Department of Psychology

When the fear of discrimination is higher than the hope for support

The effect of hiring procedures on mental health help-seeking in young adults

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Master's Thesis in the field of psychology (PSYP01)

May, 2024

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Acknowledgements

I would hereby like to express my greatest gratitude to my supervisor Patric Nordbeck. I could not have had a better person besides me and in this project than you. You helped me to approach research from a new angle and have been such an incredible support throughout the entire process. Whenever I felt like I had hit a barrier in the process, you were able to ask the right questions and provide the right feedback that allowed me to continue. Whenever I just had the slightest feeling that something might not be working, you were able to point out the problem and helped me find new ways to overcome them. It was such a great journey to explore this new method and to think in new directions and I will carry all the little lessons you have taught me with me in my future. All in all, thank you for being such a competent researcher and your wisdom. Thank you for your patience, kind words, encouragement, and the fun throughout the thesis. And lastly, thank you for wanting to be my supervisor throughout the project.

I would also like to thank all of my friends and my family for your endurance and support. For about a year now you have been listening to me while I was complaining about society. Thank you for the inspiration that sparked the idea for this project. Thank you for sharing your thoughts and insights related to the topic at hand. I also appreciate all the help you have given me when sharing or and participating in my study although it was not the shortest and easiest to do. You all have been part of this process and helped me come this far.

More specifically, I would like to thank my parents who have helped me to generally come this far in my education and for supporting my every step of the way. Although it meant that I moved several hours away from you, you have always been a phone call away. It was always such a great support to know that you are there.

Lastly, to end on a bit more humorous and yet serious note, I would also like to thank the world for the existence of coffee as it was a constant companion throughout the process of this thesis.

Abstract

Research on mental health (MH) help-seeking behavior is still trying to understand influencing factors that hinder individuals in obtaining professional help. This becomes particularly important as young adults show a high prevalence of mental illness (MI) but a low prevalence of seeking help. So far, MH stigma resulting from self-directed and public attitudes, emotions and behaviors has been considered as an important barrier to help-seeking. However, the stigma deriving from employers and the resulting discrimination against individuals with MI throughout hiring processes are widely uninvestigated. As young adults pose a specific group, with employment and financial independency being relevant life goals, this study aims to understand whether stigmatizing hiring processes affect their help-seeking intentions in interaction with increasing symptoms of an MI. Participants are exposed to two different scenarios with either MH stigmatizing or MH supporting hiring conditions and respond with their help-seeking intentions while considering serially worsening MH symptoms. Although the analyses did not find stigma-related changes in help-seeking, there is evidence for that participants perceive and worry about hiring discrimination. Also, stigma deriving from employers was found to relate to public and self-stigma. Apart from foundational insights into another type of stigma, this study shows that investigating help-seeking across different psychopathologies adds to existing research as it can measure symptom-dependent changes of help-seeking decisions. Implications for stigma-related theories are discussed along with suggestions for further research to support young and stigmatized individuals in their process of obtaining MH help and employment.

Keywords: Mental health stigma, Hiring discrimination, Emerging Adulthood, Help-seeking Intentions, Structural Stigma, Self-Stigma, Public Stigma, Mental health literacy

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The fear that seeking formal help for a mental health issue could cost one the career, is common among German students that aim to become a teacher, police officer or lawyer (Feininger, 2021). It is also something that student counselors make them aware of when they are consulted for lower-level formal help. What these students have in common is that they belong to a specific group of workers in Germany, the so called "Beamt*innen auf Lebenszeit" (English: "lifetime appointed civil servants") who are employed to serve the country. To ensure that applicants that would obtain such a position reliably serve the country for a lifetime, examinations of health and mental health (henceforth abbreviated MH) are a common part of application and hiring procedures (see §34 in BBG, 2009). However, this procedure seems to become a problem for young people aspiring to civil servant positions. As there are no clear rules and regulations for what kind of mental illness (henceforth abbreviated MI) constitutes an exclusion criteria during the hiring procedure, the rulings appear to be unpredictable (Feininger, 2021). Consequently, students avoid MH diagnoses or treatment in order to not compromise future job prospects. This trend of reduced help-seeking in relation to future career worries was studied by Nohr et al., (2021) with an original aim to understand cross-cultural differences in the influence of stigma on help-seeking behaviors (henceforth abbreviated with HSB). In the German sample, they discovered that despite the comparatively positive public and individual beliefs about MI, participants had high self-stigma (i.e., negative self-perception if one would seek help) and negative attitudes towards seeking professional help. Based on that finding, the authors also considered that the rather young sample might avoid MI labels or treatment to protect future careers, which in turn could relate to their low help-seeking attitude.

In many countries, including Germany, anti-discrimination regulations are in place to prohibit employers to either request MH information if the position does not require it or to forbid the exclusion of applicants with equal qualifications based on an MI (Baldridge et al., 2018). However, despite these regulations, employment seems to be less accessible to individuals with MI. Related to that, the recent publication from the World Health Organization and United Nations, advised countries to forward inclusive and supporting legislations for people with MI (WHO & OHCHR, 2023). These legislations include, inter alia, employment regulations, which should be changed and adapted so that MH is approached in a more holistic way rather than with isolated regulations. Without a holistic

approach, it can occur that employers continue implementing discriminating hiring procedures despite existing anti-discrimination laws. For instance, a recent US investigation shows that employers from different work sectors ask applicants for MH information during application processes, some with more legal justifications and others with less (Branning et al., 2021). Especially for jobs in public or governmental sectors, it is common that employers evaluate applicants' MH during application procedures. While it is a legal concern in which way employers deploy and use MH information during application procedures, the example from Germany shows that these hiring procedures should also be considered as a societal concern.

Currently, however, there has been little research on the effect of hiring discrimination on MH help-seeking decisions in young adults (Ueno & Krause, 2019). To understand this phenomenon and the related contributing factors, this study aims to experimentally investigate the influence of employers' hiring procedures on young adults' MH HSB. Therefore, the following five main areas will be introduced:

(1) *MH stigma deriving from workplaces,* in order to understand the effects and motives behind stigmatizing workplace procedures,

(2) *Emerging adulthood,* as structural stigma is examined in relation to this specific phase in life,

(3) *MH in young adults*,

(4) *MH HSB in young adults*, and

(5) *Stigma* as a barrier in HSB.

