Exploration of the relationship between resilience, social support and formal help seeking, and evaluation of Guelph’s 1 in 5 mental health awareness initiative

by

Krista K. Westfall

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ABSTRACT

EXPLORATION OF THE RELATIONSHIP BETWEEN RESILIENCE, SOCIAL SUPPORT AND FORMAL HELP SEEKING, AND EVALUATION OF GUELPH’S 1 IN 5 MENTAL HEALTH AWARENESS INITIATIVE

Krista K. Westfall
University of Guelph, 2014

Advisor: Dr. M. Preyde

The primary purpose of this thesis was to explore the relationship between resilience, formal help seeking, and social support, given that the association between resilience and help seeking behavior is not fully understood (Schomerus et al., 2013). A cross-sectional online survey was conducted and data were analyzed with hierarchical multiple regression. Participants’ (N=52) mean age was 24.18 years (SD=8.421) and 80.8% were female. Analyses revealed a significant positive association between social support and resilience. Few published evaluations of university-based mental health initiatives were located, thus a secondary purpose involved conducting an exploratory end-of-session evaluation of the Panel event of the University of Guelph’s Mental Health Awareness Initiative. Evaluation results from 92 respondents (M age = 23.64 SD = 7.466, 80.4% female) revealed discrepancies between targets of recruitment efforts and actual attendees, high event satisfaction, and participants considered the event successful in addressing stigma. Practice and research implications are discussed.
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Introduction

Resilience is the process of prevailing over the harmful effects of risk exposure, successfully dealing with distressing experiences, and avoiding damaging paths associated with certain threats (Smith et al., 2008) and is prevalent in mental health research but the association with help seeking behaviour is not fully understood (Schomerus et al., 2013). Instead, resilience is often examined in terms of psychopathology with higher resilience levels associated with lower levels of depression and anxiety (Carbonell et al., 2002; Reivich, Gillham, & Chaplin, 2005). Additionally, low levels of resilience have been associated with higher levels of formal help seeking in depressed individuals (Schomerus et al., 2013) and social support (a key resource/promotive factor in resilience) has been associated with both low (Ten Have, Vollerbergh, Bijl, & Ormel, 2002) and high levels (Schomerus et al., 2013) of help seeking. In order to fully understand the relationship between resilience and help seeking it is necessary to consider promotive factors that affect resilience, such as social support, that may be key when addressing mental illnesses and fostering resilience (Fergus & Zimmerman, 2005). Additionally, as expressed by Wilson, Pritchard, and Revalee (2011), the relationship between formal and informal help seeking is not clear. Informal help seeking may be a first step in the help seeking process, eventually leading to formal help. Conversely, informal help seeking may also be a barrier to formal help seeking (Wilson et al., 2011). Primary purposes of the present study were to explore coping strategies and the relationship between resilience, formal help seeking, and social support in a sample of students who attended at least one event from Guelph’s Mental Health Awareness Initiative.

Secondary purposes involved conducting a preliminary, exploratory evaluation of the University of Guelph’s 1 in 5 Mental Health Awareness Initiative, which is a week-long series of
events that takes place each year (since 2011) to promote mental health awareness and demonstrate how attendees can maintain their own mental health. One in five Canadians will experience a mental illness in their lifetime and the remaining four will know a family member, friend, or colleague who will struggle with a mental illness (Offord et al., 1996; Patel, Flisher, Hetrick, & McGorry, 2007). In addition to the normal stresses of post-secondary education, the age of onset for most mental illnesses is 17-24 years (Kessler et al., 2005), which suggests University/College students may be a critical population when addressing mental health and mental illness. What is particularly concerning is that the majority of college students with mental health disorders are not receiving formal treatment (Eisenberg, Hunt, Speer, & Zivin, 2011). Furthermore, most University/College campuses have a mental health program in place but very few published evaluations of these initiatives have been located. This research may foster understanding of resilience and help-seeking behaviour and may have implications for the development of mental health initiatives. Researchers used an online survey to examine resilience, formal help seeking, social support, and coping, and conducted an end-of-session evaluation to explore the 1 in 5 Mental Health Awareness Initiative.

Defining Mental Health and Mental Illness

There are several definitions associated with mental health that have evolved over time. In the past, the World Health Organization (WHO) defined mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2005). There are three distinct elements captured in this definition: well-being, effective functioning of an individual, and effective functioning within a community (WHO, 2005). The WHO has since updated their definition of mental health but these three core
elements remain evident. More recently, the WHO has defined mental health as “a state of complete physical, mental and social well-being, and not merely the absence of disease” (WHO, 2010b).

Westerhof and Keyes (2010) stressed the importance of the three elements present in the WHO definitions. In line with the updated WHO definition, Westerhof and Keyes (2010) preferred to view mental health as “a positive phenomenon that is more than the absence of mental illness” (p. 110). Further to this idea, they added three elements similar to those in the WHO definitions. The first core component is feelings of happiness and satisfaction with life, which they referred to as emotional well-being. Next is psychological well-being, which is the idea that an individual positively functions in terms of self-realization. The last component is social well-being, which involves positive societal functioning and being of social value (Westerhof & Keyes, 2010).

It is important to address the differences between mental illness and mental health as these two terms are often used interchangeably but they have important differences. The definition of mental health was previously discussed and the following will address the definition of mental illness. According to Health Canada (2002), mental illnesses involve changes in thinking, mood, or behaviour that are associated with significant distress as well as the impairment of daily functioning. Manderscheid et al. (2010) provided a historical view of the definition of mental illness and outlined the changes to the definition over the last half-century. In the 1960s and 1970s mental illness was defined solely by diagnosis. Through the 1980s and 1990s it was recognized that a diagnosis alone was not sufficient and an updated definition was necessary to classify severity of mental illness. To do so, the concepts of disability and duration were included. Disability refers to impairments in daily functioning and duration refers to the
length of time that the disability is present. The definition of mental illness as it is widely
accepted today refers to a situation in which cognition, emotion, or behaviour is affected such
that it is long lasting (duration) and impacts daily functioning (disability) (Manderscheid et al.,
2010). Changes may only appear in one aspect of thinking, mood, or behaviour or as a
combination of two or more of these elements. Mental illness symptoms vary widely and may be
felt only mildly; however, they can also be severe. Severity depends on the individual, the
specific mental illness with which they are dealing, and a number of social factors such as family
and environment. People may be equipped with coping skills to deal with certain levels of stress
and pain. It is the duration and intensity of the painful feelings to the extent that they interfere
with daily life that classifies a mental illness. Interference in daily life can include impairments
in functioning within the family, in school, and at work. These coping skills become
overwhelmed which marks the point when someone may need help to restore themselves to a
healthy state (Health Canada, 2002).

Now that the definitions of mental illness and mental health have been discussed, it is
possible to examine the two in relation to one another. To accomplish this comparison,
Westerhof and Keyes (2010) used the two continua model of mental illness and mental health to
explain that even though these two terms are associated they are distinct dimensions. There is the
presence or absence of mental illness and the presence or absence of mental health. Mental
health is not simply the absence of mental illness but also the existence of psychological
wellbeing. The two form a complete state; you cannot just consider one or the other individually
(Westerhof & Keyes, 2010), as is reflected in the updated WHO definition. When referring to
mental health, the concept of mental illness (presence or absence of disease) is included.
However, when the focus is solely on mental illness, the additional concepts that form mental
health (such as emotional, individual and social well-being) are not included in this definition. Updated definitions of mental illness and mental health are generally agreed upon in the literature and despite the addition of key concepts, such as breaking down well-being into emotional, physical, and social elements, core components such as individual and social functioning from early definitions remain.

**Development and Effects of Mental Illness.** Mental illness is a pressing issue that affects numerous people. When considering the global burden of disease about 14% is accredited to mental illness (Prince et al., 2007). Worldwide, there are hundreds of millions of people with mental illnesses including, but not limited to, depression, alcohol use disorders, schizophrenia, and anxiety disorders (WHO, 2010a). Additionally, among young people, suicide is the third leading cause of death with close to one million people dying due to suicide each year (World Health Report, 2001). Worldwide, four of the top 10 causes of disability as a result of health-related conditions are unipolar depressive disorders, schizophrenia, bipolar disorder, and alcohol use disorders (WHO, 2004).

In addition to the effects of poor mental health, there are multiple determinants of mental illness. The exact etiology is unknown; however, biological/genetic, genetic-environmental interaction, psychological, and environmental factors are associated with mental illness. Patel et al. (2007) outlined social, psychological, and biological factors as having immense impacts on onset and course of mental illness. For example, unrelenting socio-economic pressures may lead to mental health problems, including mental illness, and negatively affect pre-existing mental illnesses in individuals and communities. In addition, stressful working conditions, discrimination, and unhealthy lifestyles are all associated with developing mental illnesses (Paananen, Ristikari, Merikukka, & Gissler, 2013).
People are more vulnerable to mental illness if they possess specific psychological or personality traits, such as learning disorders, maladaptive personality traits, having suffered sexual, physical or emotional abuse/neglect, or have a difficult temperament (Patel et al., 2007). Effects of childhood physical abuse are long lasting and predict poor mental and physical health decades after the abuse (Springer, Sheridan, & Cames, 2007; Sugaya et al., 2012). Conversely, people who are able to learn from their experiences, have good self-esteem, possess high levels of problem-solving ability, and those with good social skills are least likely to be affected by mental illness (Patel et al., 2007). In terms of biology, some causes of mental illnesses include genetic factors, chemical imbalances in the brain, and exposure to toxins (tobacco or alcohol) before birth (Patel et al., 2007). Taking into consideration the numerous determinants of and negative effects associated with mental illness, it is essential to address issues of poor mental health, specifically mental illness.

**Mental Illness in Canada**

Health Canada (2002) reported that whether directly or indirectly, mental illness will touch the life of all Canadians: 20% will experience a mental illness in their lifetime and the remainder of the population will know someone who will struggle with a mental illness (Offord et al., 1996; Patel et al., 2007). It is extremely important to effectively deal with mental illnesses because people of all ages, cultures, and education or income levels can be affected (Health Canada, 2002) and the effects can be felt in every aspect of a person’s life. According to Flett and Hewitt (2013) of those who are suffering with a mental illness and need to access services only one-third actually receive any treatment. One reason that so many people are not receiving treatment may be that some problems, such as anxiety and depression, are easier to conceal as opposed to more overt behavioural problems (Flett & Hewitt, 2013).
The effects of mental illness are felt throughout the Canadian economy. In Canada, the annual cost of mental illness in terms of health care and lost productivity is an estimated $51 billion (Lim et al., 2008), and more specifically, in the Ontario economy these annual costs are $34 billion (Gnam et al., 2006). Mental illness represents more than 15% of the total burden of diseases in Canada yet only 5.5% of health care dollars is committed to these illnesses (Institute of Health Economics, 2008). Mental illness is the second leading cause of disability and premature death in Canada (Canadian Medical Association, 2008). The effects of mental illnesses are greatly felt within the workplace. As a result of mental illness, on any given week, approximately 500,000 employed Canadians are unable to work. Additionally, approximately 175,000 full-time employees miss work due to mental illnesses (Institute of Health Economics, 2008). Furthermore, according to the Ontario Disability Support Program (ODSP), mental illness is one of the most common disabilities for which support is available. The effects of mental illness are not only felt in every aspect of a person’s life but also in every life stage.

**Why Focus on Students on University and College Campuses?**

University/College is a critical period in a young adult’s life. It is during these years that a great deal of development occurs and they may also be some of the most stressful years that a young adult faces. In addition to the normal stresses of University/College, the age of onset for most mental illnesses is 17-24 years (Kessler et al., 2005) which generally aligns with the years spent in post-secondary education. It is important to address the mental health of University/College students because a sizeable proportion, approximately half (Zivin, Eisenberg, Gollust, & Golberstein, 2009) to 65% (US Department of Education, 2008) of all young adults pursue post-secondary education. Mental health is a growing concern, particularly among University/College students, because campuses provide a medium for reaching a large number of
people during a significant life period. Hunt and Eisenberg (2009) explained, “College represents the only time in many people’s lives when a single integrated setting encompasses their main activities—both career related and social—as well as health services and other support services” (p. 3). It is important that mental illnesses are identified and treated given that impacts are felt in educational, economic, and social outcomes (Zivin et al., 2009). According to the World Health Organization the economic and social impacts of mental illness are diverse and broad resulting in poor educational outcomes which attribute to high unemployment rates, homelessness, high rates of poverty, and in turn, poor health outcomes (WHO, 2010a). University/College years are a shift into adulthood that can be developmentally challenging. Dealing with this transition in addition to an untreated mental illness may have substantial implications for academic success, efficiency/productivity, social relationships, and even substance use (Weitzman, 2004; Hunt & Eisenberg, 2010).

