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thesis entitled

Predictors of Seeking Psychological Counseling: Distress, Prior Exposure, Fear, and Downward Comparison

presented by

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has been accepted towards fulfillment of the requirements for

M.A. degree in Psychology

Major professor

Date August 22, 1995

Predictors of Seeking Psychological Counseling: Distress, Prior Exposure, Fear, and Downward Comparison

By

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A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

Department of Psychology

1995

ABSTRACT

Predictors of Seeking Psychological Counseling:
Distress, Prior Exposure, Fear, and Downward Comparison

By

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This study was designed to replicate previous findings regarding distress, prior exposure to psychological counseling, and fear of psychological counseling as well as to also identify the effects of downward comparison across 334 undergraduate women. Both distress and prior exposure correlated significantly (rs = .22 and -.13, $p < .05$, respectively) but oppositely with fear of psychological counseling. Distress and exposure did not demonstrate an anticipated interaction. Downward comparison was assessed by vignette-induced mood shifts. As expected, distress predicted negative mood reductions ($p < .05$). Participants' reported likelihood of seeking future psychological counseling was associated with prior exposure, personal distress, and the interaction of these variables. A robust 33% of the variance in the likelihood of seeking future counseling was predictable from these measures.

ACKNOWLEDGMENTS

I would like thank Drs. Robert Caldwell and Norman Abeles for their interest and constructive comments as committee members. I am especially appreciative of Dr. John Hurley who provided many helpful observations and comments and gave abundant support to my work throughout the project.

Credit for the data collection of this study goes almost entirely to Rosa M. Rigol, M.S., who devoted many hours to assessing participants. Her clinical training was invaluable in assuring that the testing environment was sensitive to participants' questions. Additionally, I would like to thank her for her patience and constructive feedback throughout the duration of the project. I would also like to thank Janelle Ettema for her efforts in data collection.

Finally, I would like to express my gratitude to Dr. Jane Harding for inspiring and nurturing an interest in research. Her support of my educational interests and willingness to share her own knowledge made this study possible.

TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

INTRODUCTION

Substantial evidence indicates that a large percentage of the general population suffers from psychological distress and yet only a small fraction utilizes mental health services. Wills (1983) concluded that seeking professional help for psychological problems is a minority response. Extensive research has assessed the need for mental health services and sought to identify those persons who seek services. Additional studies have concerned what distinguishes help seekers from non-help seekers. Barriers to seeking mental health services studied include cultural, social, and personality factors. This paper reviews related prevalence and utilization rates and explores selected variables related to help-seeking, including psychological distress, prior exposure to mental health services, fear of mental health services, and social comparison.

Prevalence and Utilization Rates

General Population

One of the largest attempts to assess prevalence rates was the Epidemiological Catchment Area (ECA) Study. Data were collected from 20,291 persons over 18 years-old in five U.S. cities. Results from the study identified prevalence

rates for any alcohol, other drug, or mental disorders based on the Diagnostic Interview Schedule (DIS) to be 15.7% for one-month, 19.5% for 6-months, and 32.7% for lifetime in the US population (Regier et al., 1990). Thus in a six-month period, approximately 20% of the individuals interviewed suffered from symptoms disruptive enough to warrant a psychiatric diagnosis.

Using an ECA sub-sample to assess utilization, Shapiro et al. (1984) reported that 6-7% of an adult population sought medical or psychological help for a mental health problem in the six months prior to the study. When only those diagnosed with a psychiatric disorder were considered, merely 17.6% had sought medical or psychological services in the six-months prior to the survey. This suggests that while almost 20% of individuals suffered symptoms warranting a psychiatric diagnosis in a 6-month period less than one-fifth of them sought help.

The above rates provide estimates of prevalence and utilization for the general population. However, the issue about why some individuals seek psychological help and others do not is complex, and there are notable variations associated with age, sex, culture, social-economic status, availability of mental health services, and other variables (Shapiro et al., 1984). Help-seeking research has been fragmented in its focus and implicates a range of phenomena from personality characteristics (DePaulo, Nadler, & Fisher,

1983) to ecological/community service barriers (Nadler, Fisher, & DePaulo, 1983). Because of these complexities, much of the help-seeking research has focused on the more homogeneous population of college students who are available in a somewhat static system for four-year intervals, have accessible records, can be followed through alumni membership (Reifler & Liptzin, 1969), and who typically have some access to free or low cost university psychiatric and counseling programs.

College Students

Many studies since the 1920's have assessed prevalence rates for psychiatric illness and psychological distress in college students. These works have yielded a wide range of rates that reflect differing cutoffs for what constitutes disorder or impairment and instruments differing in whether they focus on psychophysiological or behavioral symptoms. Extensive reviews have provided the most accurate estimates since they combine studies and narrow what are individually only rough estimates. They also tend to focus on methodologically superior studies, usually those with large sample sizes.

In a comprehensive review of epidemiological studies from 1920 to 1966, Reifler and Liptzin (1969) found prevalence rates for "emotional disturbance" in college students to range from 6-16.4%. In a review of four studies from 1973 to 1980 with large sample sizes (Ns from 1200 to

2100), "definite impairment" was found to range from 5.3-11% (Schwartz & Reifler, 1984). When less severe criteria were used, much higher proportions were obtained including 45% "some impairment" (Mechanic & Greenley, 1976), 17% "borderline-psychiatric disorder" (Thompson & Bentz, 1975), 55% "subclinical impairment" (Thompson, Bentz, & Liptzin, 1973), and 30.2% some impairment (Nagelberg & Shemberg, 1980).

More recent studies reflect changing methodologies and higher rates. Following a cohort of college students for four years, Rimmer, Halikas, and Schuckit (1982) found a four-year prevalence rate of 39% for psychiatric illness. Illness was diagnosed by trained psychiatric interviewers who based their decisions on behavioral symptom criteria clusters from DSM-III. In an epidemiological study of high school students, 60 were followed-up through their first year of college, and of those, 20% were considered disturbed (Offer & Spiro, 1987). In a recent Ivy League survey, more than a quarter of the respondents indicated that suicidal/homicidal thoughts were a concern for them with 6% indicating that these were a crucial concern (Bertocci, Hirsch, Sommer, & Williams, 1992). Respondents were also concerned about depression, sadness, and mood changes (76%, 19% crucial) and anxieties, phobias, and panic attacks (56%, 10% crucial). These studies indicate a substantial level of psychological distress among college students when measured

by a variety of instruments based on both psychophysiological and behavioral symptoms.

Usage rates represent the proportion of students who sought mental health services regardless of level of distress or presence or absence of a diagnostic label. Summarizing results from 14 colleges and universities between 1930 to 1966, Reifler and Liptzin (1969) found a median usage rate of 6.3% with a range of 1.5-9.9%. Reviewing methodological developments and major studies over the subsequent 15 years, Schwartz and Reifler (1984) concluded that the usage rate for volunteer, unsystematic, modest-sized institutions seemed stable and estimated it between 4-7%. Thus, multi-study reviews indicate that usage rates are relatively low compared to the level of impairment suggested by prevalence studies.

Recent studies seem to find higher usage rates, although this is often confounded by methodological or sampling problems. Reinhold (1973) found that of 1290 students matriculated in 1964 and graduating in 1968 from a large midwestern university 19.4% had utilized the university counseling and/or psychiatric services. Following 158 cohorts for four years, Rimmer and colleagues (1982) reported an average usage rate of 14%. Twelve percent of freshman at a small, liberal arts college for women received services at the counseling center at least once during their first year (Clary & Fristad, 1987). A

random survey of students at Columbia University (Bertocci et al., 1992) found that 16% had used the university mental health services, and overall, 39% reported previous contact with a mental health practitioner. Similarly, Robbins (1981) found in a random survey that 29% of students at a private New England university had previously obtained psychiatric or psychological services.

These more recent studies highlight higher usage rates, but are still well below many of the prevalence rates indicating distress and impairment. Overall, prevalence and usage rates demonstrate an increasing number of students who appear to need services and students who are seeking them, and a substantial number of students indicate seeking counseling prior to, or outside of, university-provided services. Yet despite increases in usage, there still seems to remain a significant proportion of students who are distressed and would benefit from mental health services, but who do not access those services.

Help Seeking and Non-Help Seeking

The difference between prevalence and usage rates brings to the fore the distinction between help-seekers and non-help seekers. Wills (1983) noted that there is an obvious ambivalence on the part of those in distress to seek mental health services, and that "help-seeking from professionals is a minority response" (p. 117). Several factors are likely to contribute to this difference,

including fear of mental health services, psychological distress, exposure to mental health services, and downward social comparison.

Kushner and Sher (1991) reviewed the literature on fear of psychological counseling and avoidance of mental health services. They noted that help seeking can be conceptualized effectively as a classic approach-avoidance conflict as delineated by Miller (1944). In this conflict, a person has strong tendencies (gradients) to both approach and avoid the same goal (help seeking) and is "trapped part way to the goal, unable to either achieve or leave it" (Miller, 1944, p. 451) where the approach and avoidance gradients intersect. Resolving the conflict (reaching the goal) is dependent on the strength or steepness of the gradients. If the approach gradient is raised and the avoidance gradient is lowered, the individual will likely move closer to the goal, or may even reach it if these gradients no longer intersect.

This paradigm seems particularly suited for understanding help-seeking where individuals have strong tendencies to seek help because of distress, impairment, and exposure to the positive effects of seeking help, but must also face significant psychological and/or financial costs. Individuals must also confront and overcome the fear associated with seeking services and must risk the possibility of being stigmatized and negatively evaluated.

While they may want help, they simultaneously work to avoid it both to protect their self-esteem and to avoid the time and monetary costs of treatment.

Fear of Mental Health Services

Recent research on the difference between help-seekers and non-help seekers has also attended to the fear of mental health services. Fear of services has been recognized as a factor inhibiting help-seeking behavior with treatment fearfulness defined as "a subjective state of apprehension arising from aversive expectations surrounding the seeking and consuming of mental health services" (Kushner & Sher, 1989, p. 251). Cook et al. (1984) found that while 83% of students agreed that counseling was helpful for a variety of problems, most also had multiple fears about entering counseling. Students were fearful that others would know about it (74%), their problems would not be taken seriously (69%), and friends or family would disapprove if they sought counseling (81%). In a community sample, reasons for delaying or avoiding seeking mental health services focused on fears of exposing and facing problems (Amato & Bradshaw, 1985). Assessing the perceived advantages and disadvantages of counseling, Halgin, Weaver, and Donaldson (1985) found that prevention was the most frequently cited advantage by non-help seekers, but wholly unmentioned by help-seekers. This suggests that to non-help seekers psychological distress is something to be prevented or warded-off in order

to protect self-esteem. This interpretation is congruent with a second finding which indicated that non-help seekers perceived a disadvantage of counseling as indicative of a lack of self-effectiveness.

Non-help seeking students often have fears and negative expectations about university counseling services (Figueroa, Calhoun, & Ford, 1984). More than help-seekers, non-help seekers tend to believe that counselors will see mental illness in whatever problem a person brings in and that university counseling services exist more to train graduate students than to help students with problems. They also expressed less optimism about being helped through therapy than help-seekers.

Individuals who do not seek help were also found to be more fearful of seeking help. After developing their Thoughts About Counseling Survey (TACS) to assess client fears, Pipes, Schwartz, and Crouch (1985) found that students who had sought services at the university mental health center had significantly less fear than those not seeking therapy, both overall and on two specific subscales (Therapist Responsiveness and Image Concerns). In a replication and extension of the study by Pipes et al. (1985), Kushner and Sher (1989) added a third factor, Coercion Concerns, to assess fear of coercion or pressure to change. They found that students seeking services at the university mental health center reported less fear than non-

help seeking students on all three subscales. Because these help-seekers were assessed prior to service delivery, it could not be determined whether fearfulness initially moderated the decision to seek services or whether initiating services had decreased fearfulness.

