceptualized intentions to seek treatment as a function of attitudes toward seeking treatment, and perceived judgments or pressure from others (e.g., stigma; Ajzen & Fishbein, 1980; Eisenberg et al., 2012). There are many contextual variables, however, not being taken into account (Biglan & Hayes, 1996). For instance, across cultures males report greater stigmatization, more negative attitudes and fewer intentions to seek treatment than females (Addis & Mahalik, 2003; Seyfi, Poudel, Yasuoka, Otsuka, & Jimba, 2013). Another important contextual factor is that these intentions to seek treatment are occurring during various developmental periods. A majority of psychological research is conducted with undergraduate student samples. Understanding undergraduates’ intentions to seek treatment in the context of emerging adulthood, a time of pursuing autonomy,
while considering the need for psychological treatment is important. Wilson, Rickwood, Bushnell, Caputi, and Thomas (2011) found that emerging adults are more likely to intend to seek help from family and friends than they are to seek treatment from professionals. This finding is unsurprising given the importance of relationships in emerging adults’ lives. However, Wilson and Deane (2010) found that increased suicidal ideation is associated with decreased intentions to seek help from both formal and informal help-seeking sources. Therefore, as previously mentioned, how an individual responds to, or copes with, distressing thoughts, feelings, and emotions is important.

**Attitudes toward seeking treatment.** Another barrier to seeking psychological treatment is negative attitudes toward seeking treatment (Kim, Britt, Klocko, Riviere, & Adler, 2011; Eisenberg, Hunt, & Speer, 2012). Previous research has focused on the importance of this barrier such that most models attempting to predict treatment-seeking behavior include attitudes toward seeking treatment (Eisenberg et al., 2012). Additionally, studies conducted with varying cultural samples have demonstrated that negative attitudes toward seeking treatment predict decreased intentions to seek psychological treatment in emerging adults (Pheko, Chilisa, Balogun, & Kgathi, 2013; Thomas, Caputi, & Wilson, 2014). Negative attitudes have been shown to be predicted by avoidant factors including the decreased tendency to disclose, increased anticipated risk of disclosing, and increased tendency to conceal personally distressing information (Vogel & Wester, 2003; Kelly & Achter, 1995).

**Experiential Avoidance**

Experiential Avoidance (EA) is a process involving attempts to avoid private events (i.e., thoughts, feelings, emotions), combined with an unwillingness to be present with and experience those events (Hayes et al., 1996). When engaging in thought suppression, or cognitive avoidance,
individuals are likely to experience, with greater frequency, the very thoughts and emotions they are attempting to escape (Hayes et al., 1996; Wenzlaff & Wegner, 2000). Unsurprisingly, Kashdan, Barrios, Forsyth, and Steger (2006) found that individuals engaging in EA are more likely to report more frequent negative life events, negative life appraisals, and greater negative affective experiences. Negatively interpreting private events is an important aspect of EA, and influences the exacerbation of psychological symptoms. For instance, individuals high in EA are more likely to experience emotional distress in the form of anxiety, depression, and stress (Bardeen & Fergus, 2016; Feldner, Zvolensky, Eifert, & Spira, 2003).

As Blackledge and Hayes (2001) describe, when individuals avoid negatively labeled thoughts, feelings, and emotions that occur when taking, or even considering taking risks, individuals likely avoid the very risks that might lead them to achieve a goal that is personally important. Therefore, when the goal is to seek-treatment for one’s psychological difficulties, risks that may be involved in attaining this goal might include experiencing negatively labeled thoughts and feelings associated with self-stigma and perceived public stigma of, low intentions to, and negative attitudes and beliefs towards seeking treatment. If individuals actively engage in avoidance to experience relief from the previously mentioned risks, the relief can come at the price of achieving a personally important goal: seeking treatment. This is important because goals enable individuals to behave consistently with their values, or freely chosen life directions.

Van Dyke, Rogers, & Wilson (2006) found that individuals who report low valuing (i.e., not behaving consistently with what is personally important), also report greater distress and greater EA. This finding is consistent with several studies demonstrating that high valuing is negatively correlated with various symptoms of psychopathology (Adcock, Murrell, & Woods, 2007; Taravella, 2010; McCracken & Yang, 2006). Taken together, these studies suggest an
inverse relationship between valuing and experiential avoidance, and a positive association between experiential avoidance and psychological distress.

The relationships among valuing, EA, and psychological distress are important when considering differences between the aforementioned well adjusted, externalizing, and poorly adjusted emerging adult college student groups (Nelson & Padilla-Walker, 2013). One major distinction between the three groups, in the study by Nelson & Padilla-Walker (2013) was that the well adjusted group had a stronger sense of internal values than the externalizing and poorly adjusted groups. Perhaps the externalizing and poorly adjusted groups are experiencing greater EA. Vogel and Wester (2003) found that various forms of avoidance predicted low intentions to seek, and negative attitudes and beliefs towards seeking treatment. Similarly, Corrigan (2004) posits that individuals might avoid seeking treatment due to attempts of distancing themselves from perceived public stigma. Further, negative attitudes toward seeking treatment, which are significantly negatively predicted by self-stigma of seeking treatment, are significantly associated with a low willingness to seek treatment (Vogel et al., 2007), another important aspect of EA. Since research has established that emerging adults are experiencing psychological distress, but many are not seeking treatment, EA may be a contributing factor.

The Present Study

Emerging adulthood is characterized by exploring one’s identity in the midst of feeling in-between adolescence and adulthood (Arnett, 2014). This developmental period also includes unstable lifestyles, being focused on one’s self to identify interests, and optimism about possible future relationships as well as academic, and career options to pursue and obtain (Arnett, 2015). A setting in which these emerging adult characteristics often may unfold and be experienced is college. For individuals trying to figure out themselves and their desires; however, the pressures
and expectations of college can be difficult (Beiter et al., 2015). When experiencing life stressors some individuals engage in avoidant coping (Mahmoud et al., 2012). The very nature of emerging adulthood (e.g., instability & feeling in-between) may contribute to the maintenance of engaging in avoidance. Avoidant coping strategies such as suppression have been linked to decreased experience and expression of positive emotions, increased experience of negative emotions, decreased interpersonal functioning, and decreased well-being (Gross & John, 2003).

Research indicates there is a subset of the emerging adult college student population experiencing psychological distress. Despite many campuses providing psychological services for students (Reetz et al., 2014), there are many emerging adults not seeking the help they likely need (American College Health Association, 2014). Although various studies have identified barriers to seeking treatment, research had yet to explore the role EA plays as a barrier to seeking professional psychological treatment in the context of emerging adulthood. This study therefore sought to investigate the relationship between EA and treatment seeking behaviors when accounting for previously identified treatment-seeking barriers and dimensions of emerging adulthood.

Hypothesis 1: EA would be significantly related to self-stigma of seeking treatment, perceived public stigma of seeking treatment, intentions to seek treatment, psychological symptoms, and attitudes and beliefs toward seeking treatment. Specifically:

1a. There would be a significant positive relationship between EA and self-stigma of seeking treatment.

1b. There would be a significant positive relationship between EA and perceived public-stigma of seeking treatment.
1c. There would be a significant negative relationship between EA and intentions to seek treatment.

1d. There would be a significant positive relationship between EA and psychological symptoms.

1e. There would be a significant negative relationship between EA and positive attitudes and beliefs toward seeking treatment.

Hypothesis 2: Based on previous studies, self-stigma of seeking treatment, perceived public stigma of seeking treatment, intentions to seek treatment, psychological symptoms, and attitudes and beliefs toward seeking would significantly relate to treatment-seeking behaviors.