Increasingly, mental health rates are surfacing in the media, which increases awareness of the issue. Craggs (2012) publicized the rates of mental health problems at McMaster University. The campus survey revealed that over half of students felt overwhelmed with anxiety and 6.5% of students had contemplated suicide. Lunau (2012) publicized findings from the 2011 University of Alberta National College Health Assessment. Of the 1600 surveyed students: 51.3% felt hopeless, 87.5% felt overwhelmed (in general), 52.1% felt overwhelmed specifically by anxiety, 34.4% reported feeling so depressed it was impacting their daily functioning, and 57.1% reported experiencing more than the ‘normal amount’ of university stress. Additionally, students were asked about factors that negatively affect academic performance and the top ten answers were listed with numbers one and two being stress (33.9%) and anxiety (25%) (University of Alberta, 2011). Stress and anxiety have been shown to negatively affect university
students’ relationships with peers and faculty, levels of engagement in campus activities and clubs, grades, and graduation rates (Regehr, Glancy, & Pitts, 2013). Taking into consideration these high levels of stress and anxiety in Canadian university students, in combination with low rates of formal individual treatment, Universities should tailor prevention programs that have the potential to reach large groups of students. Relying on students seeking individual counseling and treatment services appears to be unrealistic (Regehr, Glancy, & Pitts, 2013).

Taking these impacts into consideration, what is particularly concerning is that despite the fact that effective treatments exist (Burns, Hoagwood, & Mrazek, 1999; Seligman, 1998; Satcher, 2000; Nathan & Gorman, 2002) the majority of college students who screened positive for a mental illness were not receiving treatment (Eisenberg et al., 2011). There has been a great deal of research dedicated to investigating the reasons and barriers for students who need help but are not receiving it. Eisenberg, Golberstien, and Gollust (2007) reported that of University students who screened positive for major depression only 36% actively sought out treatment and received help for their mental illness. Those who did not seek treatment reported beliefs that it is not effective and a lack of perceived need for help. Furthermore, 59% of University students were unaware of the free counseling offered at their institution (Eisenberg Golberstien, & Gollust, 2007). Previously, researchers identified mental health stigma as one of the key reasons people suffering with mental illnesses do not actively seek treatment (Hogan, 2003). However, Eisenberg, Hunt, and Speer (2012) found that 65% of students with untreated mental illnesses reported that personal stigma was not a factor in their decisions regarding treatment. Additional reasons students provided for not seeking help were beliefs that the problem would improve with time, realizing that stress is normal in University and not recognizing healthy/unhealthy levels of stress/anxiety, questioning the severity of the problem, and given deadlines and due dates for
papers and exams it is difficult justifying time to seek treatment (Eisenberg, Hunt, & Speer, 2012). These findings suggest that students are often aware of a mental health problem and consciously deliberate how urgent treatment might be. Despite new evidence suggesting that the effects of stigma on help seeking may be decreasing, further evidence is needed to support this notion and stigma remains an important factor in help seeking.

**Theoretical Approaches to Stigma.** Thornicroft, Rose, Kassam, and Sartorius (2007) describe stigma as an umbrella term that includes three factors: “problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination)” (p. 192). Stigma can be considered a feature that separates an individual or a group of individuals based on a judgment formed in a social context. An individual or group of people decide someone is “tainted” or “less than” based on a particular feature (physically or mentally) they possess. The judgment leads to stereotypes (negative beliefs about the individual/group), prejudice (social acceptance of the negative beliefs as authentic), and discrimination (actions to avoid/exclude the person/group who have been assigned the stigmatized status) (Corrigan et al., 2003; Link & Phelan, 2001). Early studies also maintain that stigma is created and carried out through social interaction (Goffman, 1963).

Pescosolido et al. (2008) provided an alternative way to examine stigma through a Framework Integrating Normative Influences on Stigma (FINIS). These authors used this framework to examine the various divisions of social life where stigma forms: micro, meso, and macro. Within FINIS these three levels interact and create normative expectations which causes anything outside of these normative expectations to potentially be stigmatized. The micro level consists of psychological and socio-cultural levels and individual factors. At this level stigma is likely to increase if there is a noticeable difference between the target (the person being
stigmatized) and the receiver (member of society). These differences can be based on ethnicity, age, or, for example, how easily an individual can be identified as an outsider. The meso level is comprised of social networks and organization level factors. Within this level, friend groups, schools, and workplaces are all sources of information that people use to form their beliefs. Within these settings, it is important to encourage interaction between “marked” and “unmarked” individuals in an effort to form beliefs based on real world experience. The macro level consists of factors that influence society as a whole. Stigma is embedded in a larger cultural context, for example, the media can influence peoples’ perceptions of what is “normal” or “accepted” in society. Additionally, thinking on a national level there are overarching ideas and beliefs about which groups to categorize and stigmatize. There are competing ideas that stigma can be implicit and the person who holds the stigma might be unaware of it. However, stigma may also be consciously motivated and driven by emotions and beliefs. There is also the presence of self-stigma, which a person experiences when they are influenced by an awareness of their devalued position within a society. It is important to recognize that stigma is extremely dynamic in nature and is influenced through each of the micro, meso, and macro social levels and interaction between the levels (Pescosolido et al., 2008).

One of the leading methods targeting mental health stigma is social contact. The social contact hypothesis states that mental health stigma reduction is fundamentally associated with interaction between those with, and without mental illnesses (Kolodziej & Johnson, 1996; Corrigan et al., 2001; Corrigan et al., 2012; Evans-Lacko et al., 2012). The social contact hypothesis employs the same situation in which stigma is created and perpetuated in an effort to reduce it. However, the existence of stigma has resulted in people hiding their mental illness, which in turn, creates difficulties when organizing social contact situations. One alternative to
actual social contact is imagined intergroup contact, which involves imagining a positive
counter with a person dealing with a specific mental illness (Stathi, Tsantila, & Crisp, 2012; Crisp & Turner, 2009). Participants who took part in imagined intergroup contact for a situation
involving a person with schizophrenia reported reduced stereotypes and enhanced intentions for
positive engagement as a result of reduced anxiety regarding the interaction. Evans-Lacko et al.
(2012) examined real social contact (between people with and without a mental illness) and
concluded that social contact improved intergroup relations and reduced an “us vs. them”
mentality. However, social contact did not affect willingness to disclose a mental illness, which
is concerning considering the previously discussed negative cycle of stigma, non-disclosure, and
reduced social contact.

While social contact interventions are generally successful for mental health stigma
reduction there appear to be exceptions for particular populations such as medical students
(Yamaguchi et al., 2013). The effects of social contact between patients with a mental illness and
medical students was further explored by Papish et al. (2013) and it was found that no significant
differences in stigma reduction were witnessed due to a power imbalance between medical
students and contact with patients possessing a mental illness diagnosis. The “us vs. them”
mentality Evans-Lacko et al. (2012) discussed was not overcome due to the unequal status
between a doctor and patient. Evidence suggests that social contact is a promising avenue for
addressing mental health stigma reduction and this success is dependent on equal status
relationships.

**Resilience.** Resilience is important to consider when discussing a stressful situation,
threats to health (including mental health), and stigma/adversity. Smith and colleagues (2008)
discussed the evolving definitions of resilience including resilience as a process, not a static trait,
of prevailing over the harmful effects of risk exposure, successfully dealing with distressing experiences, and avoiding damaging paths associated with certain threats (Garmezy, Masten, & Tellegen, 1984; Rutter, 1985; Luthar, Cicchetti, & Becker, 2000; Masten & Powell, 2003). In reference to health and mental health, resilience refers to the ability to avoid illness despite adversity and to strive and function above the norm when dealing with a chronic condition (Smith et al., 2008). Resilience levels can be checked by examining if people are able to revert back to a previous level of functioning following a stressful incident, if, faced with a stressful event, people are able to move to a higher level of functioning to compensate, or simply adjusting or overcoming a new or stressful situation (Smith et al., 2008). There are many resilience theories that focus on a specific population (athletes, medical students, families, communities/organizations); however, the majority of theories share three common features and resilience is viewed as: a dynamic process, changing over time, and involving many factors (the specific factors emphasized vary; Fletcher & Sarkar, 2013).

Fergus and Zimmerman (2005) discussed resilience as understanding how people can develop in a healthy manner in spite of risk exposure and adversity. The focus is on promotive factors, which take the form of assets or resources. Assets are internal factors that people may or may not possess or possess at different levels, such as coping skills or anxiety management. Resources are external to the individual, such as parental support, and are influenced by one’s social environment; therefore, resources are not necessarily static.

Fergus and Zimmerman (2005) explored three models of resilience and explained how assets and resources operate and influence outcomes when people face adversity. In the Compensatory Model (Zimmerman & Arunkumar, 1994) of resilience, how promotive factors counteract risk factors is examined. Within this model, promotive factors (internal assets and
external resources) have direct effects on outcomes but this effect is independent of the effect of a risk factor. The Protective Factor Model (Rutter, 1985) of resilience viewed assets (i.e. coping skills or anxiety management) and resources (i.e. parental support or social environment) as moderators that neutralize or reduce the effects of adversity (without completely removing it) on a negative outcome. Within this model, if the protective factors are removed the relationship between the risk and outcome is much stronger. The third model of resilience is the Challenge Model (Garmezy, Masten, & Tellegen, 1984), which viewed the relationship between risk factor and outcome as curvilinear. Negative outcomes are associated with low and high levels of risk exposure (i.e. family conflict, low levels yield no opportunity to solve interpersonal conflict but high levels of conflict may be devastating); however, moderate levels of risk exposure are related to outcomes that are more positive (moderate family conflict gives youth the opportunity to cope and overcome it without becoming exhausted). If risk levels are too low, the issue will not be addressed and if they are too high, the exposure could be overwhelming and impossible to adjust. Moderate levels of risk exposure provide an opportunity to deal with a manageable amount of risk without being overwhelmed. In this situation, the risk (too little/too much exposure to family conflict) and promotive factors (moderate family conflict exposure) are the same variable (Fergus & Zimmerman, 2005).

There are a number of difficulties that arise when examining resilience. First, resilience may be content (able to overcome one particular risk but not another) and context specific (particular environment). Second, individual and group differences (i.e. resilience may differ between urban/suburban and rural adolescents, males and females, and high and low socio economic status) exist in resilience and must be considered. It is difficult to identify universal promotive factors that positively affect groups of people in the same manner. Additionally, risk
exposure is also individually experienced (i.e. siblings differing in what they are able to overcome based on their personal experiences of promotive factors). It is difficult to take into consideration multiple assets and resources, multiple risks, and the interacting effects. With all these factors at play it is important that resilience-based interventions (which involve skill building and problem-solving in an effort to enhance the resilience process), especially those focused on prevention, focus on the development of promotive factors (assets and resources) for people who are likely to be exposed to risk factors instead of trying to obliterate risks, which is unrealistic (Fergus & Zimmerman, 2005; Reinke et al., 2012).

With mental illness rates (number and severity) increasing (American College Health Association, 2008; Gallagher, 2008), understanding factors that predict resilience and help seeking are key to help those facing poor mental health (including mental illness). Schomerus et al. (2013) examined personality-related factors as predictors of help seeking and resilience in a population diagnosed with depression and found that higher social support levels and lower resilience levels were associated with help seeking. The purpose of their study was to gain a better understanding of the relationship between resilience and professional help seeking since this relationship has been identified as highly understudied (Schomerus et al., 2013).

Help Seeking. When examining the relationship between help seeking and resilience the role of informal help seeking must also be considered. Eisenberg et al. (2011) reported that instead of receiving formal treatment for a mental illness 78% of students preferred to turn to informal supports such as family (52%) and friends (67%). In addition to turning directly to friends and family for informal support, Moreno et al. (2011) found that students often used social networking sites, such as Facebook, as a way to ask friends and family for help. An analysis of 200 Facebook profiles from undergraduate students revealed that 25% of students
used the “status update” function to publicly display content and express feelings consistent with depressive symptoms. With so many students turning to informal support systems, it may be important to equip informal supports with necessary information regarding mental illness and treatment options to provide useful support or direction to appropriate support for someone struggling with a (potential) mental illness. There are potentially dire consequences if informal supports ignore someone seeking help or are unable to appropriately assist them.