In an attempt to diminish this ambiguity, Kushner and Sher (1989) also classified the non-help seeking students by history of treatment needs and service utilization into Avoiders (those claiming to have needed treatment but not sought it), Seekers (those claiming to have needed treatment and sought it), and Never Needed (those claiming to have never needed treatment). Avoiders were found significantly more fearful than Seekers. That is, individuals without prior exposure to mental health services, but who had felt the need for treatment, seemed more fearful and less likely to get help. For this total sample, treatment fearfulness was also positively associated with psychological distress as measured by the Brief Symptom Inventory (BSI; Derogatis, 1975). Thus, congruent with the approach-avoidance conflict, individuals experiencing more distress were also those more fearful of seeking help to alleviate their distress.

Psychological Distress

Suggesting that distress is a motivator for seeking services, help-seekers have also been consistently found to be more distressed than non-help seekers (Mechanic &

Greenley, 1976). Using a measure of psychophysiological symptoms, Thompson and Bentz (1975) reported that 286 undergraduate students who sought psychiatric services through the university had significantly more symptoms than the incoming freshman class (N = 2,121). At the end of the school year, 52 of these freshman (2.5 percent) had sought psychiatric services. A post hoc analysis indicated that those freshman who sought services reported significantly more symptoms at the beginning of the school year than those students who did not seek services. Lubin and Rubio (1985) found that students attending a university counseling center reported more stressful life events occurring over the past year than matched non-client controls. Clients perceived less choice and control over these events, and they felt more pressure and need to adjust to the events. Thus, it appears that help seekers indicate more distress, less control, and more need to seek professional help compared to non-help seekers and matched controls.

Exposure to Mental Health Services

Help-seekers have also indicated more prior experience with mental health services, both personally and by their family members (Figueroa, Calhoun, & Ford, 1984; Narikiyo & Kameoka, 1992). DeBarot (cited in Fischer, Winer, & Abramowitz, 1983) found that those who personally knew someone in psychotherapy had more positive attitudes toward seeking psychiatric help than those who knew no one in

psychotherapy. Those seeking help at the university counseling center during their freshman year had more previous experiences with mental health services than those not seeking help (Clary & Fristad, 1987). When assessing presenting concerns and history of services, clients were more likely to endorse personal concerns (as opposed to academic, vocational, or educational concerns) if they had a history of previous counseling (Tracey, Leong, & Glidden, 1986). Thus, exposure to services may serve to destigmatize being a client, leading individuals to feel more supported in the decision to access services, and it may enable an individual to seek services and maintain a favorable impression of oneself.

Social Comparison

Although both level of distress and prior exposure to mental health services appear important factors in determining whether or not an individual seeks help, the influence of social comparisons may also be relevant. Seeking professional help may result in unfavorable comparisons with those who do not seek help (Wills, 1983); individuals who seek help have also been found to be more disliked, rejected, and avoided. Non-help seekers, compared to help-seekers, were found to perceive the average help-seeker as more disturbed (Bosmajian & Mattson, 1980). Sibicky and Dovidio (1986) found that perceiving someone as a counseling center client had significant effects on

interpersonal interaction. Those who believed that they were interacting with a client formed more negative impressions of the person prior to their interaction and behaved in less socially desirable ways than those who interacted with someone from a psychology class (the neutral condition). The former also reported being less comfortable while interacting and enjoying the interaction less than those in the neutral condition.

Research also indicates that psychiatric diagnoses are associated with legitimate fears of negative social comparisons. Purvis, Brandt, Rouse, Vera, and Range (1988) found that persons assigned a psychiatric diagnosis, as compared to those with a similarly debilitating medical diagnosis, were judged less desirable as friends, less able to function in the community, and less likely to receive help when obtaining a job. Compared with identically behaving physically ill persons, those labeled as mentally ill were also viewed as more rejected, believed to be less predictable, and thought to have less hopeful outcomes (Socall & Holtgraves, 1992). Though distressed individuals may want to ameliorate their distress by seeking help, there appears to be solid ground for conflict, as seeking help may lead to more negative evaluations from others and an unfavorable view of the self.

Downward Comparison

Research on social comparison indicates that individuals alleviate distress by comparison with and/or derogation of others. A review of such studies indicates that individuals can "increase their subjective well-being through comparison with a less fortunate" or equally unfortunate other (Wills, 1981, p. 245). This process is referred to as self-enhancement through downward comparison (DC). Wills (1983) posited several stages linking coping and help-seeking. As the level of distress increases, individuals are more likely to engage in self-enhancing comparison. Downward comparison is more likely to occur when individuals are stressed, unhappy, or low in self-esteem. In numerous studies reviewed by Wills (1981), downward comparison occurred when there was some type of ego threat. Hence, increased distress seems to lead to increased downward comparison as a means to cope with the distress. Typically, comparison targets are individuals with similar problems. This mechanism may provide an alternative to seeking help and be influenced by the desire to minimize anticipated unfavorable evaluations from others. Downward comparison allows a distressed individual to temporarily see themselves in a positive light relative to another perceived as equally or more disadvantaged.

Target choice. Several recent studies support this formulation. Gibbons (1986) found that depressed persons

induced into a negative mood chose significantly more negative comparison targets than nondepressed-negative mood, depressed-positive mood, and nondepressed-positive mood groups. In a review of studies with cancer patients (individuals considered under threat), downward comparisons were consistently found using several different methodologies (Taylor & Lobel, 1989, p. 571).

Mood. In addition to distressed individuals choosing downward for comparison targets, Wills (1981, 1983) proposed that distressed individuals' use of downward comparison reduces negative affect. Recent research supports this contention. After reading about someone's negative life experiences, depressed persons had significantly greater mood increases than those who were not depressed (Gibbons, 1986). Gibbons and Gerrard (1989) noted that the mood state of individuals low in self-esteem improved significantly when given downward comparison information while this information had little effect on the mood state of persons high in self-esteem. In a later study employing a threat manipulation, Gibbons and McCoy (1991) found that persons low in self-esteem and highly threatened had significant positive mood changes that exceeded those of any comparison group in two experiments. This finding was replicated by Aspinwall and Taylor (1993) in two experiments. Their first study noted that, of low and high self-esteem groups induced into positive and negative moods, only the low self-

esteem/negative mood group reported increased positive mood after downward comparison. Their second study found that a low self-esteem group under naturalistic threat (academic difficulties) reported more favorable self-evaluations and expectations about future success after receiving downward comparison information than those who had received no comparison information. Thus, numerous studies indicate that persons who are clinically depressed and/or low in self-esteem under both induced and naturalistic threat respond to downward comparison with increased positive mood and self-evaluations. It seems likely that the coping benefits of downward comparison may also discourage or inhibit those who are distressed from seeking mental health services. However, these benefits may be short-lived and ultimately a liability because of the absence of information about more successful long-term coping.

Derogation. Some findings suggest that downward comparison involves a more complex process. Gibbons and McCoy (1991) found that under threat, high, but not, low self-esteem persons derogated a downward comparison target. When threatened, individuals high in self-esteem gave significantly more negative ratings of adjustment to a downward comparison target than did either threatened, low self-esteem and non-threatened, low and high self-esteem groups. These results seem to be based on the effects of perceived similarity. The low self-esteem group rated

themselves as significantly more similar to the downward comparison target than did those high in self-esteem. Additionally, a substantial correlation (.53, $p < .003$) was found only among those low in self-esteem between similarity ratings and mood change.

Another recent study found results which undermine several downward comparison predictions. Using a new instrument (Rochester Social Comparison Record, RSCR) to study social comparisons over a two-week period, Wheeler and Miyake (1992) found that participants who felt better were more likely to compare downward and that persons high in self-esteem were more likely to make downward comparisons than those low in self-esteem. One finding was consistent with downward comparison predictions and indicated that participants felt significantly better after comparing downward relative to comparing upward. These discrepancies should be approached with caution since the RSCR is a new instrument and differs methodologically from paradigms typically used to assess downward comparison.

Overall, the research evidence suggests that threatened, low self-esteem or distressed persons tend to choose a comparison target such that a downward comparison can be made. Choosing such targets seems to result in improved mood consistently and may serve as self-enhancement in an otherwise threatening situation. However, when given the opportunity for active derogation of a downward

comparison target, only threatened, high self-esteem participants engage to a significant degree and without any resultant change in mood. Persons low in self-esteem seem relieved to know that others are equally or worse off while those high in self-esteem respond with derogation. Derogation seems to be moderated by perceived similarity with the target.

Hypotheses

The present study sought to replicate previous findings regarding fear of mental health services, specifically, fear of psychological counseling in a college student population. Students with personal experience in psychological counseling and/or those with family or friend-based exposure to psychological counseling were predicted to indicate less such fear than those without such experiences; that is, fear of psychological counseling was predicted to be negatively correlated with prior exposure to psychological counseling. This fear was also expected to correlate positively with level of psychological distress, and to be moderated by exposure to psychological counseling.

The study attempted to demonstrate that downward comparison is an additional inhibitor to help-seeking among distressed college students. Downward comparison was measured by mood shifts after reading a target vignette. The downward comparison literature suggested that persons experiencing distress will show greater reductions in

negative mood after reading such a vignette.

Participants also rated statements reflecting a range of psychological, social, and occupational functioning on how much they indicate a need for psychological counseling. Perceived need for psychological counseling was predicted to correlate negatively with downward comparison and distress. That is, distressed participants were predicted to identify with statements reflecting distress and because of their fear of psychological counseling, not see a need for such services. Finally, participants rated the probability of their seeking psychological counseling over three specific time periods. Distress, exposure, fear, and downward comparison were expected to be significant predictors of participants' probability of seeking psychological counseling ratings.

Method

Participants

Participants were recruited from undergraduate psychology courses at a large, midwestern university. The sample included 334 women who volunteered, provided informed consent, and received partial course credit. Participation was anonymous to insure the confidentiality of respondents. Ninety-seven percent of the sample was between 17 and 24 years of age; participants identified themselves as 84% White, 8% Black, 1% Hispanic, 5% Asian, and 2% Other.

This study was limited to women for several reasons. First, Kessler, Reuter, and Greenley (1979) using data from a student population at a large midwestern university found that women are more likely to seek treatment "due both to differential propensities to seek help for problems and also to differential numbers of problems" (p. 557). Nagelberg and Shemberg (1980) found psychological impairment in undergraduate women (12.4%) to be twice that of men (6.0%), and counseling center women clients reported significantly higher rates of psychological symptoms than men clients (Johnson, Ellison, & Heikkinen, 1989). Second, the experimental vignette will be based on difficulties more relevant to women.

Materials

Fear of psychological counseling. The Thoughts About Psychotherapy Survey (TAPS; Kushner & Sher, 1989) is based on the Thoughts About Counseling Survey (TACS; Pipes et al., 1985) with several modifications (see Appendix D). The latter was developed to discriminate 91 college counseling center clients from 104 non-client students. Pipes et al. (1985) reported alpha coefficients for the factors of Therapist Responsiveness (alpha = .92) and Image Concerns (alpha = .84). Kushner and Sher (1989) modified this instrument by adding a third factor to assess Coercion Concerns and replaced "counselors" and "counseling" with the broader terms of "therapists" and "therapy". They found the internal reliability (i.e., Cronbach's Alpha) of all three TAPS subscales to be satisfactory (Therapist Responsiveness = .92, Image Concerns = .87, and Coercion Concerns = .88). For each of the 19 TAPS items, respondents rate their level of concern on a 5-point Likert-type scale (1 = No concern, 2 = Little concerned, 3 = Somewhat concerned, 4 = Much concerned, and 5 = Very concerned) with higher scores indicating more fear and concern. The total TAPS and subscale scores were analyzed to assess the most robust measure(s) of fear.