Mental health stigma deriving from workplaces

Current research highlights and discusses preexisting discrimination in application procedures and the way employers' MH stigma limits stigmatized individuals and their employment (Brouwers, 2020). In two field studies, discriminating tendencies in application procedures were found, when they compared employers' responses to two fictitious applications (Bjørnshagen, 2021; Hipes et al., 2016). While one of the two fictional applicants declares that they spent six months in hospital for an MI and made a full recovery, the other applicant states that they either spent the same time in the hospital for a medical illness (Hipes et al., 2016) or traveled (Bjørnshagen, 2021). In the end, the applications differed in what the applicants had done in a certain period of time (i.e., hospitalization or traveling), but the presented qualifications for the position were interchangeable. Despite the fact that each applicant would be able to perform with the same quality, both field studies show lower employers' call-back rates and interview invitations for the applicant with a MI history.

Compared to the travel applicant, employers in different work fields were about 25% less likely to invite the applicant with MI for an interview (Bjørnshagen, 2021). In comparison to the medical health hospitalization applicant employers were 33% less likely to invite applicants with MI history for an interview (Hipes et al., 2016). Consequently, although the studies are not able to provide data for the entire hiring process (e.g., likelihood of receiving a job after the interview), they do demonstrate the negative effects MI disclosure can entail during early stages of application processes and the problems arising for stigmatized individuals.

Although the reasons for such structural stigmatization are manifold, it should be mentioned that not all discrimination of applicants with MI is unjustified. That is, some job positions go hand in hand with great responsibilities and other people who depend on the work (Branning et al., 2021; Corrigan et al., 2004). For instance, the position as a police officer or emergency responder requires reliably vigilant and reactive people to maintain the safety and order within a community (Branning et al., 2021; Brouwers, 2020). In these cases, overall MH is a relevant demand to fulfill the job requirements. If an applicant or employee currently has a significant MI, then it could endanger or harm the people that they work with. Nonetheless, there are also employers that obtain MH information and derive judgements about applicants' employability, that are both illegal and MH illiterate (i.e., reflect low levels of knowledge about MH). For instance, some employers associate MI with a potential risk and fear disruption of the workplace climate (Corrigan & Bink, 2016). Others assume that people with MI are low in functionality and productivity and therefore derive them their opportunity to work (Brouwers, 2020; Elraz, 2018; Lettieri et al., 2022; Subramaniam et al., 2022). Generally, besides incidences where employers legitimately discriminate applicants based on relevant job requirements, it is illiterate and economic reasons that result in structural stigma and reduces the employment prospects for people with MI (see also Baldridge et al., 2018; Brouwers, 2020; Elraz, 2018; and Hogg et al., 2023).

When considering the findings that employers show general discriminating behaviors in application procedures and some of them purposefully use MH information to select, it becomes clear that judgements regarding MH disclosure at early stages of an application are complex. Because of that, experts advise individuals to carefully evaluate the costs (e.g., lower chances of employment) along with the potential benefits of disclosing MI during application procedures (i.e., mutual and authentic evaluation of skills and condition as well as estimation of accommodations and support; Bogaers et al., 2023; Hogg et al., 2023; Toth et al., 2022). However, there are also experts that advise individuals to conceal their MI

(Bonaccio et al., 2020; Goodman, 2008; Hogg et al., 2023), which reinforces the idea that stigma is a barrier to obtaining a job (Clement et al., 2015; Lettieri et al., 2022; Martínez-Hernáez et al., 2014).

The motivation for focusing on young adults in this study is that research in the field of MH disclosure and MH help-seeking has mainly focused on people within an employment relationship. However, young adults that are about to enter their work life and because of that are also confronted with employers' hiring procedures, are widely uninvestigated. Since this is a particularly vulnerable time in people's lives, employers with stigmatizing procedures could have a profound influence on adolescents and their transition into an adult and working life (Kerckhoff, 2003).

Emerging Adulthood

Emerging adulthood marks the phase in life in which individuals move out of their caregiver's house, begin a new education, start a career, and form new relationships (Wood et al., 2018). Almost everyone experiences this transitional phase from the guided and yet highly explorative life as an adolescent to the responsible and self-determined life as an adult (Arnett, 1997). This emergence of adulthood not only encompasses several demographic changes, but also a delicate balancing act between changing life circumstances and decisions that potentially affect the entire life as an adult (Arnett, 2000). To some young adults (henceforth used to refer to emerging adults) this phase is manageable, and they find enjoyment in its' challenges (Wood et al., 2018). Other young adults experience this phase as highly distressing and destabilizing. As it is not only high stressors and vulnerabilities that many young adults experience during this phase but also MH issues themselves (for reference see Kessler et al., 2005; Rickwood et al., 2007; Slade et al., 2009 and Wiens et al., 2020), there is a high need for appropriate help to successfully face these challenges.

Typically, the boundaries of this transitional phase are defined by age and located at the age of 18 and 25 years (Arnett, 2000). However, if you consider young adults' experience of when and why they feel like they have reached adulthood, then age and other demographics fail to mark the boundaries of transition. Instead, individualistic aspects appear to be more reliable markers of the interindividual transition into adulthood. These are, for instance, making own decisions and being able to handle responsibility for own decisions and actions (Arnett, 1997, 1998). Another relevant determinant in 'feeling like an adult' is financial independence (Arnett, 1998). Earning money and therefore being in an employment relationship becomes an important prerequisite for the transition into adulthood. Thus, young adults might adapt their behaviors to sustain a high employability. If they are aware that

certain MH help-seeking decisions could lower their chances of obtaining employment, then the adaptation might lead to limitations in HSB. Considering the prevalence of MI in this age group, compounds the issue.

Mental health in young adults

High prevalences of MI are consistently found among young adults (Rickwood et al., 2007; Slade et al., 2009; Wiens et al., 2020). Approximately every second person develops an MI throughout a lifetime, with about 75% of them starting in the mid-twenties (Kessler et al., 2005). In the case of mood disorders, about 20% of the population develop one in their lifetime (Kessler et al., 2005). Across all ages, the highest subthreshold pathologies of depressions are prevalent in adolescents, which are thereupon more likely to develop a depressive disorder (Zhang et al., 2023). With such early onset of depressive pathologies and most of the cases of a mood disorder manifesting by the age of 30 (Kessler et al., 2005), the development and manifestation of a depressive disorder is highly likely within young adults. Further research on the trends of nationwide MH surveys between the years 2011 and 2018 indicates that MH of young adults continuously worsened, and the number of diagnosed mood disorders increased over time (Wiens et al., 2020). Therefore, young adults are at a critical age to develop an MI and their MH state itself continuously worsens, which targets them as a critical group for interventions.