Wilson et al. (2011) described help seeking as a process, though the pathways of this process are not clear. Informal help seeking is potentially a first step or a barrier to formal help seeking. It is unclear if people who seek informal help share characteristics that differ from those who automatically turn to formal help seeking (Wilson et al., 2011). In an effort to improve formal help seeking, the relationship between formal and informal help seeking needs to be understood. As suggested by Schomerus et al. (2013), while resilience was a protective factor against depression, in those who were depressed resilience appeared to be an obstacle to formal help seeking. In order to fully understand the effects of resilience and help seeking it is necessary to explore other populations and consider promotive factors that affect resilience.

**Social Support.** Fergus and Zimmerman (2005) emphasized promotive factors (assets and resources) when examining resilience and specifically, the importance of social support as a resource. Social context and its effects on mental health have been studied extensively and social support has emerged as a psychosocial coping resource (Berkman, 2001). Social support is comprised of structural and functional support (Thoits, 1995). Structural support is classified by the organization of the social network, which involves the number, frequency of contact with, and complexity of social relationships (Thoits, 1995). The perceived quality of these relationships is referred to as functional support which serves four main purposes: appraisal
support (transfer of information or advice), tangible support (instrumental or material aid, i.e. financial assistance), belonging support (social companionship), and self-esteem support (feeling of value) (Cohen & Willis, 1985). While the language surrounding social support carries a positive connotation, these support systems do not necessarily serve as positive influences and compulsory social ties (parents, family, co-workers) can generate stressful demands that neutralize the positive effects associated with social support (Thoits, 1995). Often, structural and functional support are examined independently; however, it is important and useful to examine them as a whole (Hefner & Eisenberg, 2009). Social support resources are not necessarily static (Fergus & Zimmerman, 2005) and are affected by personal characteristics/abilities, including poor social skills which could result in small networks or networks of poor quality (Barrera, 1986, Heller, 1979).

In the previous section formal help seeking was operationally defined. Informal help seeking differs in that efforts to find assistance for a problem or distressing situation are not from trained professionals but from informal social relationships, such as family or friends, and are focused on understanding and advice as opposed to information and treatment (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Informal help seeking and social support may appear to be similar concepts, yet key differences exist in that informal help seeking is in response to a specific problem (similar to appraisal support); however, social support includes the additional concepts of tangible, belonging, and self-esteem support (Cohen & Willis, 1985). A key consideration, according to Schonfeld (1991), when measuring these concepts is to consider that actual received support is likely to be confounded based on the influences involved when encountering stressful situations and in turn requiring support. To remedy this problem, perceived social support, or the belief that support is available, has been shown to be a more
effective influence on mental health when compared to received social support (Dunkel-Schetter & Bennett, 1990; Wethington & Kessler, 1986).

In addition, social support has been linked to higher self-esteem and self-efficacy and has been viewed as a buffer to the negative effects associated with stress (Kaplan, Cassel, & Gore, 1977; Cohen & Willis, 1985). Cohen and Willis (1985) explored social support effects on well-being as well as the process of social support as a protective factor. They described a main effect model that showed a positive association between social support and well-being, which is attributed to the overall benefits of having a social support system. The buffering model described social support as a process that serves to protect people from negative effects when faced with stressful events (Cohen & Willis, 1985). Not only does social support influence well-being and emotional health (Berkman, 2001) but a lack of social support can be linked to mental illness by way of social isolation (Berkman, 2001; Durden, Hill, & Angel, 2007). The relationship between social support and mental health help seeking requires more attention. Previously, low levels of social support have been associated with help seeking behaviour (Ten Have, Vollerbergh, Bijl, & Ormel, 2002) but recent research suggested the opposite, high levels of perceived social support were associated with help seeking behaviour (Schomerus et al., 2013). Resilience plays an important role in overcoming adverse life events (Garmezy, Masten, & Tellegen, 1984; Rutter, 1985; Luthar, Cicchetti, & Becker, 2000; Masten & Powell, 2003) and further exploration is needed to fully understand the relationship between resilience and help seeking. To do so, aspects of resilience such as social support and coping strategies need to be taken into consideration to better develop mental health initiatives.

Coping. As previously discussed, promotive factors such as resources (social support) and assets (coping) are key when examining resilience (Fergus & Zimmerman, 2005). In terms
of assets, coping styles have been shown to predict variance in resilience (with task-oriented coping positively related to resilience while emotion-oriented coping is related with lower resilience levels) (Campbell-Sills, Cohan, & Stein, 2006). Coping is a dynamic and on-going process that involves cognitive and behavioural efforts (Folkman and Lazarus, 1988) to regulate the problem/situation causing distress and the accompanying emotions (Folkman, 1984).

Distressing emotions occur when internal/external pressures are appraised as exhausting one’s resources (Folkman & Lazarus, 1988). Due to constant reappraisals of the person-environment relationship (also constantly changing), these cognitive and behavioural responses are in turn continually changing (Folkman & Lazarus, 1988; Folkman, 1984). According to these researchers, previous models of coping are incomplete for two reasons: they underestimate the complexity of emotion and coping and view the relationship between emotion and coping as a unidirectional pattern. The animal model, which comes from a Darwinian perspective of learned behaviour, described coping as survival when faced with life-threatening behaviours (Miller, 1980; Ursin, 1980). A second model, the psychoanalytic ego psychology model, defined coping as a cognitive process combined with problem-solving behaviour in an attempt to reduce anxiety or other troubling emotional states (Menninger, 1963; Vaillant, 1977). Folkman and Lazarus (1988) preferred to focus on the flow from coping to emotion and the occurrence of both positive and negative emotions during the coping process. They emphasized that cognitive appraisals (primary and secondary) are influenced by individual factors such as motivation, beliefs, personal resources, and health, as well as environmental variables. Appraisals of harm or threat are associated with negative emotions such as anger/sadness and anxiety whereas challenges often produce positive emotions (excitement, eagerness, confidence) (Lazarus & Folkman, 1984). In addition to appraisals, coping methods such as planful problem-solving and positive
reframing have been associated with positive emotions while confrontive coping and distancing often bring about negative emotions (Folkman & Lazarus, 1988). In the coping literature distinctions are often made to characterize sets of coping strategies, such as problem-focused or emotion-focused. Emotion-focused strategies are concerned with changing or alleviating distress by reducing or altering the emotions that accompany a distressing situation (i.e. venting, distraction, positive reframing, and emotional/instrumental support). Conversely, problem-focused strategies aim to alleviate distress by targeting the cause of the problem or distressing situation (i.e. active coping or planning which involve taking action or developing a strategy to improve/resolve the problem) (Folkman & Lazarus, 1988). It may be tempting to argue for particular coping strategies that are associated with positive emotions but the adaptive value associated with the process of coping is context dependent (given that the nature of the event, the social context in which it takes place, and the personality of the individual are integral; Vaillant, 1977; Lazarus & Folkman, 1984, Folkman & Lazarus, 1988). Due to this high degree of variability, coping is viewed as a mediator of emotional response (Folkman & Lazarus, 1988).

**School-Based Mental Health Initiatives, Interventions, Program Evaluations**

In the literature, school-based mental health initiatives and interventions refer to two distinct situations. Mental health interventions are reactive and generally target one purpose (such a stress reduction) using one or two varying methods (e.g., teaching a particular technique during one or multiple session). Initiatives are preventative or promotive and refer to school-based programs that contain multiple components addressing several purposes such as knowledge transfer, stigma reduction, stress relief, and anxiety management. Mental health initiatives often refer to post-secondary level programs such as Guelph’s 1 in 5 Mental Health Awareness Week and York University’s Healthy Campus Project, which take place over a period
of time (i.e. one week).

A review of Canadian school-based mental health programs revealed a high prevalence in grade schools and a disproportionately high number that serve high school students when compared to Universities (Manion, Short, & Ferguson, 2012). Elementary and high schools are attendance-based making it easier to target all students considering they spend an average of seven to eight hours a day and five days a week in school (Walter et al., 2011) which aligns with the six to 17 year age range targeted by most programs (Kang-Yi, Mandell, & Hadley, 2013). The most common methods in Canadian school-based mental health programs involve behavioural and cognitive-behavioural approaches, rather than dissemination of information (Manion, Short, & Ferguson, 2012). This scan of Canadian school-based mental health programs identified availability in all provinces and territories with the majority in Ontario. The goals of these programs fell into three categories: risk behaviour prevention (50%), prosocial skill development (41%), and mental health literacy (37%). Unfortunately, Manion and colleagues (2012) reported that less than 50% of the programs had been evaluated.

Program evaluation is a process that is used to provide information for judging the worth of a program as well as identifying strengths and weaknesses. There are two approaches to program evaluation: process evaluation is used to examine the procedural methods used to implement and deliver the program and outcome evaluation is used to assess which and to what extent the desired results are achieved (Rossi, Lipsey, & Freeman, 2004). Furthermore, there are five types of information that can be gained from end-of-session evaluations: participant background, participant reactions, future programming, outcomes, and teaching and facilitation (Taylor-Powell & Renner, 2009).

Additionally, of the programs noted in the Canadian school-based mental health program
scan, there were very weak ties to evidence based information and it appeared that school-based mental health programs may not be taking advantage of the existing literature, which could further improve program implementation and outcomes (Manion, Short, & Ferguson, 2012). These weak ties to evidence based information could explain the vast differences in scope, intensity, and duration of school-based mental health programs (Rones & Hoagwood, 2000). While the majority of school-based mental health programs are geared towards grade school students, and more predominantly high school students, current efforts are evolving to focus on University and College students.

**Mental Health Interventions on University/College Campuses.** Eisenberg, Hunt, and Speer (2012) suggested that mental health interventions on university campuses be categorized under one of three headings: stigma reduction and education, screening and linkage, or gatekeeper training. *Stigma reduction and education* interventions are the most common methods targeting help seeking. They are considered “outreach” interventions because they aim to access a large number of students, however, they are difficult to evaluate. Often this type of intervention incorporates speakers, performances, flyers and newsletters for advertising, and catchy slogans or logos to capture students’ attention.

*Screening and linkage* interventions target students in distress and then try to steer them towards appropriate services. These objectives are often carried out through the use of screening tools such as questionnaires and trained staff offer advice on services based on students’ results. This type of intervention also has the potential to reach a large population as screening tools can be distributed through e-mail and completed online, which also means these interventions can be very cost-effective. The main difficulty with screening and linkage interventions is in motivating students to participate.
The final intervention category is *gatekeeper training*. These interventions train people who are frequently in contact with others in a community setting, known as gatekeepers. The “gatekeepers” are taught information and skills that they can use to recognize someone who is dealing with a mental health problem, how to successfully intervene with that person, and then direct them to appropriate services in the community. The challenges for gatekeeper interventions are how increasing knowledge of the “gatekeeper” translates to appropriate supportive behaviour and how the supportive behaviour links to service usage.

After reviewing the literature on post-secondary interventions, aside from research on interventions targeting help-seeking, mental health interventions targeting stress reduction and anxiety management appeared to be the most prevalent and these interventions varied greatly. They generally ranged anywhere from one session (Dziegielewski, Turnage, & Roest-Marti, 2004) to eight sessions (Oman et al., 2004) and as high as 15 sessions (Caldwell et al., 2010) with sessions ranging from multiple times daily to once a week. The reviewed interventions, on average, fell between four and six sessions. Only three interventions were identified containing a single session and are discussed below. Session length also varied from 40 to 150 minutes.

Regehr, Glancy, and Pitts (2013) conducted a systematic review and meta-analysis of school-based stress interventions and found the majority were randomized control trials using cognitive/behavioural/mindfulness methods, which were largely successful in anxiety reduction (as opposed to educational or arts-based methods); however, the focus was largely on nursing or medical students. Outcomes were most often measured using the State-Trait Anxiety Inventory and/or the Perceived Stress Scale (Regehr, Glancy, & Pitts, 2013).

**Single-Session Stress/Anxiety Reduction Interventions.** Fehringer (1983) conducted a randomized controlled trial of a single-session biofeedback and relaxation training (BRT) with
undergraduate students. The BRT group had significantly lower post-test scores on the State-Trait Anxiety Inventory and the Profile of Mood States when compared to a group that just received relaxation training and a control group. Dziegielewski, Turnage, and Roest-Marti (2004) conducted an educational single-session intervention with social work students to address stress. Post-test scores on the Stressful Situations Questionnaire, when compared to a control group, revealed significantly lower levels of stress and apprehension. Roembke (1995) conducted a single group pre-/post-test for an educational seminar he created focusing on burnout and prevention in graduate psychology students. Post-test scores of an individualized objective evaluation of participants’ understanding of the seminar content revealed significant learning had occurred. Roembke (1995) associated learning and education with actual burnout prevention improvement. Even though most Universities/Colleges have a mental health initiative in place there is sparse literature in which these interventions have been evaluated.