Distress. In regard to help seeking, Bosmajian and Mattson (1980) found that level of maladjustment was crucial to measure. Only by controlling for level of maladjustment

could the relationships between adjusted and maladjusted, help-seekers and non-help seekers be understood. Watson and Clark's (1984) review of the literature suggests that measures of maladjustment and distress (e.g., anxiety, repression, ego strength, depression, and neuroticism) seem to assess a stable and pervasive trait called negative affectivity. Two measures of this construct were used.

Neuroticism was measured using the NEO Five Factor Inventory (NEO-FFI), a short form of the Revised NEO Personality Inventory (NEO-PI-R; Costa & McCrae, 1992; see Appendix E). NEO-FFI's developers noted that the core of the neuroticism domain is the "general tendency to experience negative affects such as fear, sadness, embarrassment, anger, guilt and disgust" (p. 14). Additionally, neuroticism captures inclinations for irrational thought, poor impulse control, and inadequate coping under stressful conditions. The NEO-FFI consists of 60 statements to which respondents indicate their degree of agreement (ranging from Strongly Agree to Strongly Disagree). The .86 reported alpha coefficient for NEO-FFI's 12-item, neuroticism scale indicates good internal consistency.

Also used to assess psychological distress was the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982; see Appendix F). The BSI is a 53-item, self-report symptom inventory using a 5-point scale of distress (Not at All to

Extremely). The BSI consists of three global indices of distress. Derogatis and Melisaratos (1983) found that the General Severity Index (GSI) was the best indicator of present distress levels and had a 2-week test-retest reliability of .90.

Need for psychological counseling. Most studies assessing perceived need for psychological counseling have participants rate the severity of problems and need for psychological counseling in response to case vignettes (Robbins, 1981; Flaskerud, 1984). The typical vignette describes gross psychopathology, psychiatric syndromes, or at the least, the information necessary for psychiatric diagnosis. This method of assessing need for psychological counseling has several disadvantages. Robbins (1981) notes that education is often a strong predictor in recognizing mental illness, and as such, is basically held constant in college student populations. Additionally, the use of vignettes restricts the potential range of responses; only one judgment of perceived need can be made per vignette and the pool of valid vignettes is quite limited.

To overcome these difficulties, a Need for Psychological Counseling (NPC) measure was developed for the present study (see Appendix G). Based roughly on the Global Assessment of Functioning (GAF) Scale (APA, 1994), the NPC has 65 statements reflecting a range of psychological, social, and occupational functioning. Participants were

asked to consider each statement to be true for them, and then rate on a 5-point scale the degree to which they felt it indicated a need for psychological counseling (ranging from Not at All to Extreme). Results from the NPC were factor analyzed to obtain a scale reflecting the construct of perceived need for psychological counseling.

Self-Awareness. Research suggests that self-focused attention increases awareness of the current affective state. Scheier and Carver (1977) found that self-focused students, following induced positive or negative moods, reported stronger positive and negative moods, respectively, than those less self-focused. Similar findings were demonstrated with general psychiatric patients, especially in relation to negative mood (Gibbons et al., 1985); self-focused patients reported significantly more negative mood than patients not self-focused. Research suggests that self-focusing may also result from emotional experiences (Salovey, 1992) and despondent moods (Carr, Teasdale, & Broadbent, 1991).

To induce negative mood and self-focusing, participants have commonly been asked to write essays about their own sad or troublesome experiences. Berkowitz (1987) had students write about an incident that made them very sad and describe their feelings on the occasion. In order to encourage downward comparison, Gibbons and Gerrard (1989) had students write about difficulties related to the demands of college

life. To obtain self-focusing data, a naturalistic study had participants write about the most troublesome event of the day at the end of everyday for 30 days (Wood, Saltzberg, Neale, Stone, & Rachmiel, 1990). Baker and Guttfreund (1993) effectively induced and reduced both anxious and depressive mood states by having participants think for ten minutes about painful or happy life events. These findings suggest that having individuals write and think about their experiences seems to reliably induce negative mood and self-focusing.

To focus students' attention on their current psychological problems and induce the associated affect, the present study asked students to complete a self-report checklist of 38 potential problems in the areas of academics, interpersonal relationships, mental states (e.g., depression, anxiety, fears), psychophysiological symptoms (e.g., tiredness, headaches), and others (see Appendix H). Next, they were asked to write a short paragraph for each of the three difficulties they considered to be the most serious, describing briefly the nature of the problem and their feelings about it. A reminder that this information was anonymous and confidential was included on this task.

Mood. Mood was assessed on two occasions using two mood measures each time. The first measure consisted of 16 adjectives from the Multiple Affect Adjective Checklist (MAACL; Zuckerman & Lubin, 1965; see Appendix I). Eight

adjectives, four positive (happy, secure, pleased, and satisfied) and four negative (hopeless, discontented, discouraged, and tense), were given at pretest. At posttest, the polar opposite adjectives were used in order to reduce suspicion of the pre-post measurement; these included (negative) sad, insecure, displeased, dissatisfied, (positive) hopeful, content, encouraged, and calm. Response anchors ranged from Not at All to Very Much on a 7-point scale. At posttest, a different response format was used to reduce the transparency (cf. Aspinwall & Taylor, 1993) of this repeated measure, e.g., A = Not at All at pretest and 1 = Not at All. Negative adjective scores were subtracted from positive adjective scores to form a mood index.

This method of assessing mood change has been used repeatedly with moderate and consistent reliability. Gibbons and Gerrard (1989) found average interitem correlations to be .60 for six positive adjectives and .70 for six negative adjectives anchored on a 9-point scale. Gibbons and McCoy (1991) reported reasonable reliability based on the intercorrelations of positive and negative adjectives (minimum alpha = .78; M alpha = .82) for 16 adjectives with a 13-point scale. Using a similar format with 14 adjectives and a 7-point scale, Aspinwall and Taylor (1993) found alpha reliabilities of .93 at pretest and .89 at posttest.

Additionally, the 20-item Positive and Negative Affect

Schedule (PANAS; Watson, Clark, & Tellegen, 1988) was administered immediately following the first mood measure at both pretest and posttest (see Appendix J). PANAS differs from other mood scales in that it was developed to independently measure positive affectivity (PA) and negative affectivity (NA) and can be used to rate mood across a range of time frames. This study had participants rate mood "at the present moment" using a 5-point scale ranging from very slightly or not at all to extremely. Watson et al. (1988) reported alpha reliabilities for this time frame to be .89 for PA and .85 for NA. Positive and negative items are summed separately for PA and NA scales. No overlap exists between the adjectives used in the MAACL and the PANAS. Thus, these measures provided independent assessment of mood change in a split-half (MAACL) and repeated measures (PANAS) format.

Vignettes. It would be unethical to attempt to manipulate the decision to use or not use mental health services. Also prohibited ethically is using actual distressed persons as study participants to test hypotheses related to identification and judgment of those psychologically distressed, the impact and deleterious effects of labeling, and interpersonal responses to those diagnosed psychiatrically. As a result, analogue measures are typically employed. One technique, well-represented in the literature, is the use of case vignettes. Case

vignettes are written or videotaped presentations of a particular problem and allow for control of factors which otherwise might be contaminating.

Vignettes have been previously used to provide downward comparison targets; researchers have attempted to make such vignettes relevant and salient. Based on self-reports from previous participants, Gibbons and Gerrard (1989) used a short paragraph describing successful or problematic adjustment to college difficulties to manipulate type of comparison target. Gibbons and McCoy (1991) instructed students to create a tape recording regarding their adjustment to college, and then led them to believe that they had switched tapes with another student, who was actually a study confederate. The target tape (approximately 3.75 minutes long and given to all participants) presented a student having trouble adjusting to college, academic difficulties (problems with school work, grades, and study time), and problems with an ex-girlfriend or boyfriend. Similarly, Aspinwall and Taylor (1993) used a 200-word taped testimonial interview to present a female student failing at the university because of homesickness, few friends, and poor school work. Due to the importance of similarity to the distressed person (Wills, 1983), a same-sex vignette was used in this study as in previous research (Gibbons & McCoy, 1991). The vignette was similar to those used in previous research by

emphasizing problems relevant to women in college (see Appendix K).

Exposure to psychological counseling. Seven questions were asked to assess previous contact with psychological counseling (see Appendix M). Questions included personal contact, as well as contact through family and friends. Additionally, perceptions of how helpful participants thought that psychotherapy might be was assessed. Participants were asked to indicate the extent of exposure to psychological counseling on a 5-point scale (ranging from No Experience to Extensive Experience). Exposure scores were computed by totaling each participant's responses.

Probability of seeking psychological counseling. To determine the likelihood of help-seeking, Deane and Chamberlain (1994) used a 9-point Likert scale asking, "If you did have a personal problem, how likely is it that you would seek help from a professional psychologist or counselor." The likelihood of help-seeking for psychological counseling (see Appendix N) was addressed slightly differently in the present study. Participants rated the probability of help-seeking for three time periods (i.e., next 30 days, six months, and year). Ratings ranged from 0-100%, the latter indicating ongoing psychological counseling. Ratings for the three time periods were averaged for a probability of help-seeking variable.

Procedure

Women students were assessed in groups of 10-30. They were informed that the experiment was anonymous and that their responses were confidential (see Appendix A). They were also advised that it involved questions about difficulties they may be currently experiencing and that some persons may consider some of the questions to be intrusive. Participants were reminded of their option to not participate in the study and still receive research credit. They were presented with an Informed Consent Agreement describing the parameters of participation (see Appendix B). After reading the Informed Consent Agreement, they were instructed to open their questionnaire packet and begin. Instructions discouraged using any identifying information (see Appendix C). Since participants provided information on both the questionnaire packet and answer sheets, these items were coded for later matching before testing. Completing these measures took approximately one-hour.

Participants were first presented the TAPS questionnaire to assess concerns and fears regarding psychotherapy; then they completed the NEO-FFI, the NPC, and the BSI in that order. Next, participants identified problems they were currently experiencing from the self-report checklist and wrote briefly about the three problems they considered most serious. The third pre-vignette task

assessed mood by using two measures. They rated themselves on eight MAACL adjectives and completed the entire PANAS scale.

After completing all foregoing measures, participants were requested to read an approximately 1000-word vignette. The vignette presented "Cheryl", a woman experiencing a variety of problems common to a college student population and who is seeking career counseling at the university counseling center. Each was asked to rate "Cheryl" concerning her level of distress and need for psychological services (Appendix L); two additional questions assessed the respondents' reading comprehension. Afterwards, participants' mood was reassessed. They rated themselves on the polar-opposite MAACL adjectives and the entire PANAS scale. Finally, they completed the exposure to psychotherapy questionnaire and follow-up questions. Follow-up questions asked respondents to indicate the probability of their seeing a therapist over three time periods (i.e., next month, six months, and year) and assessed basic demographic information.

After returning all questionnaires, they were given a brief feedback sheet that also explained how to obtain more information (see Appendix O). Additionally, the feedback sheet explained that some people find that thinking about life problems and difficulties creates an interest in psychotherapy or counseling, but people do not know where to

go to obtain such services. Information about the university counseling center was provided.