Additionally, other aspects of the life of a young adult contribute to a MI. Generally, young adults in higher education show high prevalence rates of depression and MI (Acharya et al., 2018; Broglia et al., 2021; Sheldon et al., 2021). Acharya et al. (2018) studied an academic sample where they found that about 45% of participants were at risk for mild to severe depression. Higher rates were prevalent in subgroups such as female or international students, and in different fields of study such as social science and art degrees compared to, for example, engineering or nursing degrees (Acharya et al., 2018; Broglia et al., 2021). Besides that, high academic demands, changes in eating and sleeping routines as well as in the social environment relate to higher perceived levels of stress as well as sleep problems and influence depressive symptoms in students (Acharya et al., 2018; Broglia et al., 2021; Wiens et al., 2020). Consequently, there is an elevated level of vulnerability present in young adults which correlates with MI and highlights the need to support emerging adults in their MH with appropriate interventions.

Despite numerous empirically validated support and treatment options that can attenuate the high prevalence of MI (for a review on therapy for depressions see Barth et al., 2016; Corrigan et al., 2014) the rate of young adults that seek help remains low (Nohr et al.,

2021; Rickwood et al., 2007; Slade et al., 2009). Although some studies find an increase in HSB across time and different age groups, the overall HSB remains low for young adults (Brandstetter et al., 2017; Wiens et al., 2020). For instance, in a German longitudinal study between 1998 and 2010, individuals of different ages with an existing MI were assessed regarding their non-help-seeking (Brandstetter et al., 2017). During 1997-1999, about 69% of 18 to 34-year-olds with an MI did not seek help, a trend that for the time period 2009-2012 continued with about 63%. Apart from non-HSB, additional problems arise from years-long delays of seeking treatment after onset of an MI (Wang et al., 2007). In the case of mood disorders, most people tend to delay their treatment between 1 and 14 years, which can eventually compound life circumstances and future prospects.

When considering career and employment-related factors, the consequences of reduced HSB can be particularly problematic for young adults. A nationwide cohort study in Finland shows that having an MI during the young adulthood relates to lowered educational success (i.e., unachieved secondary or higher educations), and shorter durations of employment (Hakulinen et al., 2019). It also correlates with lower earnings and income. If an MI manifests before the age of twenty-five, issues with education, employment and income increase over the course of lifetime and lead to problematic personal economics. In countries where the pension depends on the employment time and rate of income, the effects of MIs on personal economics extend even further. Conversely, problematic economics and unemployment can promote MI such as a depression (Lorant et al., 2003; Lund et al., 2018). Therefore, supporting employment and personal economics besides supporting young adults in seeking help could further promote MH.

Concluding, the prevalence of MI in young adults is high while HSB is low (Slade et al., 2009). Not seeking help and suffering from an MI relates to problems and negative consequences in employment and personal economics which can sustain or foster an MI. Increasing HSB is crucial to curb the consequences of reduced MH and investigating the underlying mechanisms is important to build and adapt current interventions for young adults. Among various variables that are correlated to individuals' HSB, research often highlights stigma as a relevant influencing factor (Clement et al., 2015), which is why it is targeted in this research.

Help seeking behavior in young adults

Help-seeking is defined as "an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern." (Rickwood & Thomas, 2012; p.180), where "external assistance" is divided into *formal* and *informal* sources of help.

Formal sources of help include MH care professionals such as psychologists, psychiatrists or medical doctors that have a specialization and training in the field of MH and are therefore able to provide appropriate information, treatment, and care. *Informal* sources of help include social relationships such as family, friends, and spouses, who support and encourage the help-seeker as well as provide emotional assistance by listening to them (Corrigan et al., 2014; Rickwood & Thomas, 2012). In some instances, they provide help by sharing their own experiences with the course of their MI (Corrigan et al., 2014). Besides that, people can also deploy self-help. Rather than acquiring help from others, they attempt to treat themselves or search for information that can help them independently (Rickwood & Thomas, 2012). In relation to emotional or psychological issues, young adults predominantly wait for the condition to ease by itself, or they seek informal help (Theurel & Witt, 2022). They are less inclined to utilize resources on the internet and are sometimes even avoidant of formal help (Martínez-Hernáez et al., 2014; Theurel & Witt, 2022). However, when reviewing HSB in a general sample, there appears to be a segmentation in the way people seek formal help as well (Schomerus et al., 2019). Medical doctors (e.g., General practitioners) seem to be more accessible and are more frequently contacted for MH concerns than MH professionals (i.e., psychologists, psychiatrists). The latter are rather contacted for specific or severe MH concerns. These variations in seeking different sources of help related to the psychopathology show that help-seeking is an *adaptive process*. People adopt individual illness behaviors and base their help-seeking decisions on them (Mechanic, 1962). Depending on the prevalence and course of an illness as well as the associated personal and social consequences of it, people adapt their behavior. That is, some people are more inclined to seek help for any pathology, while others await severe MI before consulting help. Further differences in HSB arise at later stages of an MI. For instance, some people show greater formal HSB when they experience severe symptoms of a depressive disorder, as the extent of consequences and the suffering motivates them (Nagai, 2015). Others are not able to bring up the motivation to seek formal help at that stage of an MI, as they are affected by their symptoms. These mixed findings represent the highly dynamic and individual nature of help-seeking decisions and show interplay with the severity of symptom.

With the aim to conceptualize this variability, two studies investigated young adults and their HSB along the development of an MI to generate overall clusters of the processes. In the initial stages of an MI, young adults commonly normalize their condition (Broglia et al., 2021; Martínez-Hernáez et al., 2014). The normalization either relates to the inability to identify and understand the current MI as a problem or to the problem that the costs and

efforts of seeking help (e.g., time constraints) deter them from the benefits of it (Broglia et al., 2021). During this phase, young adults employ a pronounced reliance on self-help, or informal sources of help and show a reduced tendency to seek formal help (Martínez-Hernáez et al., 2014). With increasing severity and duration of MI, the normalization and denial decreases while the perception of needing help grows. If help is considered, young adults begin to investigate the diverse sources of help. However, the lack of prior knowledge about MH and MH care (i.e., mental health illiteracy, Furnham & Swami, 2018) becomes a potential barrier to seeking help in this phase (Broglia et al., 2021; Martínez-Hernáez et al., 2014). Besides that, sources of help can be perceived as incompatible or inaccessible (e.g., study schedule or holidays allow no time to consult counselling services; Broglia et al., 2021), or young adults fear the diagnosis they might receive when seeking formal help (Martínez-Hernáez et al., 2014). In the later stages of an MI, emotions such as fear, shame and doubt dominate in the cost-benefit evaluation of a seeking help decision and form a barrier (Corrigan et al., 2014; Martínez-Hernáez et al., 2014). Especially stigma, shame, or doubts regarding the efficiency of formal help hinders individuals in obtaining professional care (Martínez-Hernáez et al., 2014). This could also relate to why some people still not contact formal help sources or not stay throughout the entire course of professional treatment (Broglia et al., 2021). Instead, they seek sufficient informal and self-help options, or they withdraw from formal help if they consider their MH or self-help as adequate. This process, from understanding an MI as a problem all the way to seeking appropriate help for it, shows the complexity and multiplicity of help-seeking decisions. It is important to understand it as a dynamic process, in which different influencing factors can interact and coexist at the same time (Martínez-Hernáez et al., 2014).