**Guelph’s 1 in 5 Mental Health Awareness Initiative.** The University of Guelph’s mental health initiative is called the 1 in 5 Mental Health Awareness Week. According to Eisenberg, Hunt, and Speer (2012) this program falls under the category of stigma reduction and education, as previously discussed. It is a weeklong event that has taken place in late November each year for the past three years and remains un-evaluated. Participants were taught to use the seven dimensions of wellness to maintain their own mental health. These seven dimensions are social, emotional, spiritual, environmental, occupational, intellectual, and physical. Five events made up the Mental Health Week and free t-shirts were available for pick-up throughout the week and people were encouraged to wear them on the Thursday of the Mental Health Week to show their support for mental health awareness.

The first event of the week was called the ‘Opening Doors Project’. This event was a
presentation by the CMHA (Canadian Mental Health Association), was shaped as a narrative-based workshop, and covered topics such as migration, stress, mental health, culture-shock, racism, and resiliency in peoples’ experiences of moving to a new country. The objective of this event was to equip attendees with strategies (including where to go to seek help) for dealing with the previously mentioned issues related to mental health.

The second event of the week was a one-hour stress management workshop, run by an on-campus expert in stress management, designed to equip attendees with methods to cope with stress. The objectives were to teach participants how to recognize the difference between normal stress and distress, realize when they should be seeking help for their distress, and easily employ techniques to manage stress including behaviour changes (controlling anger/anxiety through relaxation techniques), lifestyle changes (such as better sleep techniques), biofeedback, and how to break the cycle of worry.

The third event was a yoga class that taught participants about physical activity and its benefits for mental health. Participants were taught different yoga poses and breathing techniques and how they help with decreasing stress and anxiety, focusing on the physical and spiritual dimensions of wellness and their impact on mental health.

The fourth event was a mental health and nutrition presentation led by a Student Health Services Registered Dietician who covered topics such as eating to decrease stress and boost immunity (effective eating habits), disordered eating (ineffective eating habits), and eating disorders and body image. Participants were taught effective and ineffective eating habits (and strategies for overcoming ineffective eating habits) and their impact on stress and mental health.

The fifth and final event took the form of a question and answer session called ‘Let’s talk mental health’ where a panel of past and present University of Guelph students shared their
lived experiences with mental illnesses (anxiety, depression, substance use, self-harm, obsessive compulsive disorder, and bipolar disorder). The main objective of the panel stories were to show that people who have mental illnesses are no different from others and mental illnesses are much more common than most people perceive. Once the panelists shared their stories about their struggles, participants had the opportunity to ask questions.

There were four specific learning outcomes from the Mental Health Week events. After attending the events participants will be able to identify options available to gain support for themselves or a friend, recognize when they may be in need of support (even if it is not a serious mental health crisis), understand and use the seven dimensions of wellness to improve mental health, and better understand mental health (and mental illness) and the adverse impact of stigma.

The Present Study

The purposes of the present study were two-fold. First, the main purpose was to explore resilience, formal help seeking, social support, and coping strategies in people who participated in a mental health awareness event. While there was no specific hypothesis, researchers expressly examined how social support (assistance/advice from friends, family, or significant other) and formal help seeking (would access a professional health service provider) were associated with resilience (the process of healthy development in spite of risk exposure and adversity). The research design chosen was a cross-sectional online survey.

Secondly, the purpose of the evaluation was to assess each component of Guelph’s 1 in 5 Mental Health Awareness Week, with a focus on the Mental Health Panel event, with an end of session evaluative, anonymous survey. The present evaluation was driven by the interest of the collaborators and may be used to improve future initiatives. Therefore, the research questions
and evaluation purposes were:

**Resilience, Social Support, and Formal Help-Seeking**

Are perceived social support and formal help seeking associated with resilience?

What coping strategies are employed by people who chose to attend a Mental Health Awareness event?

**Mental Health Panel Event**

Who is attending this event?

How are attendees reacting to this event? Are they satisfied/dissatisfied? Would they recommend any changes or additions?

Do attendees believe that stigma is being addressed through social contact?

**Method**

**Procedure**  

**Recruitment.** Participants were recruited at the Mental Health Panel event, which took place on the University of Guelph campus. All attendees were invited to complete a post-event evaluation and provide an e-mail address for contact regarding the online survey. Within one week of the event, the researcher e-mailed interested attendees with additional information and the link for the online survey. Participants were sent two additional reminder e-mails at four and nine weeks following the event. Those who agreed to the online survey were given the opportunity to enter a draw for one $50 gift card of their choice (gas, grocery store, Stone Road Mall, campus food). There were no restrictions for participation based on ethnicity, class, gender, age, or mental health status. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board (REB). REB clearance was received for all events; however, the application was not submitted in time and clearance was obtained at a date
that allowed only evaluation of the Mental Health Panel event.

**Data Collection.** Prior to the commencement of the Panel event, a package of forms was placed face-down on each desk containing two consent forms (yellow paper; available in Appendix A), one end-of-session evaluation (white paper; available in Appendix B), and one e-mail form for follow-up contact (blue paper; available in Appendix C). At the beginning of the Panel event, the researcher explained the present study to all attendees and indicated that participation was voluntary (recruitments scripts available in Appendix D). Immediately following the event, the researcher directed attendees to complete all forms (if they wished to participate). Attendees were directed to fold the contact form in half to maintain privacy and to keep one consent form for their records. Two volunteers were placed at each exit to collect end-of-session evaluations, consent forms, and folded contact forms (whether they had been completed or not, to increase privacy) as attendees exited the event. The volunteers ensured that consent forms and contact sheets were separated from evaluations, removing all identifying information from evaluations.

For the online survey, the researcher contacted interested participants via e-mail with additional study information (see Appendix E for e-mail script), the survey link, and consent form for their records (available in Appendix F). The survey began with informed consent, which was required for participants to access survey questions. The online survey was pilot-tested on one graduate student for language, comprehension, and ease of completion. Based on this pilot test, the survey was expected to last 10-30 minutes. Participants were thanked for their time and were able to download a debriefing sheet containing contact information for mental health services available on and off campus (available in Appendix G).
End-of-Session Evaluation

The end-of-session evaluation was comprised of demographic questions (gender, age, ethnicity, year of study, mental health status) as well as questions about participant reactions, perceived outcomes of the event, and suggestions for future initiatives. All of the questions featured in the end-of-session evaluation were guided by the recommendations of Taylor-Powell and Renner (2009) and through consultation with the manager of the University of Guelph’s Wellness Center (the head of the Mental Health Awareness Initiative). Items gauging event satisfaction were rated on a 5-point Likert-type scale with higher ratings indicating higher satisfaction.

Online Cross-Sectional Survey

The online survey was created using Qualtrics (www.qualtrics.com) and was completed by participants who had previously provided e-mail contact information at the event. Similar to the end-of-session evaluation, demographic information was collected (gender, age, ethnicity, year of study, mental health status). Data for the primary purposes of the present study were collected using a number of scales:

Measures

Resilience. A general measure of resilience was collected using the Adolescent Resilience Scale (ARS) developed by Oshio, Kaneko, Nagamine, and Nakaya (2003). The ARS was developed to measure the psychological features of individuals who are viewed as resilient. The ARS is comprised of 21 items based on 3 factors: novelty seeking, emotional regulation, and positive future orientation. Novelty seeking taps into interest in new things or events, emotional regulation measures composure and control of emotions, and positive future orientation is concerned with outlook on life, dreams, and goals. All items were rated on a 7-point Likert-type
scale. The overall score on the ARS was computed by calculating the mean score of the 21 items and means scores were also calculated for each subscale (higher scores indicate higher resilience levels). The ARS was tested on undergraduate students and shows support for reliability and construct validity. Coefficient alpha values were calculated overall (.85) and for each subscale (novelty seeking .79, emotional regulation .77, and positive future orientation .81) which provide evidence of high internal consistency. Construct validity was examined by comparing known-groups and scores on the ARS were significantly lower for vulnerable students when compared to well-adjusted or resilient students (Oshio et al., 2003).

**Perceived Social Support.** Perceived social support was measured by functional and structural social support (Thoits, 1995). Functional social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). This 12-item, 7-point Likert scale, was made for use by University/College students. There are three, four-item subscales that measure perceived support from family, significant others, and friends. Mean scores were calculated overall and for each subscale with higher scores indicating higher quality support systems. Zimet et al. (1988) reported that the MSPSS has good internal consistency such that Cronbach’s alpha scores for reliability were .88 and .85 for test-retest reliability. Additionally, the MSPSS yields good construct validity when compared to other scales, such as depression (Zimet et al., 1988).

Structural social support was measured as the quantity of contact with friends or family members. As a result of the MSPSS measuring only functional support, as per the recommendation by Hefner and Eisenberg (2009), two items were added from the Berkley Graduate Student Mental Health Survey to measure structural support. These two items measured frequency, within the last 12 months, of attendees interacting with family members or
a close friend (quick phone call, e-mail, or in person). Response options included: at least once a day, at least once a week, at least once a month, less than once a month, and not at all (Berkeley Graduate & Professional Schools Mental Health Taskforce, 2004).

**Formal Help Seeking.** Help seeking was measured by the General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005). The GHSQ measures intended help seeking behaviour for various formal and informal supports (people) in two situations: personal/emotion problems and suicidal ideation. For each situation, respondents rate their likelihood of turning to each of eight help seeking options (intimate partner, friend, parent, other family member, mental health professional, phone help-line, doctor, religious leader, or no one). A key concept to the main purposes of the present study was formal help seeking which was operationally defined as an attempt to find assistance to improve a situation or problem from a professional health service provider (Wilson et al., 2005; Boldero & Fallon, 1995; Benson, 1990). Of the eight help seeking options in the GHSQ, mental health professional, general practitioner (doctor), and phone help-line were considered modes of formal help seeking as each has a professional role in providing relevant advice, support, and/or treatment (Wilson et al., 2005; Boldero & Fallon, 1995; Benson, 1990). Responses were rated on a 7-point Likert scale ranging from 1 (extremely unlikely) to 7 (extremely likely). Research has shown that intentions predict behaviour (Ajzen, 1991; Kim & Hunter, 1993) and the GHSQ, which is used to measure intended help seeking, has been shown to correlate ($r = .17$ to $.48$ depending on source of help) with actual help seeking behaviour (Wilson et al., 2005). Additionally, the GHSQ appears to be flexible to a range of contexts (Wilson et al., 2005) including university students (Ryan, Shochet, & Stallman, 2010). The GHSQ has a Cronbach’s alpha value of .85 and test-retest reliability of .92 (Wilson et al., 2005).
Coping. Methods of coping, other than informal help seeking from a person, were measured using the Brief COPE (Carver, 1997). The Brief COPE is a 28-item questionnaire developed from the original 60-item COPE (Carver, Scheier, & Weintraub, 1989). Mean scores were calculated for 14 subscales (2 items each) that are used to measure behavioural and cognitive responses to stressful situations and were rated using a 4-point Likert-type scale (1= I usually don’t do this at all to 4= I usually do this a lot). The 14 coping responses are self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame. The Brief COPE is flexible: the introduction of the scale and verb tense of items are easily altered to gauge reactions to a specific situation that has happened or a general reaction to stressful life events (Carver, 1997) and has been used with a multiple populations (Carver, 1997; Pritchard & McIntosh, 2003; & Wilson, Pritchard, & Revalee, 2005). Overall, the subscales of the Brief COPE yield acceptable alpha values (.50-.90) supporting internal consistency and has been validated (Carver, 1997; Perczek, Carver, Prive, & Pozo-Kaderman, 2000).

Data Analysis

Demographic information, evaluative components, and coping were analyzed with descriptive statistics (means, standard deviations, and frequencies). The association between social support, formal help seeking, and resilience was examined using a hierarchical multiple regression analysis to control for gender and age. According to Cohen (1992), with two independent variables, alpha set at .05, and a large effect size of .35 the required sample size estimation is 30. The assumptions for hierarchical multiple regression, specifically, a linear relationship between the independent and dependent variables, independence of observations,
equal variance around the regression line, normally distributed errors, and uncorrelated independent variables were tested using the Durbin-Watson statistic, examining Tolerance/VIF values, and visually inspecting standardized residual plots (P-P plot and histogram).