Analyses

Power. The two studies assessing fear of psychotherapy with clinical and non-clinical participants have yielded effect sizes between .30 and .50 (Kushner & Sher, 1989; Pipes et al., 1985). Previous studies of downward comparison found mood change effect size for low self-esteem and depressed persons to be approximately r = .53 (Gibbons, 1986; Gibbons & McCoy, 1991; Aspinwall & Taylor, 1993). According to Cohen (1992), these represent medium to large effect sizes and with power of .80 and an alpha of .05 suggest that the N = 85. In an attempt to increase power, compensate for lower effect sizes, and offset students who drop out or submit incomplete data, this study recruited 334 students.

Statistics. Most participants completed their questionnaire packet, resulting in little missing data. However, listwise deletion was used for all analyses resulting in slight variations in sample sizes across analyses.

Hierarchical multiple regression was used to assess the relationships between the fear score (total TAPS; dependent variable) and distress (Neuroticism and GSI) and exposure to psychological counseling (independent variables). To assess whether participants' mood corresponds to psychological

distress following the self-awareness component, pretest PANAS scores were correlated with distress measures (Neuroticism and GSI). Moderate negative and positive correlations were predicted for the PA and NA scale, respectively.

Several questions were used to check the effect of the vignette manipulation. All participants were expected to perceive "Cheryl" as moderately to extremely distressed and in need of mental health services. Two questions assessed how thoroughly participants read the vignette.

Mood change was assessed in two ways. First, the difference in mood index scores on the MAACL adjectives was calculated (posttest minus pretest). To control for pretest mood differences, the second calculation of mood change covaried out pretest mood to assess mood change from a common average across participants. To assess the effects of downward comparison, separate hierarchical regression analyses were run with each calculation (similar results were expected) to determine the relationship between mood change (dependent variable) and distress (independent variable).

Hierarchical multiple regression was used to identify the relationships between perceived need for psychological counseling (dependent variable) and downward comparison and distress (independent variables). Hierarchical multiple regression was also used to assess the impact of distress,

prior exposure, fear of psychological counseling, and mood change on the probability of seeking psychological counseling. All suspected interactions were also assessed for significance.

Results

Thoughts About Psychotherapy Survey (TAPS)

Factor analysis of the TAPS. To determine whether the TAPS had a factor structure consistent with previous studies (Pipes et al., 1985; Kushner & Sher, 1989), factor analysis was performed using principal components with iteration and varimax rotation. This analysis was modeled after the procedures used by Kushner and Sher (1989) who found that the TAPS items identified three factors of satisfactory reliability. As expected, a three-factor solution was found which accounted for 60.8% of the variance. Though replicating their basic factor structure, several differences were noted in the items which comprised these factors (see Table 1 for factor loadings). For instance, Kushner and Sher (1989) did not include items 1 and 5 on any of their factors. The present analysis excluded only items 17 and 18 due to equivalent factor loadings on more than one factor. This procedure added two items (1 & 5) to their first factor, Therapist Responsiveness, and reduced their four-item third factor, Coercion Concerns, to only two items. As a result of these changes, means and standard deviations are not directly comparable across studies.

Table 1

Factor loadings for the Thoughts About Psychotherapy Survey (TAPS)

Item	Factor 1	Factor 2	Factor 3
1d	.65[a]	-.02	.17
2s	.81[a]	.13	.16
3s	.87[a]	.13	.16
4s	.88[a]	.17	.13
5d	.55[a]	.38	-.02
6s	.80[a]	.15	.14
7s	.42	.60[b]	-.01
8s	.76[a]	.31	.07
9s	.07	.77[b]	.02
10s	.22	.65[b]	.18
11s	.19	.71[b]	.23
12s	.08	.74[b]	.22
13s	.02	.67[b]	.28
14s	.73[a]	.02	.23
15s	.35	.20	.75[c]
16s	.24	.31	.77[c]
17d	.17	.53	.62
18d	.18	.48	.39
19s	.01	.53[b]	.41

Note. Superscripts ([a, b, & c]) denote items used to form Factors 1, 2, and 3; a factor loading had to be at least .11 (significant at .05 level) or greater than both other factors to be included. Lower case letters denote same (s) or different (d) than factors generated by Kushner & Sher (1989).

Reliability and validity of the TAPS. Using the factor structure generated by Kushner and Sher (1989), Deane and Chamberlain (1994) reported notable correlations between the TAPS total score and some of its subscales. These varied from .51 to .80 with one exception, Therapist Responsiveness and Image Concerns (.36). Table 2 presents all TAPS

Table 2

Intercorrelations, means, standard deviations, and alpha coefficients for the TAPS total and subscale scores

	TAPS scales						
TAPS measure	1	2	3	4	Mean	SD	Alpha
1. Total	---	.86	.80	.73	57.62	14.7	.92
2. Therapist Responsiveness		---	.43	.51	28.91	8.2	.91
3. Image Concerns			---	.54	18.14	5.9	.84
4. Coercion Concerns				---	5.52	2.1	.76

Note. N = 326 and p < .001 for all statistics.

correlations, means, standard deviations, and Cronbach alpha coefficients. Results were consistent with previous findings.

Deane and Chamberlain (1994) also reported the TAPS total and subscale scores to have concurrent validity with a

measure of state anxiety (correlations ranging from .13 to .48). Concurrent validity was established in the present study by correlating the total TAPS and all subscales with both Neuroticism and the GSI. Incidentally, Neuroticism and the GSI correlated strongly (r = .66, p < .001; N = 326). With one exception (Therapist Responsiveness and Neuroticism: r = .07, p = .20), all TAPS scores correlated with the two distress measures significantly (rs = .13 to .30, p < .05), although these relationships were generally weak. The results indicate that the TAPS scales have rather modest external parallelism with other measures of distress. They also raise the possibility that the TAPS may be measuring a unidimensional construct rather than multidimensional aspects of treatment fearfulness (i.e., Therapist Responsiveness, Image Concerns, Coercion Concerns).

To test this latter notion, TAPS items were randomly assigned to one of three factors. Satisfactory reliabilities would indicate that the TAPS scales measure one unidimensional construct, and that using the factor subscales would result in superfluous divisions and measurement errors. Internal consistency analysis of the randomly assigned items supported the notion of a unidimensional construct. Cronbach's alpha coefficients were .83, .72, and .76 for factors 1 (8 items), 2 (5 items), and 3 (6 items), respectively. As a result of these

findings, only the total TAPS score was used in all subsequent analyses.

Predictors of TAPS. It had been hypothesized that measures of distress (GSI and Neuroticism) and Exposure would correlate positively and negatively, respectively, with the total TAPS score. The interaction of distress and Exposure was predicted to account for a significant amount of TAPS variance. Hierarchical multiple regression was used to assess these relationships. The independent variables demonstrated satisfactory internal consistency (alpha coefficients for this study: .86 = Neuroticism, .96 = GSI, and .76 = Exposure). The hypothesis that distress and exposure would be positively and negatively correlated, respectively, was supported (see Table 3). When the GSI, Neuroticism, and Exposure were entered simultaneously, they accounted for 9% of the of the TAPS total score variance (R^2 = .09, $p < .001$), only the GSI (beta = .20, $p < .01$) and Exposure (beta = -.18, $p < .001$) were significant.

The interaction between distress and exposure was tested separately for the GSI and Neuroticism. The hypothesized interaction between distress and exposure was not supported. Neither interaction variable accounted for significant additional variance.

Reliability and Validity of Mood Measures

The average intercorrelations for the summed positive and negative adjectives of the MAACL at pretest were .67 and

Table 3

Hierarchical multiple regression analyses predicting the TAPS

Total sample (N = 324)

	R	R^2	Delta R^2	Beta
1. First step entry				
a. GSI	.22	.05***		
b. Neuroticism (N)	.21	.04***		
c. Exposure (E)	.13	.02*		
2. Second step entry				
a. GSI & N	.24	.06***		
Adding N to GSI			.01	
Adding GSI to N			.01*	
b. GSI & E	.29	.08***		
Adding E to GSI			.03***	
Adding GSI to E			.06***	
c. N & E	.26	.07***		
Adding E to N			.02**	
Adding N to E			.05***	
3. Third step entry				
a. All variables	.30	.09***		
GSI				.20**
N				.09
E				-.18***
b. Adding E to GSI & N (2a.)			.03***	
Adding N to GSI & E (2b.)			.00	
Adding GSI to N & E (2c.)			.02**	
4. Interaction				
a. Adding GSI*E to GSI & E			.00	
b. Adding N*E to N & E			.00	

Note. *p < .05; **p < .01; ***p < .001.

.52, respectively. Alpha coefficients are presented for these scales and the PANAS scales in Table 4. All scales possessed satisfactory internal consistency. To assess whether participants' mood corresponded to their level of psychological distress, these scales were correlated with Neuroticism and the GSI (see Table 4). All correlations were in the expected direction and significant ($p < .001$). As predicted, negative mood had a moderate and consistently positive relationship with measures of distress. Positive mood was reflected by negative correlations of somewhat lesser strength, especially for the PANAS.

Table 4

Mood scale alpha coefficients and correlations with Neuroticism and the General Severity Index (GSI) at pretest

	Alpha	Neuroticism	GSI
1. MAACL-Positive Adjectives	.89	-.51	-.47
2. MAACL-Negative Adjectives	.80	.53	.65
3. PANAS-Positive Affect	.89	-.34	-.21
4. PANAS-Negative Affect	.89	.43	.58

Note. For all correlations, $N = 301$ and $p < .001$.

Vignette Manipulation Checks

It had been expected that "Cheryl", the fictitious individual presented in the vignette, would be perceived as moderately to extremely distressed and in need of help with her problems. These expectations were confirmed. Participants found "Cheryl" to be between moderately and extremely distressed (M = 4.1, SD = .69) and similarly in need of help (M = 4.2, SD = .72). Additionally, they judged her as having only "a little" ability to overcome her problems without help (M = 1.9, SD = .97). Post-vignette questions (i.e., items 4 and 5) which assessed how thoroughly participants read the vignette indicated that 98% seemed to have read the entire vignette. Analyses of the remaining 2% indicated that the cases were not statistically different from the overall sample. As a result, they were included in all subsequent analyses.

Mood Change Difference Scores

Mood index scores were formed by subtracting the MAACL negative score from the positive score separately at pretest and posttest. Then this pretest score was subtracted from the posttest score to obtain a mood index change score (MICS; see Table 5). Given the PANAS assessment of two independent factors, Positive Affect (PA) and Negative Affect (NA) (Watson et al. , 1988), and the possibility that combining the scales into a composite might mask the relationship of distress and negative mood, the PA and NA

Table 5

Mood change

	Pretest Mood	Posttest Mood	Mood Change	t-value
Mood Index	6.67 (9.3)	6.83 (8.7)	.17 (6.6)	-.45
Positive	15.75 (5.8)	14.59 (5.4)	-1.16 (5.2)	3.99***
Negative	9.08 (4.7)	7.76 (4.8)	-1.32 (3.8)	6.21***
PA	25.61 (8.4)	25.22 (9.1)	-.39 (4.8)	1.43
NA	15.69 (6.6)	14.82 (6.0)	-.87 (3.7)	4.15***

Note. For Mood Index N = 322; for PA and NA scores N = 311.
***p < .001.

scales were maintained separate. Difference scores were obtained by subtracting pretest from posttest scores. Mood change was assessed for each scale using a paired sample t-test (see Table 5). The mood index change score was found to be marginal and not significant, even though each of its components (positive and negative) declined significantly, ts(321) = 3.99 and 6.21. As suspected, participants' decreases in both positive and negative mood scores offset each other. Consequently, subtracting the negative from the positive to form the Mood Index Change Score was basically nullifying. For the PANAS, only Negative Affectivity declined significantly, t(310) = 4.15.