Hypothesis 3: EA would negatively relate to treatment seeking.

3a. EA would significantly relate to unique variance of the likelihood of treatment seeking behaviors above and beyond dimensions of emerging adulthood, self-stigma of seeking treatment, perceived public stigma of seeking treatment, intentions to seek treatment, psychological symptoms, and attitudes and beliefs toward seeking treatment.

Given that there is no current literature to date regarding emerging adulthood dimensions and treatment seeking, or EA and emerging adulthood dimensions exploratory analyses were used to address these questions.
METHODS

Participants

College students were recruited from the University of North Texas’ student population. Individuals enrolled to participate in research studies to earn extra credit, or as part of their course requirements. Of the 965 individuals who were interested in the study, 964 consented to participate. After data cleaning, the sample size of 929 was used for data analysis (see discussion below). Depending on the course in which they were enrolled, upon completion of the study they received either mandatory credit or extra credit, capped at 2 credits, for participating in the study. Given the study’s inclusionary criteria, participants spoke English fluently and ages ranged from 18 to 25 ($M = 20.36, SD = 1.99$). No additional exclusion or inclusion criteria were utilized. Participants matched the demographic composition of the Sona Systems pool (a software used to recruit university students in research and link them to studies in which they meet criteria).

The sample consisted mostly of heterosexual (84.8%), single (75%), Christian (60.7%), females (67.7%), majoring in psychology (50.6%). The majority of participants identified as White/European American (42.5%), whereas 24.3% identified as Latino/Hispanic, and 16.7% identified as Black/African American. The sample consisted of a fairly even distribution regarding classification from first year to fourth year undergraduates. Regarding income, similar percentages of individuals reported having a yearly income of less than $20,000, and a yearly income of $50,000 to $100,000. Lastly, 67.2% of participants’ parents provide more than 50% of the participant’s income. Additionally, participants were asked if they had attended mental health counseling/therapy as a student either on or off campus. The majority of participants (71.5%)
indicated they had not sought services, while 28.5% indicated they had sought services. More information about the sample's demographic composition is presented in Table 1.

**Measures**

*Demographics questionnaire.* Participants completed a demographics questionnaire to determine: age, gender/sex, relationship status, race/ethnicity, sexual orientation, religious affiliation, educational level, major, yearly income, and if someone other than themselves provided more than half of their incomes.

*Treatment-seeking behavior outcome measure.* Treatment seeking behavior was measured with the following question: “Have you attended mental health counseling/therapy as a student?”

*Self-Stigma of Seeking Help Scale (SSOSH; Vogel, Wade, & Haake, 2006).* The SSOSH is a 10-item self-report measure developed to assess an individual’s level of self-stigma associated with seeking psychological services. Items include “If I went to a therapist I would be less satisfied with myself” and “My view of myself would not change just because I made the choice to see a therapist.” Each item is scored on a Likert-like scale ranging from 1 (strongly disagree) to 5 (strongly agree), with half of the items reverse scored. Total scores range from 10 to 50, with higher scores indicating greater self-stigma of seeking psychological help. Tucker and colleagues (2013) reported that the SSOSH demonstrated good internal consistency with Cronbach’s alpha ranging from .90 for a sample of undergraduate students experiencing psychological distress, to .92 for a sample of community members with a history of mental illness. Vogel and colleagues (2007) found adequate concurrent validity where SSOSH uniquely predicted attitudes towards seeking ($r = -.65$) and intentions to seek ($r = -.37$) treatment. Additionally, the SSOSH was found to distinguish between participants who did and did not
engage in treatment seeking behaviors over a 2-month period (Vogel et al., 2006). In this sample, the SSOSH evidenced an internal consistency reliability of .84.

**Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, Good, Sherrod, 2000).** The SSRPH is a 5-item self-report questionnaire assessing an individual’s perception of the public stigma they might experience when seeking psychological treatment. Sample items include “It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems” and “People tend to like less those who are receiving professional psychological help.” Each item is scored on a Likert-like scale ranging from 1 (strongly disagree) to 4 (strongly agree). Total scores were calculated with higher scores indicating greater perceived stigma associated with receiving psychological treatment. The SSRPH demonstrated decent internal consistency (α = .72) in a sample of undergraduate students (Komiya et al., 2000). The SSRPH demonstrated adequate construct validity in significantly negatively correlating (r = .40) with attitudes toward seeking help indicating the less public stigma an individual perceives, the more positive attitudes and beliefs they hold toward seeking-treatment (Komiya et al., 2000). The α of the SSRPH in the current study was .56.

**Attitudes toward Seeking Professional Psychology Help (ATSPPH; Fischer & Turner, 1970).** The ATSPPH is a 29-item self-report measure designed to assess attitudes towards seeking psychological treatment. Items include “Although there are clinics for people with mental troubles, I would not have much faith in them” and “It is probably best not to know everything about oneself.” Items are rated on a Likert-like scale ranging from 0 (disagree) to 3 (agree). Total scores, ranging from 0 to 87, were calculated with higher scores suggesting a positive attitude toward seeking treatment. Modifications made by previous studies (Atkinson & Gim, 1989; Masuda, Anderson, & Edmonds, 2012), were used. The words
“psychologist/counselor,” and “psychological counseling center” replaced “psychiatrist” and “mental health center,” in order to enhance the relevancy for an emerging adult college sample. Masuda and colleagues (2012) reported adequate internal consistency with a Cronbach’s alpha of .85 in a sample of African American undergraduate students. The revised scale correlates with previous use of professional help for a problem, $r = .39$ (Vogel, Wester, Wei, & Boysen, 2005), and in this sample its internal consistency reliability was ($\alpha = .89$).

*Intentions to Seek Counseling (ISCI; Cash, Begley, McCown, & Weise, 1975).* The ISCI is a 17-item self-report questionnaire that measures an individual’s intentions to seek counseling from a university counseling center for various problems typically sought by college students (e.g., relationship difficulties and self-understanding; Cepeda-Benito & Short, 1998). The ISCI is comprised of three subscales including Psychological and Interpersonal Concerns, Academic Concerns, and Drug Use Concerns. Items are rated on a Likert-type scale ranging from 1 (*very unlikely*) to 4 (*very likely*). Total scores ranging from 17 to 68 were calculated, with higher scores indicating greater likelihood of intending to seek counseling. The ISCI has demonstrated good internal consistency in a sample of undergraduate students ($\alpha = .89$; Cepeda-Benito & Short, 1998). For this sample, the ISCI demonstrated adequate predictive validity ($r = .19$). The ISCI negatively associated with attitudes and beliefs towards seeking treatment ($r = -.39$), and negatively associated with self-stigma of seeking treatment ($r = -.28$). In the current sample, the Cronbach's alpha for the ISCI was .90.

*Depression Anxiety and Stress Scale – 42 Item (DASS – 42; Lovibond & Lovibond, 1995).* The DASS is a 42-item self-report questionnaire designed to assess an individual’s experience of depression, anxiety, and stress from the previous week. Items are rated on a Likert-like scale ranging from 0 (*did not apply to me at all*) to 3 (*applied to me very much, or most of the time*).
Items include “I was aware of dryness of my mouth” and “I was unable to become enthusiastic about anything.” Total scores ranging from 0 to 126 were calculated with higher scores indicating greater psychological symptoms and severity. The DASS scales have demonstrated good internal consistency of depression ($\alpha = .95$), anxiety ($\alpha = .91$), and stress ($\alpha = .93$) in a sample of undergraduate students (Schmalz & Murrell, 2010). The DASS demonstrated adequate construct validity with the depression scale positively relating to a measure of depression, the anxiety scale positively relating to a measure of anxiety, and the stress scale positively relating to measures of both depression and anxiety in both clinician and non-clinical adult samples (Antony, Bieling, Cox, Enns, & Swinson, 1998). The internal consistency reliability in the current sample was .97.