Open-ended evaluation responses were analyzed using qualitative content analysis as outlined by Graneheim and Lundman (2004). Responses were brief, ranging from a couple words to a couple sentences, therefore, the researchers agreed these data could not support an exploration of themes and instead responses were condensed into categories. Condensing involved shortening the text, while still preserving the essence, into categories, which are groups of content that share a commonality (Graneheim & Lundman, 2004). Although researchers attempted to find mutually exclusive categories this was not always possible.

Results

Cross-Sectional Online Survey

In total, 78 attendees provided additional contact information and 53 consented to the online survey (68% response rate), one survey was removed due to missing data. The majority of participants were female (80.8%) and Caucasian (76.9%) and ages ranged from 18-59 years (Table 1). The majority of respondents were students (90.4%) in their fourth year of study (36.5%) and 9.6% identified as non-student (staff or other). About 40% of participants reported having a mental illness diagnosis.

Resilience, Coping, Social Support, and Help Seeking Characteristics. The scores for overall resilience and emotional regulation are considered to reflect moderate levels of resilience while the scores for novelty seeking and positive future orientation align with high resilience levels. The most common coping strategies indicated by participants were self-
distraction, emotional support, and self-blame, while denial and substance use received the lowest scores.

Table 1
Survey Participant Characteristics, n = 52

| Characteristic                        | Gender, n (%) | Age, M (SD) | Ethnicity, n (%) | Year of Study, n (%) | MH Diagnosis, n (%) | Resilience Total, M (SD) | Novelty Seeking, M (SD) | Emotional Regulation, M (SD) | Positive Future Orientation, M (SD) | Perceived Social Support Total, M (SD) | Formal Help Seeking, M (SD) | Informal Help Seeking, M (SD) | Coping, M (SD) |
|---------------------------------------|---------------|-------------|------------------|----------------------|---------------------|-------------------------|--------------------------|-------------------------------------------|------------------------------------------|---------------------------------------|--------------------------|---------------------|
| Gender, n (%)                         |               | 24.18 (8.421) |                 |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Female                                | 42 (80.8)     |             | Caucasian        | 40 (76.9)           |                     | 4.90 (.864)             | 5.42 (.764)              | 4.35 (1.003)                                | 5.16 (1.539)                            | 5.35 (1.223)                          | 4.53 (1.199)             | 4.10 (1.144)         |
| Male                                  | 9 (17.3)      |             | 'Other'          | 10 (19.3)           |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Other                                 | 1 (1.9)       |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Age, M (SD)                           |               |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Ethnicity, n (%)                      |               |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Caucasian                             | 40 (76.9)     |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| 'Other'                               | 10 (19.3)     |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Age, M (SD)                           |               |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Year of Study, n (%)                  |               |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Years 1 & 2                           | 9 (17.3)      |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Years 3 & 4                           | 28 (53.8)     |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Fifth                                 | 5 (9.6)       |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Graduates                             | 5 (9.6)       |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| MH Diagnosis, n (%)                   |               |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| No                                    | 29 (55.8)     |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Yes                                   | 21 (40.4)     |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Resilience Total, M (SD)              | 4.90 (.864)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Novelty Seeking                       | 5.42 (.764)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Emotional Regulation                  | 4.35 (1.003)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Positive Future Orientation           | 5.16 (1.539)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Perceived Social Support Total, M (SD)| 5.35 (1.223)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Family                                | 5.00 (1.679)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Friends                               | 5.46 (1.338)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Significant Other                     | 5.63 (1.428)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Formal Help Seeking, M (SD)           | 4.53 (1.199)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Informal Help Seeking, M (SD)         | 4.10 (1.144)  |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Coping, M (SD)                        |               |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Self-distraction                      | 3.13 (.576)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Emotional Support                     | 3.01 (.872)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Self-blame                            | 2.90 (.883)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Instrumental Support                  | 2.88 (.821)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Acceptance                            | 2.86 (.636)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Active Coping                         | 2.81 (.811)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Planning                              | 2.79 (.855)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Positive Reframing                    | 2.61 (.991)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Venting                               | 2.51 (.696)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Behavioural Disengagement             | 1.84 (.732)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Religion                              | 1.70 (.991)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Substance Use                         | 1.62 (9.83)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |
| Denial                                | 1.52 (.641)   |             |                  |                      |                     |                         |                          |                                           |                                          |                                        |                          |                      |

Note. Average year of study = 3.38, SD = 1.659. Ethnicity: ‘Other’ consists of Indian, Irish, Italian, European, Jamaican, Chinese, African American, Portuguese, Jewish, Tamil (n = 1).
The overall social support score and the subscale scores for friends and significant other indicated relatively high quality levels of support systems. The score for family fell in the upper range of medium quality. Total social support and subscale scores of this sample were not statistically differently than normative scores (Table 2; Dahlem, Zimet, & Walker, 1991).

In terms of structural social support, family contact was most often rated as at least once a week (25; 48.1%) or at least once a day (20; 38.5%). Similarly, the majority of contact scores for friends were rated as at least once a week (21; 40.4%) or at least once a day (24; 46.2%). Two participants (3.8%) indicated they had no contact with friends in the past 12 months.

One paired samples t-test was conducted to compare participants’ ratings of intended use of formal ($M = 4.53$, $SD = 1.199$) and informal ($M = 4.10$, $SD = 1.144$) help seeking sources. A significant difference was found, such that participants reported higher levels of intended formal help seeking ($t (49) = 2.328, p = .024$) which is reflected by the high mean score.

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Normative Scores*</th>
<th>Sample Scores</th>
<th>T-Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total, $M (SD)$</td>
<td>5.58 (1.07)</td>
<td>5.35 (1.22)</td>
<td>$t (50) = -1.345, p = .185$</td>
</tr>
<tr>
<td>Family</td>
<td>5.31 (1.46)</td>
<td>5.00 (1.68)</td>
<td>$t (50) = -1.318, p = .193$</td>
</tr>
<tr>
<td>Friends</td>
<td>5.50 (1.25)</td>
<td>5.46 (1.34)</td>
<td>$t (51) = -.233, p = .817$</td>
</tr>
<tr>
<td>Significant Other</td>
<td>5.94 (1.34)</td>
<td>5.63 (1.43)</td>
<td>$t (51) = -1.543, p = .129$</td>
</tr>
</tbody>
</table>

* Dahlem, Zimet, and Walker (1991)

**Multiple Regression.** A hierarchical multiple linear regression for resilience was computed for two independent variables, social support and formal help seeking, while controlling for gender and age. The assumption of independent observations was confirmed with a Durbin-Watson statistic value of 2.128 (values under one and above three are problematic;
Field, 2009). VIF values are well below 10 and Tolerance values are well above 0.2 (Tolerance/VIF scores for: gender = .778/1.285, age = .768/1.302, perceived social support = .951/1.051, and formal help seeking = .971/1.030); therefore, we can safely conclude that there is no collinearity within these data (Myers, 1990; Menard, 1995). Standardized residuals were plotted against standardized predicted values and the resulting pattern of randomly and evenly dispersed points throughout the plot is indicative of meeting the assumptions of linearity and homoscedasticity. Normal distribution on the histogram and little deviation on the normal P-P plot confirm the assumption of normality of residuals. Model 1 indicated that gender and age did not significantly contribute to resilience levels ($R^2 = .064, F(2,45) = 1.530, p = .228$). However, in Model 2, the addition of perceived social support and formal help seeking was found to be significant ($R^2 = .332, F(4,43) = 5.335, p = .001$) and able to explain 33.2% of the total variance. Furthermore, using $Beta$, a change in perceived social support by one standard deviation (1.212) resulted in an increase in resilience by .514 standard deviations ($t (43) = 4.022, p < .001$). Gender ($\beta = -.097; t (43) = -.684, p = .498$), age ($\beta = .139; t (43) = .978, p = .333$), and formal help seeking ($\beta = .093; t (43) = .735, p = .466$) were not significant, therefore, only social support significantly contributed to the model.

**End-of-Session Evaluation**

In total, 92 of approximately 120 attendees (77% response rate) completed the end-of-session evaluation (six were half completed and were included in analysis). Ages ranged from 18 to 59 years and the majority identified as female (80.4%) and Caucasian (77.2%; Table 3). The majority of respondents were students (84.7%) in their fourth year of study (31.5%) and 13% identified as non-student. About a third (30.4%) of respondents reported having a mental illness diagnosis.
Table 3
*Evaluation Participant Characteristics, n = 92*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Gender, n (%)</th>
<th>Age, M (SD)</th>
<th>Ethnicity, n (%)</th>
<th>Year of Study, n (%)</th>
<th>Non-Students, n (%)</th>
<th>MH Diagnosis, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>23.64 (7.466)</td>
<td>Caucasian</td>
<td>71 (77.2)</td>
<td>Staff</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td></td>
<td>Other</td>
<td>11 (12.0)</td>
<td>Alumni</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>Related to student</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Did not disclose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. Average year of study = 3.73, SD = 1.258. Ethnicity: ‘Other’ consists of Indian, Irish, Guyanese, British, Jamaican, Polish (n = 1); European and Chinese (n = 2).*

The most common motivator for attending the event was curiosity (54; 58.7%). Respondents also reported looking for information to help with their personal mental health (32; 34.8%) or the mental health of a friend or family member (29; 31.5%). See Table 4 for all motivations and values. Other category responses included: supporting those involved in the event (10/18), personal mental health (8/18), and interest in mental health (3/18). Respondents expressed a desire to share their own story or looking for ways to relate with others “so that I don’t feel inferior because of my illnesses” (participant ID #5) and a desire to support those
involved in the event (friend/family), including panelists (despite not personally knowing them) to “honour their willingness to share themselves with the University community” (#80).

Table 4
*Frequency of Motivation for Attending the Mental Health Panel Event, n = 92*

<table>
<thead>
<tr>
<th>Motivation</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curiosity</td>
<td>54 (58.7)</td>
</tr>
<tr>
<td>Attend with Friend/Group</td>
<td>43 (46.7)</td>
</tr>
<tr>
<td>Improve Self</td>
<td>34 (37.0)</td>
</tr>
<tr>
<td>Personal Mental Health</td>
<td>32 (34.8)</td>
</tr>
<tr>
<td>Advice for Others</td>
<td>29 (31.5)</td>
</tr>
<tr>
<td>Other</td>
<td>18 (19.6)</td>
</tr>
<tr>
<td>Involved in Event</td>
<td>11 (12.0)</td>
</tr>
</tbody>
</table>

*Note. Categories not mutually exclusive, less than a third of respondents chose only one motivator.*

The majority of respondents indicated the event was extremely worth their time (59; 64.1%) and definitely recommendable to others (66; 71.7%). Additionally, the majority reported the event was a great learning experience (57; 61.9%) and above their expectations (41; 44.6%).

The bulk of respondents were very satisfied (44; 47.8%) with the current format of the event (Table 5).

Table 5
*Event Satisfaction, n = 92*

<table>
<thead>
<tr>
<th>Satisfaction Item</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend Event</td>
<td>4.68 (.575)</td>
</tr>
<tr>
<td>Learning Experience</td>
<td>4.63 (.485)</td>
</tr>
<tr>
<td>Worth Time</td>
<td>4.62 (.553)</td>
</tr>
<tr>
<td>Event Format</td>
<td>4.33 (.622)</td>
</tr>
<tr>
<td>Event Met Expectations</td>
<td>4.21 (.701)</td>
</tr>
</tbody>
</table>

*Note. All items rated on a 5-point Likert-type scale.*
The majority of respondents reported that the event addressed stigma quite a bit (38; 41.3%) or a lot (35; 38%) and they felt social contact was an extremely (59; 64.1%) good way to address and reduce stigma of people dealing with mental illnesses (Table 6). Half of the respondents (46; 50.0%) indicated that their attitudes had improved, 35 (38.0%) reported their attitudes were already positive and did not require change, and 5 (5.4%) indicated no change in their attitudes.

Table 6
*Stigma Reduction and Social Contact, n = 92*

<table>
<thead>
<tr>
<th>Stigma Item</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think stigma against people with mental health issues was addressed by this event?</td>
<td>4.26 (.706)</td>
</tr>
<tr>
<td>Do you think social contact with people who have mental health problems is a good way to address and reduce stigma?</td>
<td>4.64 (.549)</td>
</tr>
</tbody>
</table>

*Note.* All items rated on a 5-point Likert-type scale, stigma: 1 = not at all and 5 = a lot, social contact: 1 = not at all and 5 = extremely.