Mood Change and Distress

Mood change and its relationship to distress was

analyzed in two ways. First, distress measures were used to predict mood change scores (i.e., MICS, PA, and NA). The relationship between mood change and distress was tested by regression analysis. The findings are shown in Table 6. The hypothesis that mood change and distress would correlate positively was partially supported. Initially, the GSI and Neuroticism were used separately to predict the MICS. Each significantly predicted the MICS, though neither accounted for much variance (Neuroticism: $\underline{R}^2$ = .04, $\underline{p}$ < .001; GSI: $\underline{R}^2$= .03, $\underline{p}$ < .001). Jointly entered, these two measures accounted for 5% of the variance ($\underline{R}^2$ = .05, $\underline{p}$ < .001), but only Neuroticism contributed significantly (beta = .17, $\underline{p}$ < .05). Next, the GSI and Neuroticism were used to predict PA and NA change scores. Neither distress measure accounted for a significant amount of the PA or NA score variance, either separately or simultaneously.

In the second method, distress measures were used to predict posttest mood scores after pretest mood scores were entered as a covariate. Results of these hierarchical multiple regressions are presented in Table 7. In each case the pretest measure was entered first. Then the two distress measures were entered simultaneously to see if they could account for a significant amount of additional variance. After controlling for the pretest Mood Index Score ($\underline{R}^2$ = .55, $\underline{p}$ < .001), the distress measures accounted for an additional 1% of the posttest Mood Index Score

Table 6

Regression analyses predicting Mood Index Change Scores (MICS), Positive Affectivity (PA) change, and Negative Affectivity (NA) change

	R	R^2	Beta
I. MICS			
1. a. GSI	.18	.03***	
b. Neuroticism (N)	.21	.04***	
2. GSI & N	.22	.05***	
a. GSI			.07
b. N			.17*
II. PA Change Score			
1. a. GSI	.07	.00	
b. N	.05	.00	
2. GSI & N	.07	.01	
a. GSI			-.08
b. N			.02
III. NA Change Score			
1. a. GSI	.09	.01	
b. N	.05	.00	
2. GSI & N	.09	.01	
a. GSI			-.11
b. N			.03

Note. N = 322 for MICS analysis; N = 303 for PA and NA analyses.
*p < .05; ***p < .001.

Table 7

Regression analyses predicting posttest mood scores -- using pretest mood scores as a covariate

	R	R^2	Delta R^2	Beta
I. Posttest Mood Index Score				
1. First entry				
a. Pretest mood index score	.74	.55***		
2. Second entry			.01*	
a. GSI				-.12*
b. N				-.02
II. Posttest PA Score				
1. First entry				
a. Pretest PA Score	.86	.73***		
2. Second entry			.00	
a. GSI				-.04
b. N				-.02
III. Posttest NA Score				
1. First entry				
a. Pretest NA Score	.84	.70***		
2. Second entry			.02***	
a. GSI				.11**
b. N				.06

Note. N = 314 for Mood Index Score analysis; N = 303 for PA and NA analyses. *p < .05; **p < .01; ***p < .001.

variance (Delta R^2 = .01, p < .05). Only the GSI made a significant contribution (beta = -.12, p < .05).

The PA pretest accounted for 73% of the PA posttest variance (R^2 = .73, p < .001). No additional variance was accounted for by either distress measure. In regard to NA, the pretest score accounted for 70% of the posttest variance (R^2 = .70, p < .001). An additional 2% of the variance was accounted for by distress with only the GSI contribution significant (beta = .11, p < .01).

The hypothesis that distress would predict mood change scores was partially supported. Both distress measures were statistically significant, but quite weak predictors of the Mood Index Change Score. However, neither PA nor NA change scores were predicted by either distress measure. When predicting posttest scores, using pretest scores as a covariate, the distress measures accounted for an additional 1% of posttest mood index score variance. While no additional PA score variance was explained beyond that of the pretest, the distress measures accounted for an additional 2% of the posttest NA score variance.

To better understand the patterns of mood change, GSI scores were divided into tertiles. For each level of distress, paired sample t-tests were conducted to assess the significance of mood changes (see Table 8). Although five out of six mood index component scores were significant, only the high distress group evidenced a significant Mood

Index Change Score (MICS) difference, $t(105) = 2.60$, $p < .01$. This group also demonstrated the only significant PANAS mood decline with their NA scores dropping an average of 1.5 points, $t(100) = 3.61$, $p < .001$.

Additionally, ANOVAs were conducted to assess the significance of change across these three tertiles. Significant F-values were found for the MICS, $F(2, 300) = 4.82$, $p < .01$, negative mood index component score $F(2, 300) = 4.02$, $p < .05$, and NA $F(2, 290) = 3.04$, $p < .05$. Neither measure of positive mood reached significance.

Table 8

Mood change with tertile division of the GSI: Within group paired-sample t-tests and between group ANOVAs

	Lower[a]	Middle[b]	Upper[c]	F
MICS	-.72 (6.3)	-.64 (6.1)	1.72 (6.8)**	4.82**
Pos	-1.51 (5.0)**	-1.63 (5.1)**	-.44 (5.2)	1.69
Neg	-.79 (2.4)**	-.99 (3.6)**	-2.16 (4.8)***	4.02*
PA	.37 (5.1)	-.77 (4.5)	-.66 (4.8)	1.67
NA	-.26 (2.8)	-.61 (3.8)	-1.51 (4.2)***	3.04*

Note. [a]Lower (GSI <= .37). [b]Middle (.38 < GSI <.77). [c]Upper (GSI >= .78). MICS: Ns = 98\99\106. PA & NA: Ns = 95\97\101. *p < .05; **p < .01; ***p < .001.

An interesting pattern was noted in the mood index component scores of the upper and lower tertiles. The upper group had minimal positive mood changes from pre- to posttest, but substantial declines in negative mood. The lower group had statistically significant mood shifts on both the positive and negative scales, but in contrast to the upper group, their largest mood change was on the positive scale. The significance of the lower group's negative shift was in part due to a relatively small standard deviation. Thus, while distressed participants primarily declined in negative mood, the non-distressed had much lesser negative mood reductions but strong reductions in positive mood.

Need for Psychological Counseling (NPC)

A significant problem developed in regard to the NPC measure, seemingly because of its administration between the two distress measures. Though each questionnaire began with new instructions and any important changes were in boldface type, approximately 130 participants seemed to either misinterpret or fail to fully comprehend the NPC instructions. This became apparent on the extreme items where they responded to the NPC as if it were a distress measure rather than a measure of the "need for psychological counseling". Given this measure's compromised validity, it was dropped from further analyses.

Probability of Seeking Psychological Counseling

Participants' were questioned about the probability of

their seeking psychological counseling in the next 30 days, six months, and one year. For these time periods, the means and standard deviations were: 30-days (M = 9.91, SD = 23.1), six months (M = 14.87, SD = 26.5), and one year (M = 18.31, SD = 28.6). Results from the three periods were averaged across participants to form a Probability of Help-Seeking (PHS) score. Distress, exposure, fear, and mood change (i.e., MICS) were expected predictors of PHS scores.

These relationships were tested using hierarchical multiple regression (see Table 9). When entered separately, all variables except the TAPS were found to be significant predictors; as a result, the TAPS was only included in interaction analyses. Variables were combined in pairs, and then the remaining variables were added to assess changes in R^2. The Mood Index Change Score was not found to explain any additional variance after the effects of either distress measure and Exposure. Exposure retained predictive power, even when entered after the MICS and distress (Delta R^2 = .18 to .20, $p < .001$). Regarding the distress measures, while Neuroticism explained additional variance after MICS and Exposure (Delta R^2 = .04, $p < .001$), it accounted for no significant variance when entered after the GSI. The GSI added unique variance (Delta R^2 = .04 to .07, $p < .001$) after any combination of Neuroticism, Exposure, and MICS.

The GSI and Exposure accounted for 31% of the PHS variance (R^2 = .31, $p < .001$). Though the addition of

Table 9

Hierarchical multiple regression analyses predicting Probability of Help-Seeking (PHS)

Total sample (N = 317)	R	R^2	Delta R^2	Beta
1. First step entry				
a. GSI	.37	.14***		
b. Neuroticism (N)	.26	.07***		
c. Exposure (E)	.47	.22***		
d. TAPS	.02	.00		
e. MICS	.13	.02*		
2. Second step entry				
a. GSI & N	.37	.14***		
Adding N to GSI			.00	
Adding GSI to N			.07***	
Adding E to GSI & N			.18***	
Adding MICS to GSI & N			.00	
b. GSI & E	.56	.31***		
Adding E to GSI			.18***	
Adding GSI to E			.08***	
Adding MICS to GSI & E			.00	
Adding N to GSI & E			.00	
c. N & E	.53	.28***		
Adding E to N			.20***	
Adding N to E			.05***	
Adding GSI to E & N			.04***	
Adding MICS to E & N			.01	
d. GSI & MICS	.37	.14***		
Adding MICS to GSI			.00	
Adding GSI to MICS			.12***	
Adding N to GSI & MICS			.00	
Adding E to GSI & MICS			.18***	
e. N & MICS	.27	.07***		
Adding MICS to N			.00	
Adding N to MICS			.06***	
Adding GSI to N & MICS			.07***	
Adding E to N & MICS			.20***	
f. E & MICS	.49	.24***		
Adding MICS to E			.02**	
Adding E to MICS			.22***	
Adding GSI to E & MICS			.07***	
Adding N to E & MICS			.04***	

Table 9 (cont'd).

Total sample (N = 317)	R	R^2	Delta R^2	Beta
3. Fourth step entry				
All variables	.56	.31***		
GSI				.25***
N				.05
E				.43***
MICS				.06
4. Interactions				
a. Adding GSI*E to GSI & E			.02**	
b. Adding N*E to N & E			.01**	
c. Adding GSI*TAPS to GSI & TAPS			.00	
d. Adding N*TAPS to N & TAPS			.00	

Note. *p < .05; **p < .01; ***p < .001.

Neuroticism and Exposure produced no increase in explained PHS variance, additional variance was accounted for by distress and Exposure interaction effects. The product of the GSI and Neuroticism with Exposure accounted for an additional 2% and 1% of PHS variance, respectively. The interaction of distress and the TAPS was not significant. Thus the GSI, Exposure, and their interaction accounted for 33% of the PHS variance.

Of additional interest, the Exposure measure was examined for only personal experience with psychological counseling. Eight percent of participants indicated that they were currently receiving some type of psychological counseling. A surprising 44% responded that they had received some type of psychological counseling in their lifetime; of these, 23% noted that they had attended 13 or more sessions.

Discussion

The participants in this study are thought to accurately represent women from a large midwestern university population. However, given their recruitment from both lower- and upper-level psychology courses, they may be more "psychologically-minded" and/or have more psychology related experiences (e.g., previous counseling) than the average undergraduate. The sample was relatively homogeneous in terms of both age and ethnicity.

As emphasized earlier, only a small proportion of persons experiencing distress actually seek psychological counseling. This discrepancy is especially puzzling in university populations where counseling services are often readily accessible and of minimal cost. Of these college women, eight percent indicated that they were currently receiving some type of psychological counseling, a figure consistent with the utilization rates of previous studies. A surprising 44% responded that they had received some form of psychological counseling at some time in their life; though this figure seemed high, it is close to the 39% reported by Bertocci et al. (1992). These figures suggest that even though prevalence rates for distress may be higher than utilization rates for services, a large number of

college women have been exposed to psychological counseling to some degree. That is, failure to make use of such services is not due to an ignorance of psychological counseling's availability.