*Avoidance and Fusion Questionnaire for Youth (AFQ-Y; Greco, Murrell, & Coyne, 2005).* The AFQ-Y is a self-report measure used to assess psychological inflexibility engendered by cognitive fusion, experiential avoidance, and ineffective behaviors when negatively evaluated private events occur. The scale consists of 17 items assessing the dimensions of inflexibility by measuring cognitive fusion (e.g., “The bad things I think about myself must be true.”), avoidance (e.g., “I push away thoughts and feelings that I don’t like”) and behavioral ineffectiveness when unwanted internal experiences occur (e.g., “My life won’t be good until I feel happy”). Items are rated on a Likert-type scale ranging from 0 (*not at all true*) to 4 (*very true*). Total scores, ranging from 0 to 68, were calculated with higher scores indicating greater psychological inflexibility. The AFQ-Y demonstrated adequate internal consistency ($\alpha = .90$) in a validation study by Greco, Lambert, and Baer (2008). Although it was developed for children, Schmalz and Murrell (2010) found that use with adult undergraduate students was psychometrically appropriate. They reported strong reliability ($\alpha = .92$) and good construct validity in a sample of adults.
Additionally, Fergus and colleagues (2012) reported adequate convergent, discriminant, and concurrent validity predicting psychological symptoms in two adult samples. In the current study, the Cronbach’s alpha was .92.

*Inventory of the Dimensions of Emerging Adulthood (IDEA; Reifman, Arnett, & Colwell, 2007).* The IDEA is a 31-item self-report questionnaire with six factors designed to assess the characteristics of emerging adulthood. The question, “Is this period of your life a…” is posed first then items are listed as questions (e.g., time of many possibilities?, time of high pressure?). Items are rated on a Likert-type scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Total scores of each dimension were calculated with higher scores suggesting greater identification of that particular characteristic of emerging adulthood. In the original study, the IDEA factors demonstrated fair to good internal consistency with Cronbach’s alpha ranging from .70 to .85 in a sample of undergraduate students (Reifman et al., 2007). The IDEA factors are highly face valid, and evidence questionable construct validity (Reifman, et al., 2007). The present study overall demonstrated better internal reliability consistency for each dimension, compared to previous research. The dimensions in the present study had alphas of .89 for identity exploration, .87 for experimentation/possibilities, .84 for negativity/instability, .68 for other-focused, .85 for self-focused, and .80 for feeling in-between. The present study also demonstrated a different pattern than previous research. Previous studies reported alphas of .63-.66 for the self-focus dimension, with all other dimensions having alphas .70 or higher (Zaluski, 2012; Zorotovich, 2014). Significant correlations with other constructs to assess validity of the subscales in this study are presented in the results section.
Procedure

The author’s research institute’s IRB approved all research activities. Using a cross-sectional survey design, participants completed the self-report measures online through a Qualtrics survey that was accessed through UNT Sona Systems. Informed consent was obtained before access to the Qualtrics survey; without agreed consent, the survey terminated immediately. The survey consisted of measures given in the same order for each participant: SSOSH, SSRPH, ATSPPH, ISCI, DASS, AFQ-Y, IDEA. All measures were administered in one sitting. After completing the survey, participants were presented with a demographics questionnaire, including the treatment seeking behavioral measure and associated questions. The demographics questions were presented last because they contained information previously associated with the various measures given in the survey. The researcher wanted to control for participants being primed to answer a certain way on the survey measures. Credits were awarded automatically after survey completion through a secure link between Qualtrics and the UNT Sona system, based on the participant’s deidentified participant ID. Although participation time varied, 1 credit was awarded per every half hour completed.
RESULTS

Initial Data Cleaning and Analyses

All analyses were conducted using SPSS v22. Data was first inspected graphically (i.e., histograms & scatterplots) to identify univariate and multivariate outliers and missing data. Univariate outliers were found and removed from variables of interest: attitudes and beliefs (n=4), and perceived public stigma of seeking treatment (n=5). Univariate outliers for the emerging adult dimensions were not removed from analyses due to the nature of the information provided by this data (n=18). No multivariate outliers were detected. Missing data was screened for patterns as outlined by Tabachnick and Fidell (2013); no patterns were detected. Cases missing entire measures assessing variables of interest were removed (n=26). One case was removed due to the same participant completing the measure twice. Mean imputation was used to address cases that had 1 or 2 items missing per measure on variables of interest: psychological symptoms, attitudes and beliefs of treatment seeking, and emerging adulthood dimensions (0.01% of missing data).

Next, descriptive statistical analyses and inspections of distributions were performed to assess for normality, linearity, and homoscedasticity (for correlational analyses), and multicollinearity (for logistic regression analyses; Tabachnik & Fidell (2013). The following variables were not normally distributed: experiential avoidance, psychological symptoms, identity exploration, experimentation/possibilities, self-focused, feeling in-between, and negativity/instability. The following data transformations were used: square root for experiential avoidance, logarithmic for psychological symptoms and negativity/instability, and inverse for identity exploration, experimentation/possibilities, self-focused, and feeling in-between. See Table 2 for reported means, standard deviations, and ranges for variables used in analyses. After
transformations were performed, multicollinearity was tested via correlational analyses. Correlations between variables were not larger than 0.9 (Tabachnick & Fidell, 2013), tolerance was not below 0.2 (Menard, 1995), and VIF was less than 10 (Myers, 1990) indicating that multicollinearity was not found.

ISCI and IDEA Validity

Pearson’s product-moment-correlation coefficients were conducted to assess validity of the ISCI and IDEA measures. The ISCI, the intentions to seek counseling measure, was significantly positively correlated with treatment seeking \( (r = .19, p < .001) \), significantly negatively associated with attitudes and beliefs towards seeking treatment \( (r = -.39, p < .001) \), and significantly negatively associated with self-stigma of seeking treatment \( (r = -.28, p < .001) \).

The IDEA identity exploration subscale was significantly negatively associated with positive attitudes and beliefs towards seeking treatment \( (r = -1.79, p < .001) \), positively associated with experiential avoidance \( (r = .076, p =.020) \), negatively related to self-stigma of seeking treatment \( (r = -.152, p < .001) \), and positively related to intentions to seek treatment \( (r = .164, p < .001) \).

The experimentation/possibilities subscale was significantly negatively associated with positive attitudes and beliefs towards seeking treatment \( (r = -.220, p < .001) \), negatively associated with psychological distress \( (r = -.163, p < .001) \), negatively to self-stigma \( (r = -.194, p < .001) \) and positively related to intentions to seek treatment \( (r = .136, p < .001) \).

The negativity/instability subscale was significantly negatively associated with experiential avoidance \( (r = -.395, p <.001) \), negatively associated with psychological distress \( (r = -.340, p < .001) \), negatively related to perceived public-stigma of seeking treatment \( (r = -.163, p < .001) \), negatively to self-stigma \( (r = -.130, p < .001) \) and negatively related to intentions to seek treatment \( (r = -.103, p = .002) \).
The feeling in-between subscale was significantly negatively associated with positive attitudes and beliefs towards seeking treatment \( (r = -0.139, p < 0.001) \), positively related to experiential avoidance \( (r = 0.131, p < 0.001) \), negatively associated self-stigma to seek treatment \( (r = -0.133, p < 0.001) \) and positively related to intentions to seek treatment \( (r = 0.131, p = 0.002) \).