There were 80 responses to open-ended questions on the usefulness of the event covering four categories: realness (56/80), sense of belonging (20/80), learning (13/80), and interaction (6/80). Respondents described most useful elements as the panelists’ honesty, gaining an understanding that they are not alone in their mental health struggles, learning more about mental health and available resources in the community, and being able to openly engage in discussion with panelists and event volunteers. One attendee explained, “It made me feel better about asking for help and dealing with my own struggles” (#89) and a different attendee
described, “Feeling like I’m not alone; and that I guess I’m a normal type of broken. That others have gotten through this and I can too” (#14).

There were 19 responses referring to least useful event elements, which were event atmosphere (11/19), language use (5/19), and timing (3/19). Respondents described not feeling welcome and did not appreciate sitting alone, felt panelists reported some misinformation and used disease-first language, and desired a longer question and answer period. One attendee described, “I feel that they should stick with actual diagnoses rather than personal diagnosing. I also feel that it would be good to encourage ‘I have XYZ condition’ vs. ‘I AM XYZ condition’. We are all people and NOT our conditions.” (#24).

Suggestions for improvement were condensed into four categories: enhancing question and answer portion (13/31), better event organization (12/31), greater event exposure (5/31), and greater diversity (4/31). Key suggestions included better facilitation of question and answer portion (including improved ways to ask questions anonymously and the chance to approach panelists following the open question period to engage in further discussion), more interaction with volunteers, guiding panelists to avoid using triggering statements and disease-first language, more event advertising, and having a more diverse panel (gender, ethnicity, and sexuality). One attendee requested, “Please don't mention specific self-harm tools or amounts/types of alcohol (or other specifics around addictions, eating disorders, etc) as it can be extremely triggering” (#72) and another suggested, “Better representation of people of colour and queer/trans on the panel would be great, though I really appreciate everyone who spoke and their honesty and transparency” (#28). See Appendix H for a list of categories and additional respondent quotes.
Discussion

Cross-Sectional Online Survey

The cross-sectional online survey revealed that: 1) as was expected, there was a strong link between social support and resilience, yet no association was found between formal help seeking and resilience, and 2) discrepancies existed between respondents’ preference for formal support despite no association with resilience and between reported structural and functional support. In addition, lowest rated coping levels were comparable to other University samples; however, the most prevalent coping methods significantly differed and potential explanations for these differences will be discussed. This research reinforces the link between social support and resilience and suggests that social support should be the focus of mental health interventions specifically geared toward adolescent resilience. Lastly, it appears that help seeking could be a process with informal support as a first step and formal support as a second step, only when necessary. While participants in this study were open to receiving formal help, it is possible they found it unnecessary given their reliance on their informal social support systems.

Social support was found to be significantly positively associated with resilience, which is consistent with Fergus and Zimmerman’s (2005) resilience model that emphasized promotive factors (assets and resources), with social support as a main resource contributing to resilience. Considering the Stress and Coping Social Support Theory (Lazarus & Folkman, 1984) described (perceived) social support as a buffer against the negative effects of stressful events, it is reasonable, then, that social support would be integral to and positively associated with resilience. This finding from the present study is in accordance with Rutter’s (1985) Protective Factor Model of resilience. The findings of the present study reinforce the link between social
support and resilience and it appears that social support resources acted as moderators that neutralized or reduced the effects of adversity, explaining the positive association with resilience. In addition to the overall benefits of having a support system, such as the link between informal social support and well-being (Cohen & Willis, 1985), mental health interventions that are specifically geared toward improving adolescent resilience should focus on the impact of social support as a protective factor by building/strengthening informal support relationships.

While previous research findings indicated that lower resilience levels were associated with formal help seeking in a sample of adults (majority female) with depression (Schomerus et al., 2013), no association was found in the present study. Given that intended use of formal support was statistically significantly greater than informal support (although the difference in means was 0.43), a negative association between formal support and resilience might be expected. While it is possible that these participants would seek formal support if needed, they reported good support from family, friends, and significant others which made formal support unnecessary. Wilson et al. (2011) described help seeking as a process, though the pathways of this process are not clear. Viewing help seeking as a process, it is possible that while formal help would be accessed if necessary, seeking support from informal sources is the first step in the process. If this is the case, then as was previously discussed, it appears that informal social supports could act as protective factors against negative outcomes. If the protective factors are successful in buffering against negative effects, further formal support is not necessary and only if the protective factor is overcome will formal help be accessed. Therefore, it is likely that in the present sample, while intended use of formal help was higher (which could be explained by this sample that choose to attend a mental health awareness event), the actual availability and quality
of informal social support systems (which was also high) acted as a protective factor against negative outcomes, rendering formal help unnecessary, and strongly contributed to resilience.

**Perceived Social Support.** The relatively high overall functional social support score may help explain why emotional and instrumental coping were rated in the top two, which both involve turning to social supports for guidance and advice. Of the three subscales, family was rated the lowest (although scores were still moderate); however, the majority of participants rated structural social support as contact with a family member at least once a week or at least once a day. The discrepancy between ratings of functional and structural social support can be explained using Erikson’s Psychosocial Theory of Human Development (1963). The mean age of this sample was 24 (minimum was 18) which aligns with Erikson’s fidelity (13-19) and love (20-39) stages of human development. The fidelity stage involves developing a sense of identity and a concern for significant social relationships. Adolescents and emerging adults often distance themselves from family while they consider their personal ideologies (religion/politics) in addition to which school to attend and career path to follow. While emerging adults realize these supports are still available they may withhold certain issues (such as a mental illness) which could threaten independence. Those in the love stage struggle with intimacy and isolation while striving to fit in with friends and develop romantic relationships (Erikson, 1963). The high social support scores found in the present study also align with the Stress and Coping Social Support Theory (Lazarus & Folkman, 1984), which is one of the most influential theories in the social support literature. Within this theory, the support of others or the perceived support available is described as a buffer against the negative effects of stressful events on health (Lazarus & Folkman, 1984; Lakey & Cohen, 2000). In addition, using Stress and Coping Theory, the high ratings of emotional and instrumental coping on the Brief COPE, although different from other
University samples, are explained. A small portion of the sample indicated they were in contact with family or friends (even a quick phone call) less than once a month or not at all (friends only) and some of these participants had statistically lower overall support scores in comparison to the mean. For these participants, attending a mental health panel event could be their way of seeking out new sources of support to replace or supplement the support they lack.

**Coping.** Least popular coping methods aligned with previous research; however, differences appeared in the most common coping methods reported by participants of the present study when compared to other University samples. When discussing these findings it is important to recall that coping is a dynamic process dependent on the person-environment relationship and coping strategies are used simultaneously, therefore, the practical significance of these results should be considered. Li, Lindsey, Yin, and Chen (2012) compared Brief COPE responses from American and Chinese undergraduate students. Comparison of the present study data with the American sample (61% female) revealed differences in the three highest rated coping methods while no differences appeared in the four lowest rated coping methods. Stoeber and Janssen (2011) explored coping in a group of British undergraduate students (majority female, $M$ age 20.8, $SD = 2.8$) and similar to the present study (and the study by Li et al., 2012), denial, substance use, religion, and behavioural disengagement were scored in the bottom five. Similarly, Steinhardt and Dolbier (2008) found denial and behavioural disengagement as least popular coping methods within their wait-list control University sample (undergraduate and graduate students, majority female and Caucasian). Interestingly, Steinhardt and Dolbier (2008), Stoeber and Janssen (2011), and Li et al. (2012) reported active coping, planning, and acceptance as most popular coping methods. Of these options, only acceptance was rated in the top five for the present study and may be a reflection of the present sample attending a mental health
awareness event. In the present study, both emotional and instrumental support were in the top five which can be interpreted as this sample may be relying heavily on their informal support systems (friends and family) as opposed to methods of problem solving (active coping and planning) as seen in the comparison data sets. Interestingly, in an American University sample (undergraduate, majority female and Caucasian) emotion-oriented coping was related to lower resilience levels with task-oriented coping related to higher resilience levels (Campbell-Sills, Cohan, & Stein, 2006). Additionally, participants in the present study reported using self-distraction the most, which Carver (1997) defined as focusing on other tasks to take one’s mind off the stressor. Self-blame was also featured in the top three for the present study, yet Steinhardt and Dolbier (2008) and Stoeber and Janssen (2011) found it ranked in the bottom two. Furthermore, having self-blame rated so highly for this sample is potentially concerning given that in past coping research self-blame has been found to predict poor adjustment under stress (Bolger, 1990; McCrae & Costa, 1986). There were apparent differences in the coping methods reported in the present study and one approach to interpreting these differences is to consider Folkman’s (1984) work on control and coping.

Folkman (1984) emphasized the Cognitive Theory of Stress and Coping as both relational and process oriented. The theory focused on stress, which results from appraisal of the demands of the person-environment relationship as exceeding one’s resources and negatively affecting well-being. A key consideration is the bidirectional, dynamic relationship between the person and environment. The functions of coping are two-fold: first, to normalize emotions or distress (primary appraisal) and second, to manage the stressful situation (secondary appraisal). The relationship between control and coping was thought to be mediated by appraisals of threat or challenge and issues arise with these appraisals because instead of moving to secondary
problem-focused appraisals, efforts are pooled to target primary emotion-regulation appraisals (Folkman, 1984). In the present study, multiple methods of emotion-focused coping were most popular, which could be attributed to primary appraisals of threat or challenge overtaking problem-focused coping. These results suggest participants are more likely to attempt to alleviate stress by changing or minimizing their emotional reaction to a distressing situation as opposed to dealing with the cause of the problem or eliminating the source of distress. For example, self-distraction, the most popular rated coping strategy, involves distracting from negative emotions by distancing or transferring attention away from the problem. The benefits of this coping strategy are often temporary as it involves preventing or avoiding negative emotions for a short period of time until focus is returned to the distressing situation; however, it is still beneficial when the distraction involves the completion of other necessary tasks (Carver, 1997). These results are not suggesting that participants do not use problem-focused coping. As evidenced by the Cognitive Theory and Stress and Coping it is important to consider the dynamic and changing coping process in which multiple behavioral and cognitive changes occur (meaning multiple coping strategies are employed based on reappraisals and the changing person-environment relationship). Recalling that this sample has had a great deal of exposure to mental health problems (personal and family) could have impacted the types of appraisals that were made and the ensuing coping responses.

It appears that the least popular coping methods reported by participants in the present study were generally consistent with other data sets; however, the most common coping methods differed. One explanation for these differences could be due to the mediation of threat or challenge primary appraisals. Additionally, differences in coping methods could be a reflection of group differences between those who chose to attend a mental health awareness event or
possibly as a result of 40% having dealt with a mental illness diagnosis, which further highlights the individual nature of the coping process described in the literature. However, when interpreting these results, due to the context dependent nature of coping and the collection of data at one time point, conclusions regarding the uniqueness of this sample cannot be made.

**End-of-Session Evaluation**

The evaluation of the event revealed that: 1) there may be a discrepancy between targets of recruitment efforts and actual attendees, 2) satisfaction scores were relatively high (e.g., event format, met expectations, was worthwhile to attend, recommendable to others, and a great learning experience), and 3) participants considered the event successful in addressing stigma.

Initially, event attendees were expected to be students with the majority in their first year of undergraduate studies (due to main recruitment efforts taking place on campus and in first year residences). While the majority of attendees were students, there were also staff, alumni, and parents/spouses of students in attendance. The mean age of those who responded to the evaluation was 23 years, the majority were in their fourth year of study, and surprisingly, only two students reported being in first year. As was expressed by the event leaders, recruitment efforts in residences were considered to be one of the most extensive and direct strategies for reaching students but the results suggest these recruitment strategies need to be revisited and reassessed if organizers want to target this cohort. One possible explanation for the majority of respondents being in fourth year may be due to the inclusion of event volunteers (Wellness Centre and Student Support Network members) completing the evaluation as they tend to be upper year students.
The inclusion of event volunteers may also have somewhat inflated the event satisfaction scores. Regardless, attendees felt strongly that the event was extremely worth their time, definitely recommendable to others, a great learning experience, above their expectations, and they were very satisfied with the event format. These high satisfaction ratings may be a reflection of the willingness of these individuals to attend a mental health awareness event. In addition, attendees reported that mental health was important to them for various reasons including personal or family/friend mental health struggles, involvement in other mental health initiatives, and personal beliefs that mental health is an important topic that needs to be discussed. It is likely then, that those who chose to attend the event were already open-minded and thinking positively about mental health awareness.