Fear of psychological counseling among these college women was assessed with the TAPS (Pipes et al, 1985; Kushner & Sher, 1989), previously found to assess multidimensional aspects of treatment fearfulness. In contrast to these prior studies, the TAPS evidenced only weak multidimensionality in the present sample, and was fairly uniform in its factor intercorrelations and correlations with multiple distress measures (see also Deane & Chamberlain, 1994). Additionally, the random assignment of the TAPS items to three factors produced satisfactory internal consistency. These results suggest that the TAPS factors, though perhaps conceptually meaningful, did not assess independent factors, but appear to be superfluous divisions of a unitary construct. Given these findings, the TAPS total score was used exclusively to minimize measurement error.

Fear of psychological counseling was predicted by both distress and prior exposure to psychological counseling. The variables made independent contributions without interacting. Together, they accounted for 9% of the TAPS score variance. The GSI was a slightly better predictor than the Neuroticism factor of the NEO-FFI, while exposure

was the weakest predictor.

Overall, the findings replicate those of Kushner and Sher (1989), despite several differences in methodology. Different measures of exposure were used, and the current study controlled for gender by restricting participants to college women. Kushner and Sher (1989) compared male and female students who sought counseling services, but had not yet begun treatment, with "nonclinical" students. The present study addressed a wider range of prior exposure to psychological counseling, including both personal experience and the experiences of family and friends among college women.

The finding that distress and fearfulness of psychological counseling act counter to each other has led some to conceptualize the relationship as an approach-avoidance conflict (Kushner & Sher, 1989). This study's results support this notion, in part; however, the limited explanatory power of distress, even when combined with exposure, indicates that this interpretation should be made cautiously. Fear of psychological counseling appears impacted by a number of other factors not yet identified. These unknowns must be identified and explored before we can more fully understand treatment fearfulness and the failure to seek help for distress.

One possibility for the lack of explanation lies in the notion of measuring fear of psychological counseling, and

for that matter, distress. Much research calls into question the total reliance on self-report questionnaires which are subject to biases from personality traits (Schmitt, 1994) and unconscious defenses (Shedler, Mayman, & Manis, 1993). As a result of these problems, self-report measures may not accurately measure the intended construct. Additionally, they do not lend themselves to explaining causal relations, especially when used in cross-sectional designs (Spector, 1994) as utilized in this study.

These issues seem especially pertinent when asking questions about such culturally stigmatized topics as mental health, distress, and psychological counseling which tend to elicit socially desirable responses. For example, it seems quite plausible that while some individuals would defensively deny their distress, they might admit fearfulness or apprehension to seek treatment. Thus, self-report questionnaires make the task of identifying personal barriers to help-seeking quite elusive and suggest caution when interpreting such results.

Previous research suggests that distressed individuals tend to engage in downward comparison when presented with a distressed target individual (Wills, 1981). The effect of this process is a reduction of negative mood and enhanced self-esteem (Gibbons, 1986; Gibbons & Gerrard, 1989; Aspinwall & Taylor, 1993). The present study hypothesized that downward comparison would prevent help-seeking. That

is, if a more distressed person can be targeted and compared to the self, then there is a temporary relief of negative mood, and less of an immediate need to seek counseling. "Cheryl" was presented here as such a target. She was perceived as quite distressed and in need of help, and only attributed "a little" ability to overcome her difficulties without help.

Regression analyses indicated that distress was a significant predictor of the Mood Index Change Score (MICS) as expected, though curiously it predicted neither PANAS scale. Similar results were found when distress was used to predict posttest mood scores after controlling for pretest scores. However, distress also accounted for a significant amount of Negative Affectivity (NA) posttest variance.

This study found pre- to posttest change on the mood index scores to be nonsignificant, although its positive and negative components differed significantly. A closer look at these elements offered an explanation. When the mood index was calculated, positive and negative mood change cancelled each other out, producing the misleading finding of no overall mood change.

When the sample was divided into tertiles based on distress scores, this finding was more fully elucidated. These groups differed significantly on their overall mood change (i.e., MICS). Of particular interest, the low and high distress groups had unique patterns of positive and

negative mood change. After reading about "Cheryl", the low distress group evidenced both positive and negative mood change with the former much larger than the latter. The high distress group changed significantly only in negative mood. Thus, while the low distress group had primarily a reduction in positive mood, the high distress group had a reduction in negative mood.

These results suggest that those low in distress have more to lose by comparing downward or identifying with a distressed individual; that is, such a comparison diminishes their positive mood. This phenomena may offer an explanation for the "active" downward comparison or derogation among high self-esteem students reported by Gibbons and McCoy (1991). In individuals with low distress, active derogation might serve to preserve positive mood. The present study provided no opportunity for derogation. This represents an area for future research, especially insofar as high self-esteem individuals are not typically thought of as having the need to derogate others. Yet it may be an effective coping mechanism for maintaining positive mood. For those high in distress, there seems to be an "affective" benefit to reading about someone's distress: Positive mood is relatively unchanged and negative mood is significantly reduced.

Several issues may have impacted these results and should be considered regarding interpretations and

comparisons with previous reports. First, this study used polar opposite adjectives at pre- and posttest to reduce the obviousness of repeated measures, a fairly common methodological strategy (Gibbons & Gerrard, 1989; Gibbons & McCoy, 1991; Aspinwall & Taylor, 1993). Despite its popular use, no reports were found regarding the equivalency of these two sets of adjectives, and no present attempt was made to assess their equivalency. Second, the vignette manipulation provided a potentially more affect-loaded scenario (i.e., a woman seeking therapy presented in transcript form) than previous studies which typically use more academic/adjustment to college themes.

Incidentally, the PANAS which measures separate PA and NA scales, only exhibited significant NA mood change. When divided in tertiles based on distress, the only statistically significant PANAS finding was NA mood change in the high distress group. Several factors may explain why the MAACL adjectives indicated stronger mood change, for both positive and negative mood, than the PANAS scales. First, the MAACL adjectives were presented prior to the PANAS at both pre- and posttest. Second, the MAACL adjectives were "disguised" at posttest by using polar opposites with a different response format while the PANAS were merely repeated. Thus, MAACL adjectives may have tapped a primacy effect by being presented first. Alternatively, or in addition, "disguising" the adjectives

may have prevented participants from answering rotely or mechanically (to what some participants responded to in a Comments Section as "too many of the same questions"). Again, the potential inequivalency of MAACL adjectives might also explain these differences.

Given its compromised validity, the NPC measure was excluded from analyses. Instead, the Probability of Help-Seeking (PHS) was the final construct assessed. Overall, the GSI, Exposure, and their interaction produced the best explanation of variance in PHS scores, accounting for 33%. Neuroticism was also a significant predictor, although not as robust as the GSI, and prior Exposure was the strongest single predictor of PHS ratings. The Mood Index Change Score (MICS), assessing downward comparison, was also a significant predictor of PHS and added to the variance explained by Exposure, but failed to account for any additional PHS variance. Of interest, fear of psychological counseling was not a significant predictor.

Overall, these results call the TAPS measure of fearfulness into question. Variance in TAPS scores was only minimally explained by distress and exposure to psychological counseling, and TAPS failed to predict PHS ratings. As a result of these findings, TAPS' had little apparent relevance. The likelihood of help-seeking was best predicted by standard measures of distress and a measure of prior exposure to psychological counseling. Given the

limitations of a cross-sectional design, future research might profitably focus on distress, exposure, and help-seeking behavior by using a longitudinal design.

The results demonstrated that persons scoring high on distress tend toward negative mood reduction after being presented a downward comparison target. Unexpectedly, persons scoring low on distress have a similar reduction in positive mood. As mentioned earlier, these results suggest different coping mechanisms may regulate mood based on level of distress. In this context, the findings highlight the potential use of downward comparison in mood regulation and enhancement, and they give some direction to a promising area of research. That is, future studies of downward comparison might investigate under what conditions it is employed and the affective result for both low and high distress groups. Studies might also assess the duration of the affective change for each group. Additionally, research might address how persons low in distress tend to regulate the reduction in positive mood when forced to engage with a salient downward comparison target.

APPENDICES

Appendix A

Verbal Administration Instructions

Please make sure you are separated from the next person by at least one chair. You have signed up for a study about help-seeking. The questionnaires you will be asked to complete require approximately one and a half to two hours to complete. Some of the questions may relate to difficulties you are currently experiencing. Some people find some of the questions to be personal and intrusive. Therefore, please keep in mind that participation is voluntary, and you may withdraw from participating at any time without penalty.

All the information you provide will be kept anonymous and entirely confidential, so please do not write any identifying information, such as your name or personal identification (PID) number, on the questionnaire packet or answer sheet. Most answers will go on the "bubble" answer form, but some answers you will write in the questionnaire packet. The instructions should be clear. If you have any questions about the materials, please raise your hand.

Appendix B

Informed Consent Agreement

1. I have freely consented to take part in a scientific study being conducted by Jason Dahn, under the supervision of John Hurley, Ph.D., Professor of Psychology.

   This study is being conducted to investigate my feelings about seeking help for personal problems. As a participant, I will be asked to complete a questionnaire packet, and I have been informed that this will take less than 2 hours.

2. I have been informed that some people find some of the questions to be personal and intrusive. I understand that my participation is voluntary and am aware that I may withdraw from participating at any time without penalty.

3. I understand that my answers and all other information will be kept strictly confidential, and that I will remain anonymous. On request and within these restrictions results of the overall study may be made available to me.

4. I understand that my participation in the study does not guarantee any beneficial results to me.

5. I understand that I will receive some feedback about the study after I complete the questionnaire packet and that more detailed information about the purposes of the overall study will be available after its completion.

6. I have read the material above, and any questions I may have asked have been answered to my satisfaction. If I have questions later, I may contact Jason Dahn or, if he is not available, Professor Hurley.

7. I understand that by completing and returning this questionnaire I am indicating my voluntary agreement to participate.

Appendix C

Questionnaire Packet Instructions

Before you begin, please check to see that you have a "bubble" answer form. Also make sure that the code number in the upper right corner of your Informed Consent Agreement matches the number coded in the PIN area of your answer sheet. If it does not, raise your hand. Do not write your name or personal identification number (PIN) on the answer sheet or questionnaire packet.

The following packet contains a series of questionnaires. Each section begins on a new page. Be sure to read the short instructions for each section. Please answer all questions on your answer form unless the instructions indicate otherwise. Darken your answers completely and do not skip any questions. If you are unclear about a question or how to proceed, please raise your hand.

Note: There are many terms used for the situation when a person seeks out a mental health profession for services. For the questionnaires you are about to complete psychotherapy, counseling, and psychological counseling will be used interchangeably to describe the situation where an individual seeks out a mental health profession (e.g., social worker, counselor, psychologist, psychiatrist etc.) for individual therapy services.

Appendix D

Thoughts About Psychotherapy Survey (TAPS)

Instructions: If you were to imagine seeking psychotherapy or have been engaged in psychotherapy, please indicate the amount of concern you have in regard to each of the following statements.

1	2	3	4	5
no concern	little concerned	somewhat concerned	much concerned	very concerned

1. Whether therapy is what I need to help me with my problems?
2. Whether I'll be treated as a person in therapy?
3. Whether the therapist will be honest with me?
4. Whether the therapist will take my problem seriously?
5. Whether the therapist will share my values?
6. Whether everything I say in therapy will be kept confidential?
7. Whether the therapist will think I'm a bad person if I talk about every thing I have been thinking and feeling?
8. Whether the therapist will understand my problem?
9. Whether my friends will think I'm abnormal for coming?
10. Whether the therapist will think I'm more disturbed than I am?
11. Whether the therapist will find out things I don't want him/her to know about me and my life?
12. Whether I will learn things about myself I don't really want to know?
13. Whether I'll lose control of my emotions while in therapy?
14. Whether the therapist will be competent to address my problem?
15. Whether I will be pressured to do things in therapy I don't want to do?
16. Whether I will be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now?
17. Whether I will be pressured into talking about things that I don't want to?
18. Whether I will end up changing the way I think or feel about things and the world in general?
19. The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general?