The self-focused subscale was significantly negatively associated with positive attitudes and beliefs towards seeking treatment \( (r = -0.221, p < 0.001) \), negatively related to experiential avoidance \( (r = -0.075, p = 0.021) \), negatively associated with psychological distress \( (r = -0.194, p < 0.001) \), negatively related to self-stigma to seek treatment \( (r = -0.236, p < 0.001) \), negatively related to perceived public stigma \( (r = -0.072, p = 0.029) \), and positively related to intentions to seek treatment \( (r = 0.145, p < 0.001) \).

The other-focused subscale was significantly positively related to intentions to seek treatment \( (r = 0.134, p < 0.001) \).

Hypothesis Testing

Hypothesis 1 stated that EA (as measured by the AFQ-Y) would be significantly related to self-stigma of seeking treatment (SSOSH), perceived public stigma of seeking treatment (SSRPH), intentions to seek treatment (ISCI), psychological symptoms (DASS), and attitudes and beliefs toward seeking treatment (ATSPPH). Partial correlational analyses (Pearson’s product-moment-correlation coefficients) indicated that Hypothesis 1 was supported. After controlling for demographic variables, EA was significantly positively correlated with self-stigma of seeking treatment \( (r = 0.187, p < 0.001) \), perceived public stigma of seeking treatment \( (r = 0.178, p < 0.001) \), intentions to seek treatment \( (r = 0.207, p < 0.001) \), psychological symptoms \( (r = 0.713, p < 0.001) \), and attitudes and beliefs toward seeking treatment \( (r = 0.099, p = 0.003) \). See Table 3 for bivariate correlations between demographic variables and variables used in analyses.
Hypothesis 2 stated that self-stigma of seeking treatment (SSOSH), perceived public stigma of seeking treatment (SSRPH), intentions to seek treatment (ISCI), psychological symptoms (DASS), and attitudes and beliefs toward seeking treatment (ATSPPH) would significantly relate to treatment-seeking behaviors. A binomial hierarchical logistical regression was conducted. All demographic variables were entered into the first block. The continuous predictor variables, SSOSH, SSRPH, ISCI, DASS, and ATSPPH, were entered into the second block. The categorical dependent variable was treatment seeking behavior.

In the overall model, demographic variables were not significantly related to treatment seeking. In the second step of the model, self-stigma of seeking treatment did not significantly relate to seeking treatment (Wald statistic (1) = 0.97, \( p = .325 \), (\( B \)) = -0.02, \( SE = 0.02 \), \( Exp(B) = .98 \), 95% CI [0.95, 1.02]). Perceived public stigma of seeking treatment did not significantly relate to seeking treatment (Wald statistic (1) = 2.08, \( p = .149 \), (\( B \)) = -0.06, \( SE = 0.04 \), \( Exp(B) = .94 \), 95% CI [0.86, 1.02]). Intentions to seek treatment did not significantly relate to seeking treatment (Wald statistic (1) = 0.82, \( p = .367 \), (\( B \)) = 0.01, \( SE = 0.01 \), \( Exp(B) = 1.01 \), 95% CI [0.99, 1.03]). Psychological symptoms significantly positively related to seeking treatment (Wald statistic (1) = 54.64, \( p < .001 \), (\( B \)) = 4.74, \( SE = 0.64 \), \( Exp(B) = 114.49 \), 95% CI [32.57, 402.39]). Attitudes and beliefs toward seeking treatment significantly negatively related to seeking treatment (Wald statistic (1) = 13.16, \( p < .001 \), (\( B \)) = -0.04, \( SE = 0.01 \), \( Exp(B) = .97 \), 95% CI [0.95, 0.98]). Hypothesis 2 was partially supported.

Hypothesis 3 stated that EA would significantly negatively relate to treatment seeking. A binomial logistic regression was conducted. Demographic variables were entered into the first block. The total AFQ-Y score was then entered as the continuous predictor variable, and treatment seeking was entered as the categorical dependent variable. Major was significantly
related to treatment seeking (Wald statistic (1) = 5.86, $p = .016$, $(B) = 0.41$, $SE = 0.17$, $Exp(B) = 1.50$, 95% CI [1.08, 2.07]). Two levels of Income (i.e., between $20,001 - $49,999, and between $50,000 - $100,000) were also significantly related to treatment seeking as compared to those reporting a yearly income greater than $100,001. More specifically, “Between $20,001 - $49,999” was negatively related (Wald statistic (1) = 5.58, $p = .018$, $(B) = -0.63$, $SE = 0.27$, $Exp(B) = 0.53$, 95% CI [0.32, 0.90]), and “Between $50,000 - $100,000” was negatively related (Wald statistic (1) = 4.45, $p = .035$, $(B) = -0.54$, $SE = 0.26$, $Exp(B) = 0.58$, 95% CI [0.35, 0.96]).

After controlling for demographic variables, EA significantly positively related to treatment seeking (Wald statistic (1) = 29.60, $p < .001$, $(B) = 0.42$, $SE = 0.08$, $Exp(B) = 1.53$, 95% CI [1.31, 1.78]). Although EA significantly related to treatment seeking, the relationship was not in the hypothesized direction; therefore Hypothesis 3 was not supported.

Hypothesis 3a stated that EA (AFQ-Y) would significantly predict unique variance of treatment seeking behaviors above and beyond demographic variance and dimensions of emerging adulthood (as measured by the IDEA), self-stigma of seeking treatment (SSOSH), perceived public stigma of seeking treatment (SSRPH), intentions to seek treatment (ISCI), psychological symptoms (DASS), and attitudes and beliefs toward seeking treatment (ATSPPH). A binomial hierarchical logistic regression was conducted. Demographic categorical variables were entered into the first block. Continuous predictor variables (SSOSH, SSRPH, ISCI, DASS, ATSPPH, and IDEA subscales) were entered into the second block. The continuous predictor variable, AFQ-Y, was entered into the third block, and treatment seeking behavior was the categorical dependent variable.

In the overall model, demographic variables were not significantly related to seeking treatment.
After accounting for those demographic variables, self-stigma of seeking treatment did not significantly relate to seeking treatment (Wald statistic (1) = 1.72, \( p = .189 \), (\( B \)) = -0.02, \( SE = 0.02 \), \( Exp(B) = .98 \), 95% CI = [0.94, 1.01]). Perceived public stigma of seeking treatment did not significantly relate to seeking treatment (Wald statistic (1) = 1.43, \( p = .232 \), (\( B \)) = -0.05, \( SE = 0.04 \), \( Exp(B) = .95 \), 95% CI [0.87, 1.03]). Intentions to seek treatment did not significantly relate to seeking treatment (Wald statistic (1) = 2.05, \( p = .153 \), (\( B \)) = 0.01, \( SE = 0.01 \), \( Exp(B) = 1.01 \), 95% CI [1.00, 1.03]). Psychological symptoms significantly positively related to seeking treatment (Wald statistic (1) = 20.16, \( p < .001 \), (\( B \)) = 3.98, \( SE = 0.89 \), \( Exp(B) = 53.73 \), 95% CI [9.44, 305.85]). Attitudes and beliefs toward seeking treatment significantly negatively related to seeking treatment (Wald statistic (1) = 14.72, \( p < .001 \), (\( B \)) = -0.04, \( SE = 0.01 \), \( Exp(B) = .96 \), 95% CI [0.95, 0.98]).