As previous literature also shows, MH help-seeking decisions function as an interaction of internal and external processes. However, there is little research that accounts for the changes in help-seeking decisions that occur across different psychopathologies. Instead, research mainly investigates help-seeking as a generalized behavior tendency, which does not account for the multitude of variables that influence this decision process. Investigating self-, informal, and formal help in relation to clearly defined MH conditions within a narrower time frame, could allow for more information about the relationship between HS decisions and symptom severity (Aguirre Velasco et al., 2020; Gulliver et al., 2010; Rickwood & Thomas, 2012). Therefore, this study aims to measure help-seeking decisions across predefined symptoms to capture quantitative changes. This also enables understanding of it as a potentially relevant covariate in the relationship between structural
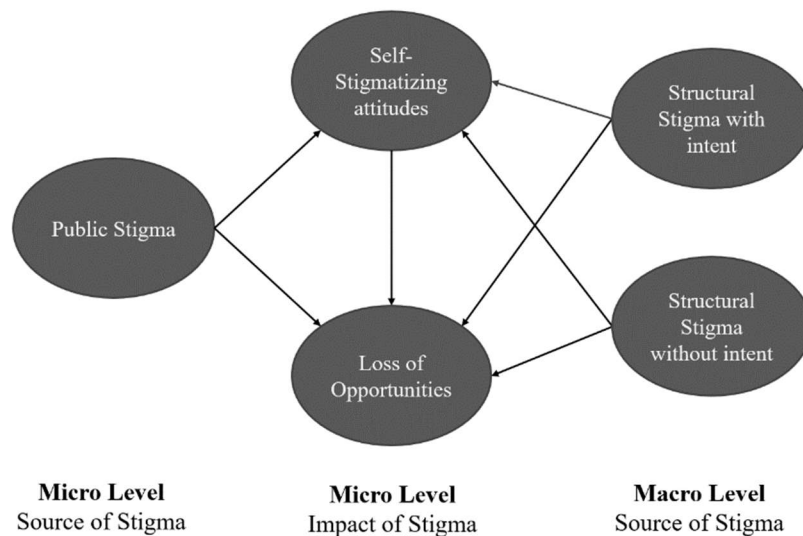
stigma and help-seeking. In order to understand further processes related to help-seeking decisions, relevant factors and covariates will be explored. Due to the specific focus of this paper on understanding help-seeking decisions in light of employers hiring procedures, the aspect of stigma and in particular structural stigma in relation to HSB will be explored in the following sections.

Stigma as a barrier in HSB

Along with every physical and psychological illness, individuals make a partially involuntary assessment of prevalence (i.e., *Is it a common illness*?), danger (i.e., *Is it related to long-lasting impact*? or *Is it lethal*?) and evaluate potential consequences of having the illness (Mechanic, 1962). For instance, people might feel less worried about experiencing sadness related to a negative event as it is a common reaction and is considered to pass. Having a hallucination on the other hand is less prevalent and therefore more likely to induce a sense of worry. However, evaluations of the consequences of illnesses not only occur on a medical or psychological level, but also on a social one. That is, people evaluate whether an illness can either lead to an experience of shame following a diagnosis or in contrast, to enhanced social support. Therefore, it is long known that in order to promote health care, one needs to understand and work with the thoughts, emotions and behaviors of the individuals and the community (Mechanic, 1962). This relates to stigma. Stigma defines a "negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency. A stigma implies social disapproval and can lead unfairly to discrimination against and exclusion of the individual" (APA, 2024). In relation to MH, stigma can present itself in three ways: Structural stigma, public stigma, and self-stigma.

Structural Stigma

This type of stigma is defined as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (Hatzenbuehler & Link, 2014; p.2). Structural stigma forms the broad working macrostructure of stigmatization in society and is commonly researched in the field of sociology (Corrigan & Bink, 2016; Hatzenbuehler & Link, 2014). Compared to that, psychological disciplines focus on micro-structures of stigma, hence public and self-stigma, which work on narrower and inter- as well as intrapersonal levels (Corrigan & Bink, 2016). However, stigmatized individuals always work within the limits of macrostructures and are therefore also affected by structural stigma (see Figure 1; Hatzenbuehler & Link, 2014).

Figure 1

Interconnections between the different types of stigma

| **Micro Level** | **Micro Level** | **Macro Level** |
| Source of Stigma | Impact of Stigma | Source of Stigma |

Note. Adapted from Corrigan et al. 2004 (p.488)

Whenever norms and policies overgeneralize MI and fail to make relevant distinctions within the heterogeneous psychopathologies, structural stigma can occur. In the context of hiring procedures at workplaces, structural stigma occurs whenever hiring policies utilize MI as a label with the means to select and outsource applicants (Corrigan et al., 2004). As mentioned earlier, applicants' MH can be relevant, if certain illnesses or symptoms impair the job of interest and could lead to harm if not executed properly (Branning et al., 2021; Corrigan et al., 2004). Nonetheless, it can become stigmatizing if employers make no differentiation between the MI, do not specify problematic pathologies for the position or if they do not account for the various experiences and levels of impairment resulting from different psychopathologies. As a result, job prospects of those individuals that are currently impaired by an MI and that are not able to perform the required specifications are limited. However, individuals that have recovered from a past MI or manage their condition sufficiently as to be able to perform well within a position are also affected (Brouwers, 2020; Corrigan et al., 2004). Without a clear definition of relevant job characteristics and a reliable as well as valid assessment of the applicants' limitations and demanded skills, qualified individuals can be wrongfully denied of work opportunities. Based on the fear of such employment-related discrimination, some stigmatized individuals limit their formal help-seeking in order to avoid the generic label of an MI (Clement et al., 2015; Martínez-Hernáez et al., 2014; Wood et al., 2020).