Attendees felt the event was successful in addressing stigma and they felt social contact (between people who are and are not struggling with a mental illness) was an extremely good method to target stigma reduction. Stigma is created and carried out through social interaction (Goffman, 1963), and the social contact hypothesis employs the same situation in which stigma is created and perpetuated in an effort to reduce it. The format of the evaluation did not allow for the examination of actual stigma reduction; however, half of respondents felt their attitudes had improved towards people experiencing a mental illness and it appears that through the use of social contact, the mental health panel event is addressing and potentially reducing stigma.

**Strengths and Limitations**

A main limitation for the primary component was the format of the cross-sectional online survey. Due to the survey being completed at one time point, the studied variables could not be used to examine prediction and no conclusions regarding causation could be made. Participants
who completed the online survey were recruited from the mental health awareness event. Therefore, this sample chose to attend a mental health promotion event and could yield differences when compared to the University population, creating issues for generalization and external validity. In addition, having previously attended the event could have impacted survey responses, specifically regarding formal help seeking intentions as this was a discussion point during the event. The evaluation and survey samples were homogenous, with the majority identifying as female and Caucasian. In general, homogenous samples are a concern; however, in this situation the sample is generally representative of the demographic characteristics of those attending the University of Guelph. According to the Council of Ontario Universities (2012), official government enrollment data for Fall 2012 indicated that 60% of students were female and 97% were domestic. Lastly, survey data were self-reported which allowed participants to describe their experiences, avoided researcher interpretation errors, and allowed researchers to easily and quickly collect data from an acceptable sample size. However, self-reported data allows for errors to internal validity including recall errors, the possibility of exaggeration (particularly in reports of intended formal help seeking), and social desirability bias (participants altering answers to portray themselves positively or providing responses researchers would view favourably). Survey questions were closed-ended which did not allow for participants to explain responses and it is possible that questions were not clear or were misunderstood.

A main limitation for the evaluation component was the design of the evaluation (end-of-session), which does not allow for conclusions regarding event outcomes. The present study was the first evaluation attempt for the University of Guelph’s Mental Health Awareness Initiative and in consultation with the event organizers, the evaluation purpose was exploratory; however, in the future, a well-designed randomized controlled trial for all events is encouraged to assess
event effectiveness in reaching outcomes such as knowledge gain and attitude change. Due to the evaluation being self-reported, social desirability may be an issue and participants could have provided responses that would be viewed favourably (particularly for event satisfaction). Qualitative responses were condensed into categories, which allows for errors regarding researcher interpretation. Another limitation and threat to internal validity for the evaluation component was the inclusion of event volunteers (12% of those who completed the evaluation reported being involved in the event). It is likely that those involved in the event would have mainly positive views, which could positively skew the data, although this number is still rather low and is therefore not a major cause for concern. In the future, those involved in the event should not be included in evaluation efforts in order to collect data that are more accurate. Additionally, it is important to keep in mind that 92 of approximately 120 attendees (77% response rate) completed the evaluation. While this response rate is quite high, findings cannot be generalized to all attendees.

A main strength of this study was the focus on formal help seeking as separate from informal help seeking in an attempt to further understand the highly understudied relationship between resilience and professional help seeking (Schomerus et al., 2013). Another study strength was the priority placed on maintaining privacy and anonymity. Efforts were made to remove all identifying information from evaluations, and the survey component was completed online (participants were encouraged to fill out the survey in the privacy of their home or at a location where they felt most comfortable) therefore providing participants with a sense of privacy and anonymity with the hope of increasing the probability of obtaining honest responses and accurate data. Furthermore, the evaluation was community driven by those involved in
organizing Guelph’s Mental Health Awareness Initiative ensuring that the results would be useful.

Implications for Research and Practice

This study has shown that high levels of perceived social support were positively associated with resilience and social support appears to be a strong protective factor contributing to resilience. Instead of examining resilience in terms of psychopathology (Carbonell et al., 2002; Reivich, Gillham, & Chaplin, 2005), the association with help seeking behaviour was the focus since this relationship is not fully understood (Schomerus et al., 2013); however, no association was found even though participants reported a preference for formal help seeking. It is likely that if formal support was required it would be sought out, however, the easily accessible and strong informal social support systems buffered against negative effects, making formal help unnecessary. For mental illnesses, many interventions are geared toward improving youth resilience and the findings from the present study suggest that social support is a strong protective factor positively associated with resilience and should be an integral component to resilience-based interventions.

While coping is an individualized process based on interactions between emotion, control, the environment, and appraisals, a comprehensive view of student coping is valuable, particularly for this sample as differences appear to exist. Frydenberg and Lewis (1991) found that understanding which coping strategies were used frequently/infrequently by students served as an aid for school-based health services. Emotion-focused coping, the most frequent strategies reported in the present study, have been associated with lower resilience levels in undergraduate students (majority female and Caucasian) (Campbell-Sills, Cohan, & Stein, 2006). Used in the context of a resilience-based intervention, these findings could be employed to encourage the
expansion of students’ repertoire of coping strategies, which is generally considered to be beneficial to all individuals (Fydenberg & Lewis, 1991).

The evaluation component of this study may have provided information that could be used to strengthen the Mental Health Panel event for future initiatives. While most Universities have a mental health awareness event in place, no published evaluations of a full initiative were located. Single mental health interventions are much more likely to be evaluated but with mental health initiatives increasing in recent years on University/College campuses, the focus of evaluations needs to include mental health events. Fully evaluating University/College Mental Health Initiatives is crucial since this period of life is extremely challenging without having to deal with a mental illness and providing students with the best possible services will help students successfully transition through post-secondary education.

Conclusion

In this study on the association between formal help seeking, social support, and resilience, a positive association was found between social support and resilience, yet no association was present between formal help seeking and resilience. It is clear that social support is integral to the process of resilience and it is important that researchers continue to examine the highly understudied relationship between help seeking and resilience. The evaluation of the Mental Health Panel event, part of the University of Guelph’s 1 in 5 Mental Health Awareness Week, revealed recruitment efforts for first year students may need to be revisited, the event was very well received, and attendees felt the event was successful in addressing and reducing stigma. This evaluation has highlighted the importance of mental health initiative evaluation, particularly at the University/College level, and future efforts are encouraged to examine event outcomes, such as actual stigma reduction.
References


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September 2008.


students’ perceived stress, coping styles, and health promotion practices. *Journal of Student Affairs Research and Practice, 49*(2), 211-227.


University of Alberta. (2011). *Student health at the University of Alberta: A report of findings from the 2011 University of Alberta National College Health Assessment*. University Wellness Services, University of Alberta.


university or college students: A systematic review. *The Journal of Nervous and Mental Disease, 201*(6), 490-503.


Appendix A: End-of-Session Evaluation Consent Form

CONSENT TO PARTICIPATE IN RESEARCH - Evaluation
Evaluation and Exploration: University of Guelph’s 1 in 5 Mental Health Awareness Week

Please read the following informed consent form carefully before signing.
This form is to request your participation in a research study by Krista Westfall, MSc Candidate, Department of Family Relations and Applied Nutrition, University of Guelph. If you have any questions or concerns about the research, please feel free to contact:

Student researcher: Krista Westfall, kwestfal@uoguelph.ca, 519 807 5664
Advisor: Dr. Michèle Preyde, mpreyde@uoguelph.ca, 519 824 4120, ext. 58599

PURPOSE OF THE STUDY
For this research I will explore who is choosing to attend the Mental Health Panel event of Guelph’s 1 in 5 Mental Health Awareness Week in addition to their evaluation of the event. The purpose of this research is to gain an understanding of who is choosing to attend this event, if they are satisfied with the event, and if they would suggest any improvements for the event. This research will form the basis of my Master’s thesis and may potentially be published in an academic journal. Your answers will remain anonymous and no identifying information will be published.

PROCEDURES
If you decide to take part in this research, you will be asked to complete a one page double-sided evaluation of the event, which will take approximately 5 minutes to complete. The evaluation will include questions about you (gender, age, ethnicity, if you are a student/faculty/staff, if you have a mental health diagnosis) and your evaluation of today’s event (satisfaction, if the event was useful, how it can be improved).

POTENTIAL RISKS AND DISCOMFORTS
Potential risks are minimal. If at any time you feel uncomfortable with any of the questions, you may choose not to answer or to withdraw from the study.

POTENTIAL BENEFITS TO PARTICIPANTS AND TO SOCIETY
Though there are no direct benefits to participating, researchers hope to use the evaluation information to improve the event in the future and to gain an understanding of who is choosing to attend this event.

COMPENSATION
There is no compensation for participating in the evaluation.
CONFIDENTIALITY
Since you are in a room filling out the evaluation you are temporarily not anonymous, however, the data you submit will not contain directly identifying information and all the data collected will be added together before it is examined which will ensure your data remains anonymous.

PARTICIPATION AND WITHDRAWAL
Participation is entirely voluntary and you can choose not to reply to individual questions or to stop answering questions altogether at any point. Data will be stored until the thesis has been published.

RIGHTS OF RESEARCH PARTICIPANTS
You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics  Telephone: (519) 824-4120, ext. 56606
University of Guelph  E-mail: sauld@uoguelph.ca
437 University Centre  Fax: (519) 821-5236
Guelph, ON  N1G 2W1

By signing this form, I indicate that I have read and understood the above form and have had any questions answered. I agree to participate in the research study.

Name of participant: ________________________________________

Signature of participant: ________________________________________

Name of witness: ______________________________________________

Signature of witness: ___________________________________________
Appendix B: End-of-session Evaluation

End-of-session Evaluation - Mental Health Panel Event

Information provided on this form may be used for a Masters thesis. There are no risks to participating and there are no direct benefits. The information provided may be used to improve future Mental Health Awareness efforts. Your responses are completely anonymous.

1. Gender: (Please circle) Male    Female    Other:_____

2. Age (in years): ___

3. What is your ethnicity? ________________

4. If you are a student, what is your current year of study? (Please circle one)
   1st    2nd    3rd    4th    5th    Masters    PhD

5. If you are NOT a student, are you: Staff    Faculty    Other:_________

6. Do you have a mental health diagnosis?     No     Yes

7. Have you attended any other 1 in 5 Mental Health Awareness Week events this year?
   No     Yes, Which ones? ____________________

8. What was your motivation for coming to this event? (Check all that apply)
   __ A friend/group wanted me to come with him/her/them
   __ Curiosity about the event/it sounded interesting
   __ I’m looking for ways to improve myself
   __ I have suffered with mental health problems and am looking for alternate ways to deal with it
   __ I have a friend/family member who suffers with mental health problems and am looking for advice to give to them
   __ Other (please explain): ____________________

The next set of questions are about today’s event:

9. To what extent did you find today’s event worth your time? (Please circle one)
   Not at all    Slightly    Moderately    Very    Extremely
   1    2    3    4    5

10. Would you recommend this event to others?
    Definitely won’t    Probably won’t    Maybe    Probably will    Definitely will
    1    2    3    4    5

11. Overall, this event was a:
    Very poor learning experience    Poor learning experience    Mediocre learning experience    Good learning experience    Great learning experience
    1    2    3    4    5
12. What was most useful about today’s event?
___________________________________________________________________________
___________________________________________________________________________

13. What was least useful about today’s event?
___________________________________________________________________________
___________________________________________________________________________

14. How well did today’s event meet your expectations? (Please circle one)
   Far below     Below     Met expectations     Above     Far above
   1             2             3             4             5

15. As a result of the Mental Health Panel, are you thinking differently about people who are currently struggling with or have dealt with mental health problems? (Please check one)

   ___ Yes, my attitudes have improved
   ___ Yes, my attitudes have become more negative
   ___ No, my attitudes were already positive and didn’t need to change
   ___ No, my attitudes remain the same

16. Do you think stigma against people with mental health issues was addressed by this event? (Please circle one)
   Not at all     A little bit     Some     Quite a bit     A lot
   1             2             3             4             5

17. Do you think social contact (interacting with people who have struggled with mental health issues, such as during this event) with people who have mental health problems is a good way to address and reduce stigma?
   Not at all     Slightly     Moderately     Very     Extremely
   1             2             3             4             5

18. Were you happy with the panel format followed by question and answer period?
   Not at all     Slightly     Moderately     Very     Extremely
   1             2             3             4             5

19. Do you think it would be better to be able to talk to the panelists and ask questions one-on-one instead of the panel format?
   Not at all     Slightly     Moderately     Very     Extremely
   1             2             3             4             5

20. Would you recommend any changes to improve this event?
___________________________________________________________________________
___________________________________________________________________________
Appendix C: E-mail Form for Follow-up Contact

We are also doing some follow-up online surveys. With these anonymous surveys we are exploring coping and support experiences. If you are willing to be contacted, please give your first name and email. This information will be kept separate from the end-of-session evaluations and will be kept confidential with the researcher and will only be used to contact you for the online survey. Those who choose to complete the online survey will be entered into a draw for one $50 gift card of your choice (campus food, gas, grocery store, Stone Road Mall).