Regarding the IDEA subscales, Identity Exploration did not significantly relate to seeking treatment (Wald statistic (1) = 0.01, \( p = .980 \), (\( B \)) = 0.02, \( SE = 0.61 \), \( Exp(B) = 1.02 \), 95% CI [0.31, 3.37]), and Experimentation/ Possibilities did not significantly relate to seeking treatment (Wald statistic (1) = .060, \( p = .807 \), (\( B \)) = -0.16, \( SE = 0.66 \), \( Exp(B) = .85 \), 95% CI [0.24, 3.08]). Further, Negativity/Instability did not significantly relate to seeking treatment (Wald statistic (1) = 0.46, \( p = .498 \), (\( B \)) = 0.57, \( SE = 0.84 \), \( Exp(B) = 1.76 \), 95% CI [0.34, 9.06]). Feeling in-between did not significantly relate to seeking treatment (Wald statistic (1) = 2.27, \( p = .132 \), (\( B \)) = -0.68, \( SE = 0.45 \), \( Exp(B) = 0.51 \), 95% CI [0.21, 1.23]) nor did self-focused significantly relate to seeking treatment (Wald statistic (1) = 0.11, \( p = .565 \), (\( B \)) = -0.24, \( SE = 0.74 \), \( Exp(B) = .79 \), 95% CI [0.19, 3.23]). Other-Focused did not significantly relate to seeking treatment, either (Wald statistic (1) = 0.66, \( p = .417 \), (\( B \)) = -0.11, \( SE = 0.13 \), \( Exp(B) = .90 \), 95% CI [0.69, 1.17]).

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Finally, after controlling for demographic variables, treatment seeking barriers, and emerging adulthood dimensions, EA did not significantly relate to seeking treatment (Wald statistic (1) = 2.27, \( p = .132 \), \( B = 0.18 \), \( SE = 0.12 \), \( Exp(B) = 1.20 \), 95% CI [0.95, 1.51]). These results indicate that EA did not predict unique variance, therefore Hypothesis 3a was not supported.

Exploratory Analyses

Logistic regression was used to explore the relationships between emerging adult dimensions (IDEA subscales) and treatment seeking. The dimensions of emerging adulthood were the predictor variables, and treatment seeking behavior was the categorical dependent variable. Identity exploration did not significantly relate to seeking treatment (Wald statistic (1) = .004, \( p = .950 \), \( B = -0.03 \), \( SE = 0.52 \), \( Exp(B) = .97 \), 95% CI = .35 – 2.70). Experimentation/Possibilities did not significantly relate to seeking treatment (Wald statistic (1) = .07, \( p = .790 \), \( B = -0.15 \), \( SE = 0.57 \), \( Exp(B) = .86 \), 95% CI = 0.28 – 2.62). Negativity/Instability significantly negatively related to seeking treatment (Wald statistic (1) = 7.73, \( p = .005 \), \( B = -1.77 \), \( SE = 0.64 \), \( Exp(B) = .17 \), 95% CI = 0.05 – 0.59). Feeling in-between did not significantly relate to seeking treatment (Wald statistic (1) = 0.91, \( p = .339 \), \( B = -0.37 \), \( SE = 0.39 \), \( Exp(B) = .69 \), 95% CI = 0.32 – 1.47). The self-focused dimension did not significantly relate to seeking treatment (Wald statistic (1) = 0.68, \( p = .408 \), \( B = -0.51 \), \( SE = 0.62 \), \( Exp(B) = .60 \), 95% CI = 0.18 – 2.02). Likewise, the other-focused dimension did not significantly relate to seeking treatment (Wald statistic (1) = 2.08, \( p = .150 \), \( B = -0.15 \), \( SE = 0.11 \), \( Exp(B) = .86 \), 95% CI = 0.70 – 1.06).

Additional exploratory analyses examined the relationships between EA (AFQ-Y) and emerging adult dimensions (IDEA subscales) using Pearson’s product-moment-correlation coefficients. EA was significantly positively related to identity exploration \( (r = .076, p = .020) \),
significantly negatively related to experimentation/possibilities ($r = -.067, p = .040$), significantly negatively related to self-focused ($r = -.075, p = .021$), significantly positively related to feeling in-between ($r = .131, p < .001$), and significantly negatively related to negativity/instability ($r = - .395, p < .001$). EA was not significantly related to other-focused ($r = .032, p = .326$).
DISCUSSION

The current study sought to determine if experiential avoidance was related to treatment seeking for mental health difficulties in a population of emerging adults attending college. Results supported the existent literature that EA was positively correlated with psychological symptoms, self-stigma of seeking treatment, perceived public stigma of seeking treatment, attitudes and beliefs toward seeking treatment, and intentions to seek treatment. Results also supported that psychological symptoms, and attitudes and beliefs toward seeking treatment were related to treatment seeking. The relationship between attitudes and beliefs toward seeking and treatment seeking, however, was in an unexpected direction. Surprisingly, results did not support that self-stigma of seeking treatment, perceived public stigma of seeking treatment, and intentions to seek treatment were related to treatment seeking. Although preliminary results supported the relationship between EA and treatment seeking, this relationship became insignificant after controlling for demographic variables. Hypothesis testing results, limitations, future directions, and implications are addressed below.

EA and Treatment Seeking

The current study found that, after controlling for demographic variables, increased EA was significantly related to increased self-stigma of seeking treatment and increased perceived public stigma of seeking treatment. These findings are consistent with previous literature suggesting that many individuals may engage in avoidance to distance themselves from negative thoughts, feelings, and emotions related to the negative labels associated with stigma (Blackledge and Hayes, 2001; Corrigan, 2004). The effect sizes of these relationships, however, were small. The current study also found that increased EA was significantly related to increased psychological symptoms. EA explained a very large amount of the variance of psychological
symptoms. Research has found that increased EA is related to increased emotional distress, such as anxiety, depression, and stress (Bardeen & Fergus, 2016; Feldner, Zvolensky, Eifert, & Spira, 2003).

Our results revealed unexpected relationships between EA and intentions to seek treatment, and EA and attitudes and beliefs toward seeking treatment. EA was significantly related to increased intentions to seek treatment with a small effect size, and more positive attitudes and beliefs toward seeking treatment with a very small effect size. These findings contradict the literature that different forms of avoidance are related to decreased intentions to seek treatment, and more negative attitudes and beliefs towards seeking treatment (Vogel and Wester, 2003). This finding is surprising considering that EA is largely understood as being maladaptive. EA, however, can at times be adaptive (Hayes et al., 1996; Kashdan et al., 2006; Schmalz & Murrell, 2010). Mitmansgruber, Beck, Schübler (2008) demonstrated that in particular populations, like paramedics, experiential avoidance can be adaptive.