Besides these findings, there has been little research on the impact of the external influence of hiring conditions on individuals' MH help-seeking decisions in the particular period of emerging adulthood (Hatzenbuehler & Link, 2014; Ueno & Krause, 2019). So far, research on the influence of structural stigma on individuals focuses on public policies and laws (e.g., related to health insurances) rather than corporate policies (Hatzenbuehler & Link, 2014). This leads to the issue, that although there are governmental laws regulating employment discrimination, there is little information on the efficiency of them let alone on the experience of the affected individuals (Baldridge et al., 2018). It could for instance be the case that despite the efforts to ensure inclusive hiring policies, employers engage in subtle forms of discrimination, which are more difficult to discover and still harmful to the stigmatized person. In case of young adults and their MH HSB, potential influence deriving from structural stigma at workplaces have been hypothesized, but the empirical evidence is missing (Hatzenbuehler & Link, 2014; Nohr et al., 2021; Peterson et al., 2008). However, structural stigma is considered to affect and interact with inter- and intrapersonal variables (e.g., public and self-stigma) and through that intensifies the issue of label avoidance and reduced HSB among young adults (Hatzenbuehler & Link, 2014). It is therefore important to explore them and to include additional variables in this study to gain a realistic understanding of this component of social life.

Public Stigma

Public stigma defines stereotypes, prejudices and discrimination that are commonly presented in society or the public (Corrigan et al., 2014; Corrigan & Kleinlein, 2005). For instance, a common public concept of individuals with MI is that they are dangerous and unpredictable, which leads to fear and avoidance of them. Just as with structural stigma, individuals try to prevent public stigmatization and being labeled by avoiding receiving a diagnosis and averting treatment (Corrigan & Bink, 2016; Corrigan et al., 2014). However, while empirical studies confirm that people perceive the publicly shared negative attitudes, emotions, and reactions towards people with MI, it is not necessarily a driving factor in help-seeking decisions (Mackenzie et al., 2019; Nohr et al., 2021). Instead, studies find the third type of stigma -self-stigma- to be a greater barrier of HSB as it mediates the relationship between public stigma and HSB (Benuto et al., 2020; Vogel et al., 2017; Wodong & Utami, 2023).

Self-Stigma

Whenever individuals with MI start to agree with public stigma, they are likely to internalize negative thoughts, emotions, and behavior (Corrigan et al., 2014; Corrigan & Rao,

2012; Corrigan & Watson, 2002). The more salient and consistent the public stigma, the more likely an individual perceives, agrees, and applies the stigma to themselves (Vogel et al., 2017). As a result of self-stigma, individuals' self-esteem and self-efficiency diminishes and leads them to think that they are not worth any effort or that they are not worth or capable of something good (Corrigan et al., 2014; Corrigan et al., 2009; Corrigan & Rao, 2012; Corrigan & Watson, 2002). This so called "why try" effect not only reinforces a depressive disorder, but it also discourages individuals from seeking help (Corrigan et al., 2018). Research on young adults finds self-stigma to be a relevant barrier to general and formal help-seeking, with a greater influence than common covariates such as gender or ethnicity (Cheng et al., 2018; Mackenzie et al., 2019; Vogel et al., 2017). However, the mediation effect of self-stigma between public stigma and HSB was greater among older participants. In young participants covariates such as gender limited the effects of self-stigma on HSB (Mackenzie et al., 2019).

Research considering the gender identity of a person, commonly indicates that women are more likely to develop a disorder such as a depressive disorder than men (e.g., Hyde & Mezulis, 2020; Li et al., 2022) while they are also more likely to seek help (Cheng et al., 2018; Nohr et al., 2021; Wang et al., 2007). However, when considering the diverse sources of help, these gender differences occur for formal but not for informal HSB (Wendt & Shafer, 2016). Across all research, gender often interacts with other variables such as stigma or cultural background (Ojeda & Bergstresser, 2008). A process that could lead to gender differences is the so called "illness danger" (Mechanic, 1962). It states that the loss of social status deriving from an MI and related help-seeking is greater for men, thus leading to diminished HSB within this group (Mechanic, 1962; Ojeda & Bergstresser, 2008). This process is also hypothesized to leads to low MH HSB among people with higher educational levels due to the associated loss of status. Some empirical evidence supports the theory that higher education levels (i.e., higher social status) negatively correlate with HSB (Benuto et al., 2020). However, other studies indicate different or mixed results (Gonzalez et al., 2011; Leaf et al., 1987). Generally, educational level is a less observed variable, and most studies include mental health literacy (MHL) instead as it varies depending on the level of education and correlates positively with HSB (Furnham & Swami, 2018).

Being knowledgeable about MH as well as MH care is considered to be a relevant influencing factor in HSB as it is crucial to understand the MI as a problem in order to infer the relevance to seek help (Broglia et al., 2021; Schomerus et al., 2019). Furthermore, MHL includes the knowledge about reliable sources of help, which is a relevant prerequisite for

people to choose appropriate care for their condition (Jorm et al., 1997). This could change individual experiences of an MI and lead to different HSBs (Nohr et al., 2021). Empirical evidence shows that MHL is able to explain HSB independently from stigma indicating that it is important to consider when investigating HSB (Cheng et al., 2018; Wodong & Utami, 2023).

Current study

The study at hand investigates how structural stigma influences MH help-seeking intentions (henceforth abbreviated HIS) in young adults. Based on gaps and issues presented by the previous literature, this study follows two main goals. Firstly, it aims to explore a new method of investigating help-seeking that accounts for the situational dependency of this decision-making process. Secondly, it aims to investigate the influence of structural stigma on these help-seeking processes and the way it interplays with public and self-stigma. To do that, the current study sets up a scenario-based help-seeking decision method to understand help-seeking in relation to ten MH issues with serially increasing severity. Furthermore, two conditions were created that account for structural stigma in different hiring processes. These were used to subject half of the participants to a scenario where employers' hiring conditions are stigmatizing of MI, while the other half is subjected to a scenario where employers' hiring conditions are supporting of their applicants' MH.