Appendix E

NEO-FFI

Instructions: Read each statement carefully. For each statement darken the number with the response that best represents your opinion.

1	2	3	4	5
strongly disagree	disagree	neutral or equally true/false	agree	strongly agree

1. I am not a worrier.
2. I like to have a lot of people around me.
3. I don't like to waste my time daydreaming.
4. I try to be courteous to everyone I meet.
5. I keep my belongings clean and neat.
6. I often feel inferior to others.
7. I laugh easily.
8. Once I find the right way to do something, I stick to it.
9. I often get into arguments with my family and co-workers.
10. I'm pretty good about pacing myself so as to get things done on time.
11. When I'm under a great deal of stress, sometimes I feel like I'm going to pieces.
12. I don't consider myself especially "light-hearted."
13. I am intrigued by the patterns I find in art and nature.
14. Some people think I'm selfish and egotistical.
15. I am not a very methodical person.
16. I rarely feel lonely or blue.
17. I really enjoy talking to people.
18. I believe letting students hear controversial speakers can only confuse and mislead them.
19. I would rather cooperate with others than compete with them.
20. I try to perform all the tasks assigned to me conscientiously.
21. I often feel tense and jittery.
22. I like to be where the action is.
23. Poetry has little or no effect on me.
24. I tend to be cynical and skeptical of others' intentions.
25. I have a clear set of goals and work toward them in an orderly fashion.
26. Sometimes I feel completely worthless.
27. I usually prefer to do things alone.
28. I often try new and foreign foods.
29. I believe that most people will take advantage of you if you let them.
30. I waste a lot of time before settling down to work.
31. I rarely feel fearful or anxious.
32. I often feel as if I'm bursting with energy.
33. I seldom notice the moods or feelings that different environments produce.
34. Most people I know like me.
35. I work hard to accomplish my goals.

Appendix E (cont'd).

36. I often get angry at the way people treat me.
37. I am a cheerful, high-spirited person.
38. I believe we should look to our religious authorities for decisions on moral issues.
39. Some people think of me as cold and calculating.
40. When I make a commitment, I can always be counted on to follow through.
41. Too often, when things go wrong, I get discouraged and feel like giving up.
42. I am not a cheerful optimist.
43. Sometimes when I am reading poetry or looking at a work of art, I feel a chill or wave of excitement.
44. I'm hard-headed and tough-minded in my attitudes.
45. Sometimes I'm not as dependable or reliable as I should be.
46. I am seldom sad or depressed.
47. My life is fast-paced.
48. I have little interest in speculating on the nature of the universe or the human condition.
49. I generally try to be thoughtful and considerate.
50. I am a productive person who always gets the job done.
51. I often feel helpless and want someone else to solve my problems.
52. I am a very active person.
53. I have a lot of intellectual curiosity.
54. If I don't like people, I let them know it.
55. I never seem to be able to get organized.
56. At times I have been so ashamed I just wanted to hide.
57. I would rather go my own way than be a leader of others.
58. I often enjoy playing with theories or abstract ideas.
59. If necessary, I am willing to manipulate people to get what I want.
60. I strive for excellence in everything I do.

Appendix F

Brief Symptom Inventory

Instructions: Listed below are problems people sometimes have. Please read each one carefully, and darken the circle on your answer sheet that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully.

1	2	3	4	5
not at all	a little bit	moderately	quite a bit	extremely

1. Nervousness or shakiness inside
2. Faintness or dizziness
3. The idea that someone else can control your thoughts
4. Feeling others are to blame for most of your troubles
5. Trouble remembering things
6. Feeling easily annoyed or irritated
7. Pains in heart or chest
8. Feeling afraid in open spaces or on the streets
9. Thoughts of ending your life
10. Feeling that most people cannot be trusted
11. Poor appetite
12. Suddenly scared for no reason
13. Temper outbursts that you could not control
14. Feeling lonely even when you are with people
15. Feeling blocked in getting things done
16. Feeling lonely
17. Feeling blue
18. Feeling no interest in things
19. Feeling fearful
20. Your feelings being easily hurt
21. Feeling that people are unfriendly or dislike you
22. Feeling inferior to others
23. Nausea or upset stomach
24. Feeling that you are watched or talked about by others
25. Trouble falling asleep
26. Having to check and double-check what you do
27. Difficulty making decisions
28. Feeling afraid to travel on buses, subways, or trains
29. Trouble getting your breath
30. Hot or cold spells
31. Having to avoid certain things, places, or activities because they frighten you
32. Your mind going blank
33. Numbness or tingling in parts of your body
34. The idea that you should be punished for your sins
35. Feeling hopeless about the future
36. Trouble concentrating
37. Feeling weak in parts of your body
38. Feeling tense or keyed up

Appendix F (cont'd).

39. Thoughts of death or dying
40. Having urges to beat, injure, or harm someone
41. Having urges to smash or break things
42. Feeling very self-conscious with others
43. Feeling uneasy in crowds, such as shopping or at a movie
44. Never feeling close to another person
45. Spells of terror or panic
46. Getting into frequent arguments
47. Feeling nervous when you are left alone
48. Others not giving you proper credit for your achievements
49. Feeling so restless you couldn't sit still
50. Feelings of worthlessness
51. Feeling that people will take advantage of you if you let them
52. Feelings of guilt
53. The idea that something is wrong with your mind

Appendix G

Need for Psychological Counseling

Instructions. Read each statement and consider it to be true for you. Then identify the degree to which you feel it indicates a need for psychological counseling. That is, **If the statement were true of you, how much do you feel it would indicate a need for psychological counseling**. Darken the corresponding number.

1	2	3	4	5
not at all	a little bit	moderate	quite a bit	extreme

1. I am often overwhelmed by school or work tasks.
2. I have only minimal problems or difficulties.
3. My feelings often interfere with my progress in school or work.
4. I occasionally leave my body.
5. I occasionally think about suicide.
6. I sometimes find myself frustrated.
7. I act violently without understanding the consequences of my actions.
8. Occasionally, I have trouble overcoming feeling down or depressed.
9. I cannot attend school or work because my thoughts are so confused.
10. I am sometimes too scared to leave my home for days.
11. I avoid making friends.
12. I often feel nervous or anxious.
13. Most of my relationships are satisfying.
14. I am unhappy with my progress in school or work.
15. My relationships are mostly satisfying.
16. I'm afraid that if I told someone how I feel they would misunderstand me or think I was crazy.
17. I function generally well in all areas of my life.
18. I sometimes have difficulties with school or work.
19. I sometimes have feelings of terror.
20. I sometimes think about hurting other people.
21. I occasionally have feelings of an overwhelming panic.
22. I am dissatisfied with my friends.
23. Usually, my problems are expectable reactions to life stressors.
24. I am sometimes preoccupied with killing myself.
25. All my relationships are meaningless and dissatisfying.
26. I have tried in the past to kill myself without realizing the implications of my actions.
27. I have a lot of trouble making friends.
28. I would rather spend time alone than with others.
29. I sometimes think that I live in a different world than everyone else.
30. I sometimes hear voices that other people around me cannot hear.
31. I feel like most of my relationships are superficial.
32. I always get hurt in relationships.
33. I often wish my relationships were more fulfilling.
34. I don't have any difficulties or problems.
35. I can sometimes be violent and dangerous to myself and others.

Appendix G (cont'd).

36. I have thoughts and ideas that other people don't understand.
37. I never have problems which seem to get out of hand.
38. I occasionally have arguments with friends.
39. I frequently have difficulty completing tasks at school or work.
40. I often think of ways to "get back" at others.
41. My relationships are frequently dissatisfying.
42. I am upset or dissatisfied with my life most of the time.
43. I think of suicide as a possibility.
44. I am sought out by others because of my many positive qualities.
45. I think about and plan ways to hurt others.
46. I usually feel as if I am in a fog.
47. My problems are typically short-lived and transient.
48. I am often afraid or unable to express myself.
49. I am interested and involved in a wide range of activities.
50. I sometimes don't feel much of anything.
51. I can frequently be dangerous to myself and others.
52. I have difficulties accomplishing my tasks at school or work.
53. I have no more than everyday problems or concerns.
54. I often think people are trying to take advantage of me.
55. Relationships often leave me feeling empty and unfulfilled.
56. I sometimes do things without being able to stop myself.
57. Sometimes my thoughts scare me.
58. I find life to be quite stressful and overwhelming.
59. I am sometimes dissatisfied with my friends.
60. I have difficulty understanding my thoughts.
61. I frequently feel upset or stressed.
62. I often feel more like a robot than a person.
63. I sometimes think and feel so many things that it can be confusing.
64. My problems last longer than other people I know.
65. I don't get meaningfulness or fulfillment from relationships.

Appendix H

Problem Checklist

Many students consider counseling at some point while they are in school. The list below contains many of the difficulties people may experience. If you were to consider counseling at the present time, please mark all of the items that are of concern to you by filling in the number 1 for the corresponding question number on your answer sheet; if the item is <u>not</u> of concern to you, mark the number 2.

For example, if you are concerned about depression (Item 22), bubble number 1 for depression:

22. Depression Answer Sheet 153. 1 2 3 4 5

If you are <u>not</u> concerned about depression, mark number 2:

22. Depression Answer Sheet 153. 1 2 3 4 5

Remember that your responses are anonymous and confidential.

1. School work and grades
2. Procrastination, getting motivated, managing time
3. Concentration
4. Test anxiety or panic
5. Stage fright, speaking or performance anxiety
6. Decision about major or career
7. Work or job related issues
8. Relationship with friends
9. Relationship with roommate
10. Relationship with family and parents
11. Relationship with romantic partner
12. Relationship with husband or wife
13. Relationship with your children
14. Loss/death of significant person
15. Sexual matters
16. Gay/lesbian issues
17. Racial, ethnic, or cultural issues
18. Religious matters
19. Shyness, being assertive
20. Self-esteem, self-confidence
21. Loneliness, homesickness
22. Depression
23. Anxiety, nervousness, worrying
24. Fears
25. Irritability, anger, hostile feelings

Appendix H (cont'd).

26. Tiredness
27. Troublesome thoughts
28. Suicidal feelings, behavior
29. Headaches, stomach pains, muscle tension
30. Sleep problems
31. Pregnancy
32. Alcohol or drug related issues
33. Eating problems
34. Legal problems
35. Financial problems
36. Sexual assault, past sexual abuse
37. Victim of other violence
38. Other (please specify)_____

Please consider the three concerns, from the above list, that you feel to be the most serious. Below, briefly describe the general nature of the problem which makes the item a concern to you and your feelings about it. If you have less than three concerns, please write about as many as you listed.

1. Write the term as it is listed in the above checklist: _____. Describe the nature of your concern and your feelings about it:

_____
_____
_____
_____

2. Write the term as it is listed in the above checklist: _____. Describe the nature of your concern and your feelings about it:

_____
_____
_____
_____

3. Write the term as it is listed in the above checklist: _____. Describe the nature of your concern and your feelings about it:

_____
_____
_____
_____

Appendix I

Mood Assessment (MAACL)

Instructions: Listed below are a number of words that describe different feelings and emotions. Read each item and darken the appropriate response on your answer sheet. Indicate to what extent you feel this way right now, that is, at the present moment. Use the following scale from A (1) to B (7) to determine your response.