Additionally, the AFQ-Y scores ranged from 0 to 68 ($M = 24.04, SD = 13.90$), which is the entire range of the measure, whereas the DASS scores ranged from 0 to 119 ($M = 33.25, SD = 26.63$), out of a maximum possible score of 126. More specifically, the AFQ-Y mean, compared to the maximum AFQ-Y total score, is higher, relative to the DASS mean compared to the DASS total scores. This comparison suggests that the individuals in this sample are on average experiencing higher levels of EA than psychological distress. Higher reported scores, or extreme scores, on the measures of EA and psychological distress are informative. The present study used transformations on certain variables of interest including psychological distress and EA. Although transformations can help data meet the assumption of normality, transformations decrease the variability within the data. This could be a potential problem when interpreting
results if the variability is informative, such as the meaning associated with extreme scores of psychological distress and EA. For this study, however, it is assumed that an appropriate amount of variance was maintained, and that transforming the data served the purpose of meeting the normality assumption for the variables of interest. Given that the variance was sufficient, and individuals are experiencing higher EA, it is possible that individuals in this sample experiencing EA were more in need of help, and sought treatment even with their lesser intentions and less positive attitudes toward seeking treatment. Upon further inspection of the items of the intentions to seek treatment measure (ISCI), this possibility of individuals with higher experiential avoidance needing the most help seems to have merit. On the ISCI, the participants are asked to rate how likely they would be to seek counseling if they were experiencing problems such as depression, speech anxiety, difficulty sleeping, and academic work procrastination. Research has demonstrated that each of these items relate to experiential avoidance (Bardeen & Fergus, 2016; Feldner et al., 2013; Hall et al., 2007; Glick & Orsillo, 2015). Therefore, emerging adults may be more likely to intend to seek treatment by a professional, as opposed to a friend or family member, in these particular areas if their daily functioning is impacted enough. The mechanism through which their functioning could be impacted to the point of seeking treatment is EA.

Furthermore, items on the attitudes and beliefs measure include “I would want to get psychiatric attention if I was worried or upset for a long period of time,” and “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.” For both of these items, it is possible that individuals high in EA may respond to the notion of desiring to not interact with such difficult emotions, or with negatively labeled internal events such as being worried or upset. They may also be drawn to the idea of wanting relief from these difficult emotions and feelings, where seeking treatment is the
means of escape. Therefore, the emerging adult population’s unique characteristics, and the item content of the measures, may account for the unexpected relationship EA had with intentions to, and attitudes and beliefs towards seeking treatment. Further exploration, however, is needed to understand if aspects of the emerging adult population may account for this difference.

In addition to acknowledging the contextual factors associated with emerging adulthood and psychological distress, the AFQ-Y measure should be examined, particularly given that EA positively related to seeking treatment. More specifically, as EA increases, the odds of seeking treatment increased. A possible explanation of this unexpected finding could be the nature of the measurement tool, the AFQ-Y, used to measure EA. The AFQ-Y asks about general EA in everyday life, rather than asking specific questions related to seeking treatment (Greco et. al., 2005). The AFQ-Y, therefore, may not capture EA as it relates to treatment seeking behaviors. In addition, an EA scale that is modified to target EA related to treatment seeking specifically could also more accurately capture the relationship between avoidance and treatment seeking. For example, a potential item may address if an individual would go to a therapy session even if they were dreading attending. This could also be addressed more qualitatively by asking participants questions related to reasons why they did not seek treatment at the time.

Treatment Seeking Barriers and Treatment Seeking

This study found that self-stigma and perceived public stigma of seeking treatment were not significantly related to treatment seeking behavior. This finding is consistent with Golberstein, Eisernberg, and Gollust’s (2008) study suggesting that perceived public stigma of seeking treatment is not significantly related to treatment seeking in a college student sample. These results are also similar with Tucker’s (2012) findings indicating a near significant, yet insignificant, negative relationship between self-stigma of seeking treatment and treatment
seeking behavior. Although research has identified significant relationships between stigma of seeking treatment and intentions of and attitudes toward seeking treatment, these studies did not include a measure of treatment seeking behavior (Komiya, Good, & Sherrod, 2000; Vogel et al., 2006). There may be contextual variables, such as emerging adulthood, or the college environment, that have not been acknowledged in these studies emphasizing stigma of and attitudes toward seeking treatment (Biglan & Hayes, 1996). Furthermore, Eisenberg and colleagues (2012) presented results of analyses from the unpublished Healthy Minds data. The Healthy Minds study is an online survey investigating with over 150,000 participants that began in 2007 (Healthy Minds Network, 2017). Eisenberg and colleagues (2012) stated that 64% of their sample of undergraduate and graduate students, who had not sought treatment for their mental health difficulties, reported low self-stigma and positive beliefs toward seeking treatment. The present study replicated this finding, therefore indicating that not only are cognitions not the same as behaviors, but that emerging adulthood dimensions and the college campus environment may be playing a role.

Our finding that attitudes and beliefs of seeking treatment significantly negatively related to treatment seeking behavior was also inconsistent with the majority of previous literature. The literature highlights a positive relationship between attitudes and beliefs of seeking treatment and treatment seeking (Kim et al., 2011; Eisenberg et al., 2012). In this study, however, as positive attitudes and beliefs towards seeking treatment increased, the odds of an individual seeking treatment decreased. The effect size of this relationship, however, was very small. This very small relationship between attitudes and beliefs towards seeking treatment and treatment seeking behaviors may be best understood within the context of emerging adults on a college campus. Participants in this study attend a university that puts forth considerable efforts toward promoting
more mental health awareness for students. Mental health resources on a college campus are affordable and accessible for students (Reetz et al., 2014). This holds true for this university where multiple avenues to seek treatment for psychological difficulties are available on this particular college campus. Students can seek help at a counseling and testing services center where sessions are included in tuition, a student health and wellness center, and an on-campus psychology clinic. This access to mental health treatment on a campus promoting mental health awareness may have contributed to the emerging adult’s ability to seek treatment even when holding less positive attitudes and beliefs toward seeking treatment. Additionally, emerging adults with more positive attitudes toward seeking treatment may have been reporting attitudes towards others’ seeking behavior rather than themselves. ATSPPH items included “If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist” and “A person with a serious emotional disturbance would probably feel most secure in a good mental hospital,” which do not capture individual behavior.

Contrary to what is found in the literature, intentions to seek treatment also did not significantly relate to treatment seeking behavior in this study. One possible explanation could originate from the characteristics unique to the population of this study. Research suggests that emerging adults are more prone to seek help from family and friends than mental health professionals (Wilson et al., 2011). The sample in this study was comprised of students attending the same university. This context should be considered when interpreting results. This university in this study is a commuter school; the school is located in a mid-sized area that is surrounded by two larger metropolitan cities. Many of these students likely live at home or near home, which makes this a unique sample of emerging adults. Therefore, the school caters to a large geographic area (both rural and metropolitan) with fewer students moving from home. This
suggests that students are more likely to have access to resources from their local support system. Unfortunately, no data was collected on whether participants lived on campus, near campus, or near family and friends, or whether they sought help from non-professional mental health providers. Data was collected on whether or not participants majored in Psychology. Even though 50.6% of the participants in this sample were Psychology majors, majoring in psychology was not significantly related to treatment seeking. Given that exploration is a defining feature of emerging adulthood (Arnett, 2015), the very nature of emerging adult individuals might lead them to pursue or try different possibilities in the service of finding what is best suited for them, regardless of initial intentions, attitudes, or beliefs. Given that these are conjectures, and the relationships have small effect sizes, additional research would need to help clarify these findings.

In this sample, increased psychological symptoms were significantly positively related to seeking treatment. These findings support previous research indicating that psychological distress is significantly positively related to seeking help (Deane, & Chamberlain, 1994). The strong positive correlation, with a large effect, between EA and psychological symptoms as described above, leads to the possibility that increased general avoidance, while maladaptive in terms of development and maintenance of psychological distress, may be adaptive if it allows individuals to avoid their distress to seek treatment. Additionally, in this sample, there were significantly less people who sought treatment than those who did not. Another potential explanation is that those who sought treatment in this study may be understood in terms of the well adjusted emerging adult college student group identified by Nelson and Padilla-Walker (2013). The well adjusted group experienced psychological distress and had higher internalized values, as compared to the poorly adjusted group who experienced psychological distress and
lower self-esteem. Perhaps the sample of this study highlighted the nature of the well adjusted group; well adjusted individuals were able to both experience psychological distress, and seek treatment in the service of their value of identity exploration as an emerging adult, in spite of their negative attitudes and beliefs towards seeking treatment. Further exploration could help determine whether this is the case.