Premised on the previous literature, people change their help-seeking decision based on the MH situation that they are in. More specifically, people tend to engage more in formal help-seeking if the symptoms become more severe (Broglia et al., 2021; Martínez-Hernáez et al., 2014; Nagai, 2015). Therefore, the level of help that participants would obtain across the increasingly worsening symptoms should increase, leading to the following hypothesis:

Hypothesis 1: *HSB increases with the severity of described mental illness symptoms.*

Besides that, stigma poses a relevant barrier to seeking help (Clement et al., 2015). In the case of young adults and their MH HSB, the importance of obtaining a job and securing a future could be an important motivator to change help-seeking decisions (Hatzenbuehler & Link, 2014; Nohr et al., 2021; Peterson et al., 2008). Young adults might be more aware of stigma deriving from employers during hiring procedures and adapt their behavior to maintain a successful career. As during hiring procedures the label of MI usually derives from seeking formal help and retrieving a record, young adults might change their HSB and avoid treatment (Corrigan, 2004). Related to this study, participants might deploy different help-seeking decisions across the different symptoms as a function of the hiring condition that they are in. To investigate this hypothesized process, this paper also explores the following hypothesis:

Hypothesis 2: *Structural stigma in hiring policies reduces help-seeking from formal help as compared to MH fostering work policies.*

As structural stigma is not working as an independent construct, the idea that structural stigma is interconnected with public and self-stigma is explored in Hypothesis 3a. Considering the finding that the effect of externally operating public stigma on help-seeking is mediated by self-stigma (Benuto et al., 2020; Vogel et al., 2017; Wodong & Utami, 2023), this study also explores whether this accounts for structural stigma (Hypothesis 3b). This leads to the following hypotheses:

Hypothesis 3: *(a) Structural stigma is related to public and self-stigma.*
(b) The effect of the macrolevel structural stigma on MH help-seeking intentions is mediated by the microlevel self-stigma.

Methods

Participants and sampling

The aim was to investigate a sample of emerging adults in their MH HSI related to prospective hiring situations. Therefore, the target population included people currently involved in an education (i.e., university, college, apprenticeship) with an age above 18. The main recruitment method was convenience sampling via social media and personal contacts. An international survey platform "SurveyCircle" was also used to gain twenty-one additional participants. Overall, a sample of N=88 participants were recruited. Participants were on average 25.45 years old (*SD* = 5.06), and a majority of the sample identified as female (female = 78,4%, male = 15,9%, non-binary = 3,4%, undefined = 2.3%). Besides 27.2% of the sample living in sixteen different countries, most of the sample currently resides in Germany (39.8%) or Sweden (33%). The commonly acquired level of education was the Bachelors level (59.8%), followed by Master's (19.5%) then High School/ Apprenticeship (10.3%) and most of the participants worked or studied in the "Health and Community Services" sector (29.9%), followed by "Science, Technology, Engineering, and Mathematics" (17.2%) and "Administration, Business, Human Resources and Management" (10.3%). Additional details on demographics can be found in Table 1 and 2. Further comparative analyses of the experimental groups yield non-significant results. This allows for the assumption that the two groups share the same overall characteristics and that there are no substantial group differences that could impact the latter group comparing analyses.

Material

Scenario material

Scenario Background. All participants are first situated in the general scenario with a *background scenario* text. Following the randomization into either the MH stigma condition or MH supporting condition, each half of the participants read the text associated with their condition (the texts are presented in full in Appendix A1). The content and the development of each text will be described in the following:

The *background scenario* describes that the participant soon finishes their degree and is about to apply for jobs of their interest. It highlights that the process of achieving the degree was stressful in order to prime participants with information about MH issues. Related to this stress, the text introduces different sources of help. On the one hand, participants are told that they can receive informal social support and that it is a reliable source of help. On the other hand, professional and formal types of help are mentioned and described. To associate certain formal help sources (i.e., medical and mental health professionals) with the subsequent hiring condition-specific scenarios, it was mentioned that choosing to seek help from them entailed that records of their MH status were kept. These mental health records (MHR), are described as being requested by employers during hiring processes. To increase the subjective relevance of this information, it is said that employers in the participants' field of work implement this method. Following this overall introduction to both texts, the two distinct conditions were described. These aim to present the justification of employers for the assessment of MH via MHR.

In the *mental illness stigmatizing hiring condition*, MH are portrayed as a prerequisite to a good work environment and acquiring applicants MHR helps employers to assess applicants' productivity and functionality. The basis for this text was mainly derived from qualitative studies that assessed perceptions of stigmatizing workplaces (Elraz, 2018; Lettieri et al., 2022; Subramaniam et al., 2022; Toth et al., 2022). There, stigmatizing workplaces are described as high stress environments with emphasis on performance, functionality, and productivity. A commonly shared notion is that people with MI disrupt the work environment and are of lower quality than other employees. It was decided against an approach to describe MHR as a tool to actively discriminate applicants with past or present MI, as this would impose a violation of common anti-discrimination laws in many countries and was perceived as unrealistic in a trail study. Instead, employers request MHR to see for job fitting and if

applicants can perform well under pressure or with the responsibilities given (Branning et al., 2021).

In the *mental illness supporting hiring condition* MHR are portrayed as a prerequisite to provide accommodations and a motivating and joyful employment and a way for employers to assess individual skills and limitations. The basis for this text was derived from empirically studies, intervention programs and networks that inform employers of employment of people with disabilities (Drake & Bond, 2023; Job Accommodation Network, 2024; Schur et al., 2005; Toth et al., 2022). There, commonly stated aspects of MH supporting workplaces are inclusion, individuality, support and a focus on individual job fit as well as an environment that supports the success of an employee.

Mental health issue series. The content of the vignettes in the mental health issue series were written to represent stereotypical experiences of individuals with an MI (see Appendix A2). The MI *major depression* was chosen to be presented in the mental health issue series as it is highly prevalent within the general population, among young adults and students (Acharya et al., 2018; Broglia et al., 2021; Cheng et al., 2018; Kessler et al., 2005; Sheldon et al., 2021). Furthermore, when presented with vignettes about different MI, student samples show good recognition rates related to depressive disorders (Coles & Coleman, 2010). The second consideration was to determine the five most commonly experienced symptoms of a major depression. Therefore, a cross-cultural literature review was examined (Haroz et al., 2017). The exclusion criteria of the symptom selection were that they have to be officially accredited diagnostic criteria of a depressive episode (i.e., DSM-5). This is relevant in order to increase clinical relevance and the likelihood of receiving a diagnosis, with increasing number of symptoms. Due to ethical issues resulting from presenting participants with suicidal thought descriptions, this symptom was also excluded from the final selection. This yields the selection of the following five symptoms: depressed mood or sadness, fatigue, sleep problems, appetite changes and loss of interest.

To ensure a relatable order of symptoms, network models were used to determine common interrelations between symptoms (Cramer et al., 2016; Lass et al., 2020). These show strong associations between the symptoms *sleep issues* with *fatigue* and the symptoms *loss of interest* with *depressed mood/sadness.* The association between *weight/appetite changes* with *depressive mood/sadness* was derived from Cramer et al. (2016) as only they included both loss and gain of appetite/weight. The changes of appetite and weight are

supposed to be vague in order for participants to project their own experiences onto it. These considerations led to the following order of symptoms: Sleep, Fatigue, Loss of interest, Depression/Sadness and Appetite/Weight.