A	B	C	D	E	F	G
not at all	a little	somewhat	moderately	quite a bit	much	very much

1. happy
2. hopeless
3. secure
4. discontented
5. pleased
6. discouraged
7. satisfied
8. tense

1	2	3	4	5	6	7
not at all	a little	somewhat	moderately	quite a bit	much	very much

9. calm
10. dissatisfied
11. encouraged
12. displeased
13. content
14. insecure
15. hopeful
16. sad

Appendix J

Mood Assessment (PANAS)

Instructions: Below are different words that describe feelings and emotions. Read each item and then mark the appropriate response on your answer sheet. Indicate to what extent you feel this way right now, that is, at the present moment. Use the following scale from 1 to 5 to determine your response.

1	2	3	4	5
very slightly or not at all	a little	moderately	quite a bit	extremely

1. interested
2. distressed
3. excited
4. upset
5. strong
6. guilty
7. scared
8. hostile
9. enthusiastic
10. proud
11. irritable
12. alert
13. ashamed
14. inspired
15. nervous
16. determined
17. attentive
18. jittery
19. active
20. afraid

Appendix K

Vignette

The following passage was transcribed from a taped intake interview at a University Counseling Center. The client provided written consent for its use. Due to the legal confidentiality of this material, the individual's name and background information have been altered to protect her identity. All other information is provided verbatim as she presented herself. A series of periods (. . .) represents pauses in her presentation. This passage represents approximately 7 minutes of a 50 minute interview.

Background Information

Cheryl is a 19 year old sophomore who transferred to MSU after completing a year at a small community college in western Michigan. Recent events prompted her to seek academic counseling. She came into the Center on November 12, 1993 concerned that she was going to "fail out of MSU".

Cheryl's parents were divorced when she was 11, and she reports seeing her father who lives in Florida only once or twice a year. She has an older brother (24 years) who lives in Florida and a younger sister (17 years) who resides with her mother near Holland, Michigan.

Transcript

Cheryl: It has just been really hard getting used to being away from home. I mean, I thought I was ready but now . . . I don't know . . . (beginning to cry) Just like this, I can't seem to stop crying, and I don't know why I'm doing it . . . It really bothers me . . . (crying more heavily). It just makes it where I can't get anything done. All I want to do is sit and cry, and I know no one wants to be around me. I feel like I'm driving everyone away. My roommates say they understand, but I know they are getting tired of it. I don't care about doing anything, and they want to go out all the time. When I go out I just don't feel a part of it, like I'm just seeing things happen. It feels so alone, and I don't get anything done. I'd rather be in my room and feel that way. I'd rather be sleeping. I sleep a lot; I try to sleep a lot because if I'm sleeping then I'm not crying, and I can cry myself right to sleep . . . I don't know. I hate it, whether I go out or not I just can't focus, and I don't know what to do.

Interviewer: For how long have you been feeling like this?

Appendix K (cont'd).

Cheryl: What, the crying? Basically, for as long as I can remember. I mean, I've always been an emotional person, but it seems to have gotten much worse. And this semester, it has really messed everything up, . . . I don't know what I'm going to do. I dropped from four classes to two and I'm failing both of them. In one, I try and try and I just can't seem to pass the quizzes, and in another, well, I've only been to it four or five times this semester and the final is coming up and I know I'm going to fail it, but in all my classes when I sit down to read my eyes just move over the words, and next thing I know I'm crying . . . and I just give up and cry because it's too frustrating . . . I don't go to one of the classes because my ex-boyfriend is in it. We agreed to take the course together, but then we started fighting and broke up and I just don't want to see him. I mean it is just hard because I really still care for him (beginning to cry again) but seeing him just brings it all back, and I remember everything that happened and I think over and over: What should I have done, what did you do wrong, if you would've given him more space . . . then you wouldn't be flunking out of school . . . Also, seeing him reminds me of how lonely I am, and how I need someone in my life (crying), and I start crying like this, I don't know what to do . . . But, I'm going to fail this class and screw up my GPA because I can't deal with these feelings for him. And I feel so guilty for feeling like this; why can't I handle this. I mean I did fine at a smaller school, and I was doing more things than I do now. Is it just because we broke up, why do I let it affect me so?

Interviewer: How long ago did you break up with him?

Cheryl: Well, we broke up for the first time after dating 11 months. That was this past summer, but then we got back together when we both moved here for school. Then he decided he wanted to see other people in October, and that's when we broke up again . . . I should've known better. My mother told me it wouldn't work when I moved here.

Interviewer: What's your relationship with your mother like, how often do you talk with her?

Cheryl: It's OK. I mean, I call home, or we talk about once a week, but I know she's busy and that I can't put too much of all this on her. I mean, I've always been pretty independent; I had to be after the divorce. The next year my brother moved to Florida to go to college, and my mother
started working, she's had to struggle to make ends meet, and I helped by taking care of my sister. We talk now, but never for very long . . . I can't put this on her. She struggles too much anyway, and I shouldn't have to rely on her. She thinks I'm doing fine in classes . . . She expects me to be independent . . . and I don't know if I can do it (crying) . . . I just feel so bad about it all, and I don't know what to do. It is just so hard to keep feeling like this.

Appendix L

Post-Vignette Questions

1. After reading about the difficulties Cheryl is experiencing, how would you rate her overall level of psychological distress?

1	2	3	4	5
very slightly or not at all	a little	moderate	quite a bit	extreme

2. How would you rate her need for help with the problems she is facing?

1	2	3	4	5
very slightly or not at all	a little	moderate	quite a bit	extreme

3. If Cheryl were to choose after this interview <u>not</u> to seek additional services, how would you rate her ability to overcome these difficulties on her own?

1	2	3	4	5
very slightly or not at all	a little	moderate	quite a bit	extreme

4. How would you characterize Cheryl's relationship with her mother?

1	2	3	4	5
very close	close	average	distant	very distant

5. How would you characterize Cheryl's relationship with her father?

1	2	3	4	5
very close	close	average	distant	very distant

6. What percentage of students on campus do you estimate have problems such as Cheryl's?
<u>Write your answer here</u> _____%

Appendix M

Contact with Mental Health Services

Instruction. The following questions address the extent to which you have had contact with mental health services personally or through family and friends. Mental health services specifically refers to experience with psychotherapy or counseling. The general term **psychological counseling** will be used to refer to these types of experiences. Read each question carefully and darken the number which best represents your experiences. Be sure to darken only one answer for each question.

To help you decide on the extent of your experience with psychological counseling, please refer to the following guidelines:

1 = no experience
2 = one to six sessions of psychological counseling
3 = seven to twelve sessions of psychological counseling
4 = thirteen to twenty-four sessions of psychological counseling
5 = over twenty-four sessions of psychological counseling

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1. Indicate the extent of your personal experience in psychological counseling **at the present time**? (That is, if you are presently receiving services, how many sessions have you attended.) If you are not **presently** participating in psychological counseling, mark number (1).

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

2. Indicate the extent of your experience in psychological counseling <u>over your lifetime</u>? If you have never participated in counseling, mark number (1).

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

Appendix M (cont'd).

3. Indicate the extent of your mother's experience in psychological counseling, over her lifetime, that you know about? If you also have step- or foster mother relationships, use the total number of sessions when all these relationships are combined.

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

4. Indicate the extent of your father's experience in psychological counseling, over his lifetime, that you know about? If you also have step- or foster father relationships, use the total number of sessions when all these relationships are combined.

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

5. Indicate the extent of your brothers' and sisters' experience in psychological counseling, over their lifetime, that you know about? Include step-, half-, and foster sibling relationships and use the total number of sessions when all these relationships are combined. If you do not have sibling relationships, mark number 1.

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

6. Indicate the extent of your friends' experience in psychological counseling, over their lifetime, that you know about? If more than one friend has had such experiences, use the combined number sessions across all friends with such experiences.

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

Appendix M (cont'd).

7. Think about your experiences and all of the people you have close relationships with, family and/or friends, and their lifetime experiences with psychological counseling. Indicate below how much experience you feel you have had personally and through these relationships with psychological counseling?

   1 = no experience
   2 = a little experience
   3 = moderate experience
   4 = quite a bit of experience
   5 = extensive experience

8. Considering again all the experience you feel you have had with psychological counseling. How helpful would you generally rate such services to be?

   1 = not helpful
   2 = a little helpful
   3 = moderately helpful
   4 = quite a bit helpful
   5 = extremely helpful

9. Considering again all the contact you feel you have had with psychological counseling. How likely is it that you would recommend such services?

   1 = not likely
   2 = a little likely
   3 = moderately likely
   4 = quite a bit likely
   5 = extremely likely

Appendix N

Follow-up Questions

1. Given your feelings about yourself and the difficulties you are facing at the present time. What is the probability of your seeking psychotherapy or counseling within the next 30 days (0-100%)? (For example, if you feel there is a 50 percent chance, indicate 50%.)
   Write your answer here: _____%

2. Given your feelings about yourself and the difficulties you are facing at the present time. What is the probability of your seeking psychotherapy or counseling within the next 6 months?
   Write your answer here: _____%

3. Given your feelings about yourself and the difficulties you are facing at the present time. What is the probability of your seeking psychotherapy or counseling within the next year?
   Write your answer here: _____%

This experiment presented a short passage from an interview with a student named Cheryl. If you think back on your perception of the interview:

4. How realistic did you find the interview with Cheryl to be?

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

5. How believable did you find the interview with Cheryl to be?

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

6. What is you current age?

1	2	3	4	5
(17-18)	(19-20)	(21-22)	(23-24)	(over 24)

Appendix N (cont'd).

7. Ethnicity?

1	2	3	4	5*
White	Black	Hispanic	Asian	Other

*If you indicated Other, please write in:_____

Thank you very much for participating in this study about help-seeking. Please return your packet to the front of the room to receive experimental credit. Be sure and pick-up a Feedback Sheet.

Appendix O

Feedback Sheet

Note: In order to prevent bias in future participants and to protect the integrity of study results, please keep this information confidential and do not share it with others who may be signed up for the study. This assures that results are not biased by preconceptions of study content and is essential for valid results.

College students have been extensively researched since the 1920's in regard to level of psychological distress and usage of psychological counseling services. A consistent finding is that there are more distressed students than users of available mental health services. This situation raises questions about what motivates a student to seek help, or conversely, what inhibits a student from seeking help. Several factors seem to contribute.

This study is examining the impact of distress, fear of psychological counseling, exposure to services, and downward comparison. Distress consists of a variety of problems. It may involve other people such as parents, friends, and significant relationships, or it may be more intra-personal such as depressive feelings, anxiety, or headaches. Distress seems to be the primary reason people seek help -- they want help in understanding and relieving the distress. However, many distressed students do not seek help.

Based on previous research, fear seems to be a strong inhibitor of seeking services. This study attempts to replicate previous findings and hypothesizes that fear acts in conjunction with distress to inhibit help-seeking. That is, the more distressed a student is the more they will fear seeking help.

Research suggests that exposure to services acts in the opposite direction. The more experiences someone has had personally or through family and friends with services, the less fear they will have and the more likely they will seek help for distress. This study hypothesizes that those with more exposure will have less fear regardless of distress level.

The last factor this study examined is a process called downward comparison. In this process, a person feels better about themselves if they can compare themselves to a less fortunate person. The ability to make downward comparisons may lead a person to postpone help-seeking since there are others who are worse off. Research suggests a positive association between downward comparison and distress. This study seeks to replicate this finding and also postulates a negative association between downward comparison and perceived need of psychological counseling.

Several aspects of this study focused on current problems and difficulties. Some people find that thinking about their difficulties creates an interest in psychological counseling, but often they do not know where to access such services. If you are interested in counseling, please contact the Michigan State University Counseling Center. The Center is located in two locations: 207 Student Services Building (355-8270) and 335 Olin Health Center (355-2310). Feel free to contact either location for walk-in hours.

Thanks again for participating in this study. If you have any questions or are interested in the results of the study, please feel free to contact me at my office, 133 Snyder Hall, 462-3684.

Jason R. Dahn

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