Emerging Adulthood Dimensions

Due to a dearth of research in this area, emerging adult dimensions were explored more specifically to understand the relationship between emerging adulthood characteristics and treatment seeking behaviors. Findings demonstrated that most emerging adulthood dimensions (i.e., identity exploration, experimentation/possibilities, feeling “in-between,” self-focused, and other-focused) were not significantly related to treatment seeking. Negativity/instability, however was significantly negatively related to seeking treatment in this study. This relationship had a very small effect size. Arnett (2004) conceptualized negativity/instability as a tendency to have an unstable and changing lifestyle. A possible interpretation could be that the more people view themselves as having a changing and unstable lifestyle, and expect and accept the changes that occur on a college campus (e.g., relationships, academic pursuits, & residences), the more in contact they are with those feelings. Being willing to attune with feelings or experiences (particularly negatively labeled internal experiences), is the opposite of EA. Consistent with this idea, this study found that EA significantly negatively related to negativity/instability, which also had a very small effect size. Participants who reported higher negativity/instability are likely less distressed by associated feelings or emotions, and in turn, are less likely to need to avoid them. They therefore have fewer difficulties seeking treatment.
As noted previously, EA involves not only avoiding experiences that may occur in an individual’s external environment, but also includes being unwilling to attend to internal events, including thoughts, feelings, and emotions (Hayes et al., 1996). The emerging adult dimension of being self-focused could be conceptualized as attuning with internal experiences to understand and determine personal interests and desires. Being self-focused allows an individual to become more self-sufficient and experiment with different possibilities associated with that individual’s interests (Arnett, 2015). Therefore, it is unsurprising that EA was negatively associated with being self-focused, and with experimenting, or trying out, various opportunities. For both relationships however, EA explained very little variance of the negativity/instability, and experimentation/possibilities dimensions. The more experiential avoidance an individual engages in, the less likely that individual may attune with internal events associated with personal interests, and the less likely the individual may be willing to actually experience various life opportunities. Arnett (2004) posited that experimentation/possibilities may result from emerging adults having a naïve outlook of the actual possibilities available to them, and that this optimism decreases as emerging adults age and gain more life experiences. The more life experiences an individual has, the more likely the individual is to identify as an adult, and less likely to feel “in-between” being an adolescent and adult. The finding that EA was positively associated with feeling “in-between’ is, although small in effect, is understandable.

Interestingly, in this study, EA was also positively related to identity exploration. This finding may be tapping into the ruminative exploration described by Luyckx and colleagues (2008, 2013). Ruminative exploration, or maladaptive exploration, was positively related to low self-esteem, anxiety, and depressive symptoms (Luyckx et al., 2008, 2013). Given that EA was explaining very little variance of identity exploration, it stands to reason that EA would be
mostly associated with only one aspect of identity exploration. Out of the three emerging adult groups (i.e., well adjusted, externalizing, and poorly adjusted) identified by Nelson and Padilla-Walker (2013), the poorly adjusted group had the lowest levels of self-worth and highest levels of depression and anxiety. This finding gives credence to the idea that the process of identifying one’s own interests and living meaningfully can be challenging.

Limitations

Although this study included strengths, such as a large and relatively representative sample and using an emerging adulthood measure, limitations to this study should also be considered when interpreting these results.

One limitation is that all of the significant findings, except for the relationships between psychological distress and EA, and psychological distress and treatment seeking, had very small – to – small effect sizes. Therefore, although relationships were significant, EA explained very little variance of most of the variables of interest. It is possible these overwhelmingly small effect sizes resulted from the large sample size. Therefore, results of this study should be interpreted with caution. Another limitation involves the measures being presented in the same order for each participant. This may have impacted results in-terms of order effects, where participants became tired of answering questions near the end of the survey. This also may have impacted results in-terms of carryover effects, where taking measures of stigma of treatment seeking may have influenced responses on the intentions to seek treatment, and attitudes and beliefs toward seeking treatment measures. One of the measures of stigma, the scale looking at stigma for receiving help, was not particularly reliable in this sample. Thus, all analyses using this measure may not be accurate either.
As mentioned previously, the sample from this study came from a university that was currently engaged in a campus wide mental health awareness campaign that was launched in April 2015. Although various universities have mental health awareness campaigns, this particular campaign was specific to this university. The campaign included a taskforce to create awareness, and a website to promote education regarding available resources on campus and in surrounding areas. Participants, however, were not asked questions related to their own awareness or knowledge of this campaign. This campaign may have impacted our findings, particularly because the campaign aimed to minimize stigma and normalize help-seeking behavior. This campaign (especially if successful in carrying out its intent) may have impacted individual willingness to seek treatment, despite attitudes toward, or perceptions of treatment seeking of mental health.

Another limitation to this study is that only one measure was given per variable, limiting the possibility for a more comprehensive measurement of each variable of interest, or the ability to check relationships between variables across measures. Including more than one measurement type would have been particularly useful in this study, as several unexpected relationships between variables of interest occurred. Without having the ability to compare findings from one measurement to another, there is no way to explore whether these findings are due to the nature of the sample, or because of measurement errors. Additionally, the measure for treatment seeking behavior was based on only one self-report question rather than a scale that has been used consistently across the help-seeking or treatment-seeking literature. In the future, a more standardized approach and the development of a scale may help with reducing error due to measurement.
Implications and Future Directions

The findings from this study have various implications for clinical practice, research, and college campus interventions. Future research should include specific questions related to campus outreach programs, and consider context around their sample (e.g., commuter school) when developing a survey to plan for possible confounding variables. Questions around specific outreach programs can serve evaluative purposes for the campaign itself, such as asking questions related to if the campaign is impacting students’ attitudes, intentions, level of stigma toward self- and others, and treatment seeking behaviors. In addition to asking questions about behavior, future research could utilize psychological services as a means to collect data on treatment seeking behavior. More specifically, researchers could look at multiple levels of treatment seeking behavior, such as scheduling and actually attending the first session. These behaviors could also be compared across psychological services on campus, including counseling and testing services centers, on-campus mental health clinics, and wellness centers.

Results indicated that individuals who seek treatment may not always have positive attitudes towards seeking treatment or even intentions to seek treatment, but they can still choose to utilize help. Furthermore, the individuals who do seek treatment are likely experiencing psychological distress, suggesting that they need the psychological services being provided. This study provides evidence for the idea that although self-stigma and perceived public stigma may not act as a significant barrier for emerging adult college students, and prevent treatment seeking, individuals are still experiencing self-stigma and perceived public stigma while utilizing services. This stigma may initially hinder progress during treatment. Additionally, EA is related to stigma and psychological distress, suggesting that if treatment targets EA, stigma and psychological distress may consequentially decrease. Previous research has shown that as EA is
targeted, psychological symptoms also decrease (see Hayes, Luoma, Bond, Masuda, & Lillis, 2006 for a review). Research also suggests that individuals who sought treatment had less stigma after one session (Wade, et al., 2011). These decreases could therefore likely be seen in treatment that targets EA (see Hayes, Pistorello, & Levin, 2012 for a review). Given that EA is significantly related to various emerging adult characteristics, targeting EA in treatment may facilitate healthy identity development in emerging adults in particular.