To generate the final and in total 10 symptom descriptions the following questionnaires and vignette studies were used: Center for Epidemiologic Studies Depression Scale (Radloff, 1977), Patient Health Questionnaire-9 for depression (Kroenke et al., 2001), the initial patient statements that led to the Symptoms of Major Depressive Disorder Scale (McCarrier et al., 2016) and three vignettes (Amarasuriya et al., 2015; Heim et al., 2005; Jorm et al., 1997). All these scales and vignettes outline and conceptualize depressive symptoms. Therefore, they provided a good empirical basis to describe the different symptoms of the mental health issue series.

Measurement of help-seeking intentions. The scale used to measure HSI was derived from Theurel and Witt (2022) who investigated young adults' HSB. For the sake of this study and to understand in which way participants are influenced by MHRs that are required from employers and set up by medical and MH care professionals the following considerations were made: Based on a systematic review, the order of the scale was altered to represent an increasing intensity of informational and emotional help (Rickwood & Thomas, 2012). Therefore, the order of measured types of help is (1) *self-help* with the lowest associated level of help, (2) *informal help*, (3) *formal help that does not leads to a record* and lastly (4) *formal help that leads to a record*, which the highest associated level of help (see Appendix A3). *Self-help* is measured with two items. One item incorporates the option to not seek help as one would wait until the situation improves by itself, while the other item incorporates self-guided search for information on the internet. *Informal help-seeking* is measured with one item that includes all close relationships (i.e., family members, friends, and spouses). These sources of help are pooled into one cluster, as they all provide a similar level of informal help. A differentiation would lead to a lengthy survey with comparatively low informative value. *Formal help*, however, was divided into three items. The first item measures seeking formal help without records (e.g., hotlines as well as communal and religious/spiritual services), while the last two items measure formal help-seeking that includes an entry in the record (i.e., medical health care professional and MH care professionals). The distinction between these three items is relevant in order to (1) understand whether people differentiate help sources that involve records and (2) if they differentiate between medical and MH professionals. The latter reasoning bases on studies indicating that

in some countries medical health professionals are gatekeepers or first contact point for MH issues (Reavley et al., 2018). Besides that, general practitioners are perceived to be easier accessible than MH professionals, which relates to reduced help-seeking of MH professionals and consultations of MH professionals when there are specific or severe MH concerns (Schomerus et al., 2019). After this forced choice matrix of different help sources, participants can elaborate on their decision with an open text box.

Questionnaires

The six questionnaires and measurements, explained in the following, were selected for two reasons. Firstly, they serve to validate the scenario-based decision method by providing an insight into participants general HSIs, their perception of MH itself as well as of MH stigmatization. Furthermore, as the introduction highlights, individuals affect and are affected by their multifaceted environment. Therefore, it is important to understand the different intra- and interindividual variables besides the structural stigma of MH help-seeking. The included questionnaires were adaptations of established measurements. Their aim is to assess (1) participants' perception of different employers, (2) overall HSI, (3) social as well as structural stigmatization, (4) self-stigmatization and (5) MHL.

Employer perception measurements. To understand how participants generally understand and react to different employers and their hiring conditions, this employer perception measurement was created. It comprises three descriptions of employers (see Appendix A4). Two of them are short descriptions of the employer descriptions used in the scenario-based decision measurement (i.e., MH supporting and MH stigmatizing employers) and one new description was generated to understand if participants perceive the first two employers different than the last explicitly stigmatizing employer. Related to these descriptions, participants rate two questions on a 4-point Likert scale ranging from 1 (definitely not), 2 (probably not), 3 (probably yes) to 4 (definitely yes). Firstly, they rate if they would apply for a job with these employers. Secondly, participants are asked to rate their MH disclosing behavior in the event that they applied to the company and experienced MH issues but have not yet received an MHR for. Both of these can help to assess how attractive employers appear to the participants depending on the hiring conditions.

Overall help-seeking intentions. The measurement of overall HSI is based on the first part of the General Help Seeking Questionnaire (GHSQ; Wilson et al., 2005a). The introductory question that asks participants for the likelihood of seeking certain sources of

help for an emotional-personal problem, was reformulated to form a baseline measurement of help seeking intentions (see Appendix A5). To be able to relate this questionnaire to the scenario-based decision method the items including different sources of help were changed. Firstly, the option "*teacher*" and "*others*" were excluded. Besides that, one item was added to understand use of online information platforms and the item "I would not seek help from anyone" was transformed into a separate question in order to enhance the understandability. This leads to an overall of eleven items with a scale from 1 (completely uncomfortable) to 7 (completely comfortable). While the original scale yields an internal consistency of α= .7 (Wilson et al., 2005b), the current and adapted version provides a satisfying internal consistency of α= 0.784. The correlations between this scale and the mean value for each source of help across the scenario-based help-seeking measurement are presented in Table 3. Most of the measurements of HSI correlate significantly for related sources. Exceptions are the "*other relatives*" item from the GSHQ that did not yield any significant correlation with the scenario items. Also, the GSHQ item measuring self-help and the scenario item "*waiting until it gets better*" did also not correlate, but one could argue that not seeking help from external sources still allows for other help options as opposed to waiting until the mental health issue resolves itself. Apart from that, all related constructs show significant and the highest correlations.

      Overall public and structural stigmatization. The scale of both public and structural stigma is based on the Stigma Scale of Receiving Psychological Help (SSRPH; Komiya et al., 2000b). The first question was deleted as it has the lowest item-total correlation and to provide a more coherent and shorter questionnaire (Komiya et al., 2000a). The remaining items (i.e., items 2 -5) were used and slightly changed in wording to ask participants for their perception of MH stigma deriving from other people (i.e., public stigma; see Appendix A6) or from employers (i.e., structural stigma; see Appendix A7). Participants rate on a scale from 0 (strongly disagree) to 3 (strongly agree) if they agree with the eight provided statements. While the original scale with the focus on public stigma has an internal consistency of α=.72 (Komiya et al., 2000a), the current and adapted public stigma scale provides an improved and satisfying internal consistency of α= 0.76. The structural stigma scale yields even greater internal consistency with α= 0.82.

      In order to validate that both scales measure different constructs an exploratory factor analysis was conducted. When considering the scree plots as well as the factors with an Eigenvalues above 1, a 2-factor solution shows the best fit of the data. The suggested factors,

confirm that both scales measure different constructs as one factor includes the items used to measure public stigma and the other factor includes the items used to measure structural stigma (for further results, see Table 4).