First name:
E-mail address:

Whether you have provided an e-mail address or not, please fold this sheet of paper in half (so e-mail addresses are kept private) and hand it to the volunteer located at the exit as you leave the event.
Appendix D: Researcher Evaluation Recruitment Script

Before event:

Hi I’m Krista Westfall and I’m a second year Masters student in the Family Relations and Human Development program. For my Masters thesis I have partnered with the Wellness Center to evaluate Guelph’s 1 in 5 Mental Health Awareness Week. We are hoping to learn what your opinion is of the event. Our hope is to use your feedback to improve future efforts. You’ll notice three forms on your desk. The first is a consent form with our contact information, and we encourage you to keep it. The next one is an end-of-session evaluation that we invite you to complete after the event has finished. It’ll be about how you experience the event so please don’t fill it out before the event has ended. We are also going to be conducting additional online surveys on social support and coping. If you are interested in helping us with that please provide your email address on the blue sheet in front of you. I will be contacting you at that email address with the link for the online survey which is also short and those who complete it will be entered into a draw for a $50 gift card of your choice (gas, grocery, campus food, or Stone Road Mall). I will go over all of this at the end of the event as well I just wanted to give you a heads up and explain the forms on your desk so you aren’t bothered with them during the event.

After event:

I hope everyone really enjoyed that event. Just to reiterate what I said at the beginning, we’re hoping to learn the participants’ perspectives about this event. The end-of-session evaluation which is the white form in front of you will only take max 5 minutes to complete. It is completely voluntary but it would be beneficial to us and may be used to inform future events so you’re also helping yourselves and other students. The blue sheet is where you can provide an email address to receive the online survey link. The purple form and keep it as it has my information on it if you have any questions. Also, please fold the email sheet in half so your email is kept private. You can hand in both forms as you leave the room to the volunteers at the doors. White forms go in the white box and blue forms in the blue box. Thank you very much for helping me with my Masters thesis and a big thanks from the Wellness Center who will be able to use your information to make their events bigger and better.
Appendix E: E-mail Script for Online Survey

My name is Krista Westfall and I am a second year Master’s student at the University of Guelph in the Family Relationships and Human Development program. You are being contacted because you have attended at least one event from Guelph’s 1 in 5 Mental Health Awareness Week and provided an email address for further contact regarding the online survey portion of the project. The purpose of proposed project, Evaluation and Exploration: Guelph’s 1 in 5 Mental Health Awareness Week, is to explore help seeking and coping in people who attended an awareness event.

If you choose to complete the online survey you will be entered into a draw for one $50 gift card of your choice (campus food, gas, grocery store, Stone Road Mall).

If you have any additional questions or for more information regarding the study please contact me, Krista Westfall, by replying to this email.

If you are interested in participating in the online survey click the link below:

Link: https://guelphfran.eu.qualtrics.com/SE/?SID=SV_0k7EmsYYaMUeBoN&Preview=Survey&BrandID=guelphfran

Thank you for your interest in this study! Your time is greatly appreciated. If you are interested in the results of this research please reply to this email and indicate your interest so I can add you to the distribution list upon completion of the project.

Krista Westfall
MSc student, FRHD
University of Guelph
kwestfal@uoguelph.ca
519-***-****
Appendix F: Online Survey Consent Form

CONSENT TO PARTICIPATE IN RESEARCH - Online Survey Evaluation and Exploration: University of Guelph’s 1 in 5 Mental Health Awareness Week

Please read the following informed consent form carefully before signing.
This form is to request your participation in a research study by Krista Westfall, MSc Candidate, Department of Family Relations and Applied Nutrition, University of Guelph. If you have any questions or concerns about the research, please feel free to contact:

Student researcher: Krista Westfall, kwestfal@uoguelph.ca, 519 807 5664
Advisor: Dr. Michèle Preyde, mpreyde@uoguelph.ca, 519 824 4120, ext. 58599

PURPOSE OF THE STUDY
For this research I will explore the intended help seeking behaviours, alternate coping strategies, and perceived levels of social support in people who have attended at least one event from Guelph’s 1 in 5 Mental Health Awareness Week. The purpose of this research is to explore relationships between help seeking, coping strategies, and social support. This research will form the basis of my Master’s thesis and may potentially be published in an academic journal. Anonymity will be maintained and no identifying information will be published.

PROCEDURES
If you decide to take part in this research, you will be asked to complete an online survey, lasting approximately 30 minutes. The online survey will include questions about intended help seeking behaviours, alternate coping strategies, and perceived levels of social support.

POTENTIAL RISKS AND DISCOMFORTS
Potential risks are minimal. Researchers are interested in intended help seeking behaviour and perceived social support. If at any time you feel uncomfortable with any of the questions, you may choose not to answer or to withdraw from the study.

POTENTIAL BENEFITS TO PARTICIPANTS AND TO SOCIETY
Though there are no direct benefits to participating, researchers aim to advance knowledge about intended help seeking behaviour for mental health issues, specifically informal help seeking from a person, coping strategies, and social support. The knowledge gained may inform mental health awareness programs.

COMPENSATION
After completion of the online survey, you will be eligible to be entered into a draw for one (1) gift card in the amount of 50.00 dollars. The winning participant will be contacted via email and will be asked what type of gift card is preferred from the following options: campus food, gas,
grocery store, or Stone Road mall. The student-researcher will purchase the gift card according to the participants’ preference and deliver it to the participant.

CONFIDENTIALITY
Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study. Participants who have provided an email address have been contacted by the student-researcher with the online survey link. No names or contact information will be linked to the online survey so surveys are completely anonymous. Since data are transmitted over the internet we cannot guarantee confidentiality. If you are using a public computer, please ensure you close the browser when you have completed the survey.

PARTICIPATION AND WITHDRAWAL
Participation is entirely voluntary and you can stop answering questions at any point or choose not to reply to individual survey items. Data will be stored until the thesis has been published.

RIGHTS OF RESEARCH PARTICIPANTS
You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Sandy Auld
Director, Research Ethics
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236

By clicking ‘Proceed to survey question’ you will be implying consent and will be directed to the survey questions. If you choose not to consent please close your browser.

Proceed to survey questions
Appendix G: Online Survey Debrief- Resource Contact Sheet

Additional Resources and Sources of Support
Thank-you for participating in this research project. If you have ever thought you may need additional help dealing with problems or a situation arises in the future where you think you need additional support here are some helpful resources you can contact.

On-Campus

Tel: 519-824-4120 x52131
Email: health@uoguelph.ca
1st Floor, J.T. Powell Building
Walk-in clinic hours: 8:30am-4:00pm daily

Tel: 519-824-4120 x53327
Email: wellness@uoguelph.ca
2nd Floor, J.T. Powell Building

Off-Campus

A free, completely confidential and anonymous service that offers you professional counseling, mental health information and connections to local resources.

Concerned about your mental health? Check out this website for some great information for people with an early diagnosis or those going through treatment and looking to manage mental health disorders.

Crisis Line

Community Torchlight is a 24/7 hotline for people of all ages experiencing a mental health or suicide crisis. The hotline also supports concerned family/friends or professionals/support workers.

Local: 519-821-0140
Toll-free: 1-877-822-0140

A full list of on- and off-campus resources for any problem you might be experiencing is available at: https://www.uoguelph.ca/studenthealthservices/community-resource-list
## Appendix H: Most/Least Useful Event Elements and Suggestions for Improvement

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most Useful</strong></td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realness</td>
<td>56</td>
<td>Appreciation of how honest/genuine/strong panelists were.</td>
<td>“The variety of personal stories shared by current students or Guelph alumni” (#64)</td>
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<tr>
<td></td>
<td></td>
<td>Humanizing/putting a face to mental illness since panelists were peers</td>
<td>“The openness of the panel and their willingness to express their struggles head-on. Their courage is an inspiration, particularly to those struggling with mental illness.” (#29)</td>
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<tr>
<td></td>
<td></td>
<td>(U of G students/alumni)</td>
<td></td>
</tr>
<tr>
<td>Sense of Belonging</td>
<td>20</td>
<td>Gaining an understanding of not being alone in their mental health struggles</td>
<td>“It made me feel better about asking for help and dealing with my own struggles” (#89)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Feeling like I’m not alone; and that I guess I’m a normal type of broken. That others have gotten through this and I can to” (#14)</td>
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<tr>
<td>Learning</td>
<td>13</td>
<td>Gaining a better understanding of mental health, the struggles of people</td>
<td>“Gaining perspective and more knowledge about mental health” (#49)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dealing with mental illnesses, what services are available/where they are</td>
<td>“Learned more about campus resources available for treating mental health issues” (#24)</td>
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<tr>
<td></td>
<td></td>
<td>located, and take home advice to help others</td>
<td>“The panelists' advice about how to help a friend cope with their mental illness” (#47)</td>
</tr>
<tr>
<td>Interaction</td>
<td>6</td>
<td>Asking panelists questions and communication with event volunteers</td>
<td>“Sharing stories and opening discussion” (#83)</td>
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<td></td>
<td></td>
<td></td>
<td>“I was so impressed with how the team handled people in crisis and people who were having trouble expressing themselves, very touching!” (#28)</td>
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<tr>
<td>Least Useful</td>
<td>19</td>
<td></td>
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<tr>
<td>Event</td>
<td>Atmosphere</td>
<td>Language Use</td>
<td>Timing</td>
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<td>11</td>
<td>Dissatisfaction with how the event was received or the way in which the event proceeded. Respondents expected a more personal experience.</td>
<td>“‘What we are’-- I felt people described their mental illness as who they are. This can be hurtful to people. They can feel trapped. Rather focusing on the illness as part of us. Not all of us.” (#78)</td>
<td>“Would have liked to have more time for questions-- they were helpful and would have been nice to speak more openly with audience.” (#45)</td>
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<td>11</td>
<td>“Did not feel welcoming” (#19)</td>
<td>“I feel that they should stick with actual diagnoses rather than personal diagnosing. I also feel that it would be good to encourage ‘I have XYZ condition’ vs. ‘I AM XYZ condition’. We are all people and NOT our conditions.” (#24)</td>
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<tr>
<td>11</td>
<td>“Sitting on my own” (#21)</td>
<td>“‘What we are’-- I felt people described their mental illness as who they are. This can be hurtful to people. They can feel trapped. Rather focusing on the illness as part of us. Not all of us.” (#78)</td>
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<td>11</td>
<td>“Would be better to divide into small groups to talk more openly” (#83)</td>
<td>“I feel that they should stick with actual diagnoses rather than personal diagnosing. I also feel that it would be good to encourage ‘I have XYZ condition’ vs. ‘I AM XYZ condition’. We are all people and NOT our conditions.” (#24)</td>
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<tr>
<td>Category</td>
<td>Score</td>
<td>Suggestion</td>
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<td>Better Organization</td>
<td>12</td>
<td>“Have some of the volunteers perhaps do more greeting and perhaps check in on those that might be currently struggling and/or isolated.” (#21)</td>
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<tr>
<td></td>
<td></td>
<td>“Please don't mention specific self-harm tools or amounts/types of alcohol (or other specifics around addictions, eating disorders, etc) as it can be extremely triggering.” (#72)</td>
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<tr>
<td>Greater Event Exposure</td>
<td>5</td>
<td>“More advertising prior to event. Maybe bring it up in the 1st week of school (O-week) and through October” (#3)</td>
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<td></td>
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<td>“It seems less advertised than earlier years?” (#55)</td>
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<td>Greater Diversity</td>
<td>4</td>
<td>“Better representation of people of colour and queer/trans on the panel would be great, though I really appreciate everyone who spoke and their honesty and transparency” (#28)</td>
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<tr>
<td></td>
<td></td>
<td>“More diversity on the panel-- could you not find any people of colour who were willing to talk?” (#67)</td>
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</table>