Exploring the emerging adult dimensions for this study was important due to the lack of research using the emerging adulthood measure. Previous researchers targeting emerging adults as a sample, have theorized that relationships between variables occurring in their study were related to the characteristics of emerging adulthood. This study, however, used the measure of emerging adulthood to provide empirical evidence for the type of relationship between emerging adult dimensions with treatment seeking behavior, and with EA. Due to some of these relationships occurring in an unexpected direction, it is therefore imperative that future research uses the emerging adulthood measure. As the findings of this study demonstrate, more intentions and positive attitudes are not always a necessary component to behavior, and more contextual factors, like EA, should be considered. Therefore, a focus on empirical evidence when generalizing findings is necessary for further research in this area.

Lastly, given that many emerging adults attend college, it is important to focus our efforts on how to intervene on the college campus. We can create workshops that cater to emerging adults by focusing on the importance of behaving in relation to living meaningfully. The findings of this study could inform both didactic presentations of information and experiential exercises. More specifically, didactic presentations could focus on the importance of seeking treatment for mental health, and psychoeducation for the impact of psychological symptoms on an individual’s
daily functioning on a college campus such as class attendance and academic performance. Additionally, didactic presentations could emphasize the importance of being in the present moment, and engaging in value consistent behaviors, such as seeking treatment even when experiencing less positive attitudes toward seeking treatment, and adaptive and maladaptive forms of EA. Furthermore, experiential exercises could promote being in the present moment, and identifying values. These experiences may promote more healthy identity development in emerging adults who are self-focused and engaging in identity exploration. These experiences may also promote emerging adults behaving consistently with what is important to them, like autonomy, even when they are having more psychological distress, less positive attitudes and beliefs, or not yet feeling like an adult.
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*(table continues)*
Table 1 (cont.)

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<th>Yearly Income</th>
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<td>Between $20,001 - $49,999</td>
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<th>Financial Provider</th>
<th>Count</th>
<th>Percentage</th>
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</thead>
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<tr>
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<table>
<thead>
<tr>
<th>Awareness</th>
<th>Count</th>
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<tr>
<td>Yes</td>
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<tr>
<td>No</td>
<td>154</td>
<td>16.6</td>
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</table>

*Note. Financial Provider = “Does someone other than you provide most (more than 50%) of your income?”; Awareness = “Were you aware that as a student you have free sessions at the Counseling and Testing Services center on campus?”*
Table 2
*Means, Standard Deviations, and Range for Variables of interest*

<table>
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<th>Variables</th>
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<th>SD</th>
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<td>DASS</td>
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<td>AFQ-Y</td>
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</tr>
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<td>IDEA EP</td>
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<td>1 – 4</td>
</tr>
<tr>
<td>IDEA NI</td>
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<td>1 – 4</td>
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<tr>
<td>IDEA FIB</td>
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<tr>
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<tr>
<td>IDEA OF</td>
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*Note.* SOSSH = Self-stigma of seeking help; SSRPH = stigma scale for receiving psychological help; ISCI = Intentions to seek counseling; ATSPPH = Attitudes toward seeking professional psychology help; DASS = Depression, Anxiety, and Stress Scale; AFQ-Y = Avoidance and Fusion Questionnaire for Youth; IDEA IE = Identity Exploration; IDEA EP = Experimentation/Possibilities; IDEA NI = Negativity/Instability; IDEA FIB = Feeling in-between; IDEA SF = Self-focused; IDEA OF = Other-focused.
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**Note.** Financial Provider = “Does someone other than you provide most (more than 50%) of your income?”; Awareness = “Were you aware that as a student you have free sessions at the Counseling and Testing Services center on campus?”; SOSSH = Self-stigma of seeking help; SSRPH = stigma scale for receiving psychological help; ISCI = Intentions to seek counseling; ATSSPH = Attitudes toward seeking professional psychology help; DASS = Depression, Anxiety, and Stress Scale; AFQ-Y = Avoidance and Fusion Questionnaire for Youth; IDEA IE = Identity Exploration; IDEA EP = Experimentation/Possibilities; IDEA NI = Negativity/Instability; IDEA FIB = Feeling in-between; IDEA SF = Self-focused; IDEA OF = Other-focused. *p < .05; **p < .001
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Note. SSRPH = stigma scale for receiving psychological help; ISCI = Intentions to seek counseling; ATSPPH = Attitudes toward seeking professional psychology help; DASS = Depression, Anxiety, and Stress Scale; AFQ-Y = Avoidance and Fusion Questionnaire for Youth; IDEA IE = Identity Exploration; IDEA EP = Experimentation/Possibilities; IDEA NI = Negativity/Instability; IDEA FIB = Feeling in-between; IDEA SF = Self-focused; IDEA OF = Other-focused. *p < .05; **p < .001
APPENDIX

DEMOGRAPHICS QUESTIONNAIRE
1. What is your age?
   a. 18
   b. 19
   c. 20
   d. 21
   e. 22
   f. 23
   g. 24
   h. 25

2. What is your gender?
   a. Male
   b. Female
   c. Transmale
   d. Transfemale
   e. Other_______

3. What is your current relationship status?
   a. Single
   b. Cohabitating
   c. Married
   d. Separated
   e. Divorced
   f. Widowed
   g. Other ________

4. What is your race/ethnicity?
   a. White/Caucasian
   b. Black/African-American
   c. Asian/Pacific Islander
   d. Latino/Hispanic
   e. Native American
   f. Multiracial _________
   g. Other _________

5. What is your sexual orientation?
   a. Heterosexual
   b. Homosexual
   c. Bisexual
   d. Other _________

6. What is your religious affiliation
a. Christian  
b. Muslim  
c. Buddhist  
d. Hindu  
e. Jewish  
f. None  
g. Other __________

7. What year are you in school?  
a. First Year Undergraduate  
b. Second Year Undergraduate  
c. Third Year Undergraduate  
d. Fourth Year Undergraduate  
e. Fifth Year or Higher Undergraduate  
f. Other __________

8. What is your major?  
a. Psychology  
b. Other _______

c. Buddhism  

9. What is your household yearly income range?  
a. Less than $20,000  
b. Between $20,001 and $49,999  
c. Between $50,000 - $100,000  
d. Greater than $100,001  

e. Other _______

10. Does someone other than you provide most (more than 50%) of your income?  
a. Yes, parents  
b. Yes, significant other  
c. No  
d. Other _______

11. Have you attended mental health counseling/therapy as a student?  
a. Yes, on campus  
   i. Where?  
      1. Counseling and Testing Services  
      2. Psychology Clinic  
      3. Other _______
   
b. Yes, off campus  
c. No  

12. Please indicate the type of mental health professional you saw (select all that apply):  
a. Licensed professional/counselor  
b. Guidance counselor/social worker  
c. Couples/marriage counselor  
d. Psychologist (a mental health doctor who could not give medicine)
13. For how long did you attend counseling?
   a. 1-3 sessions, or less than 1 month
   b. 4 – 12 sessions, or 1 – 3 months
   c. 4 – 6 months
   d. 6 months – 1 year
   e. 1 – 2 years
   f. 2 years or more

14. Do you have any current psychiatric diagnoses?
   a. Yes
   b. No

15. Were you aware that as a student you have free sessions at the Counseling and Testing Services center on campus?
   a. Yes
   b. No
REFERENCES


Van Dyke, J., Rogers, L., & Wilson, K., (2006). *Valued living, experiential avoidance, and psychological well-being*. Presentation at the annual meeting of the Association for Behavior Analysis, Atlanta, GA.


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