Overall self-stigmatization. Self-stigma is measured with the Self Stigma of Seeking Help Questionnaire (SSOSH; Brenner et al., 2021). The seven items measure what people think about themselves if they would seek professional help on a scale from 1 (strongly disagree) to 5 (strongly agree) (see Appendix A8). In previous studies, this scale had a high internal consistency of $\alpha = .89$ and correlated with public stigma scales, which is also of interest for this study (Brenner et al., 2021). In the current study, the scale yields a lower but still satisfactory internal consistency of $\alpha = 0.87$ and correlates significantly with the public stigma scale ($r = 0.31$; $p < .01$) but not significantly with the structural stigma scale ($r = 0.11$; $p = .30$).

Mental health literacy. The last measurement comprises a self-rated MHL assessment (see Appendix A9). Participants receive a major depression vignette derived from (Jorm et al., 2007) and rate their knowledge level on a scale from 1 (very low) to 5 (very high) related to four sub-questions derived from (Moll et al., 2017). These focus on the understanding of the presented MI, as well as knowledge about prevention and intervention possibilities for it. This specific measurement was selected to balance the number of questions that a common MHL assessment would comprise with more differentiated information on participants' different MH knowledge levels. While this measurement leads to a subjective evaluation of MHL, the different areas of knowledge allow for a better understanding of which areas of knowledge in MH (i.e., the disorder itself, the intervention/therapy options, prevention options, etc.) relate to certain HSB and which require intervention (Moll et al., 2017). For this sample, the scale reaches an internal consistency of $\alpha = 0.73$.

Procedure

After reading the overall purpose and content of the study, participants consent to the presented terms before being able to continue to the survey. Then they are introduced into the first part of the study, the scenario-based help-seeking decision measurement. Afterwards, participants receive a randomly assigned hiring condition scenario description (i.e., either MI stigmatizing or supporting hiring condition) and continue with the ten consecutive scenario-based help-seeking decision measurements. Halfway through, they receive a reminder to think about the initial scenario background accompanied with a brief description of the hiring

conditions in their field of work. After they have finished answering the questions to the last mental health issue scenario, participants are told that the scenario is over and that all the following questions are to be answered out of their current perspective and situation.

The second section of the study consists of questionnaires. Firstly, participants receive the three employer descriptions from the employer attitude measurement. On the following page, the remaining questionnaires are presented in the following order: the adapted General Help Seeking Questionnaire (Wilson et al., 2005a), MHL questions (Jorm et al., 2007; Moll et al., 2017), the adapted Stigma Scale of Received Psychological Help (i.e., both the public and structural stigma version; Komiya et al., 2000b) and Self Stigma of Seeking Help Questionnaire (Brenner et al., 2021). The third section of the survey constituted the demographics questionnaires which concluded with an additional open text-field, allowing participants to state remaining thoughts and comments. Lastly, they were thanked for their participation and received a comprehensive debriefing.

Ethics

This study did not require ethical approval. The content of the study allows for an assessment of participants' perception of stigma and help-seeking decisions and to see if the manipulation of scenarios would change their intended help-seeking decisions. While the content describes situations that participants are likely to confront on a regular basis in real life, participants might still experience discomfort reading about different MH symptoms. Therefore, participants were informed about the procedure and content of the study before participation. They were also reminded that their participation is voluntary and can be interrupted at any given point without repercussions. Also, participants received an extensive debriefing after they had finished the study. The debriefing informed participants about the concrete content of the study (i.e., which hiring conditions and MH conditions they experienced) and provided additional resources for information and help. Additionally, there is no sensitive personal data assessed throughout the study which also ensures the participants anonymity. Overall, the risk of harm for participants resulting from this study are considered low and the gain in knowledge outweighs the potential risks.

Analyses

To assess the hypotheses at hand, several analyses were administered in both R and Jasp. A hierarchical regression was administered in order to test the established hypothesis that symptom severity positively relates to HSI (i.e., Hypothesis 1: *HSB increases with the*

severity of described MI symptoms.) and to test the influence of structural stigma on participants MH HSIs (i.e., Hypothesis 2: *Structural stigma in hiring policies reduces help-seeking from formal help as compared to MH fostering work policies.*). Therefore, R and the linear modeling function ('lm' in preloaded stats package) was used to perform a stepwise analysis of the HSI. The related outcome variable should therefore represent the different levels of HSI. To achieve this, the data generated in the scenario-based MH help-seeking decision method was transformed as follows: For each level of symptom in each participant one score is obtained representing the highest source of help that was chosen. That is, if a participant at a given symptom has only chosen "1= *I'm waiting for the situation to get better by itself.",* then the value "1" would be retrieved for this symptom level. If any source higher than this was chosen, the according scale value was retrieved for this symptom resulting in ten values for each participant ranging between 0 (i.e., if none of the provided options was chosen) and 6 (i.e., if professional psychological help was chosen). The higher the value, the higher is the associated level of emotional and informational help that participants intended to obtain in relation to the symptom. With this outcome variable as a criterium, the analysis adds the following predictor variables in a stepwise manner: (1) Covariates (i.e., demographic variables and MHL), (2) other stigma variables (i.e., self and public stigma), (3) symptom severity (Scale from 1-10) and (4) structural stigma (i.e., the scale measurement and the condition variable with "1" for MH stigma hiring condition and "2" for MH supporting hiring condition). If the variable symptom severity yields a significant ($p < .05$) and positive predictive value, the first hypothesis would be supported. That is, symptom severity apart from other influencing variables would be able to predict increases in HSI. If furthermore the variable structural stigma were a significant and a positive predictor, the second hypothesis would be confirmed as well. That is, the MH stigmatizing hiring condition (coded as "1") would lead to lower levels of emotional and informational help that participants intended to obtain, than the MH supporting hiring condition (coded as "2"). This means, that participants in the stigma condition were seeking less professional medical and psychological help (highest values 5 & 6) when being placed in a stigmatizing environment.

Lastly, to explore the last hypotheses (i.e., Hypothesis 3: *(a) Structural stigma is related to public and self-stigma; (b) The effect of the macrolevel structural stigma on MH help-seeking intentions is mediated by the microlevel self-stigma*) a structural equation model was built using the "lavaan" package in R (Rosseel et al., 2023) to analyzes the interconnection of the different types of stigma and their influence on HSI. Therefore, the

different scale measurements GSHQ, SSRPH with the subscales focusing on public and structural employer stigma and SSOSH were used. As stated in the introduction, MHL poses an important covariate to HSI and might therefore explain variance in stigma scales and help-seeking. For this reason, it was included as a covariate of all latent variables. Furthermore, indirect effects were included to account for potential mediating influences of self-stigma on the relationship between structural stigma on HSI. Also, the mediating effects of public stigma between structural and self-stigma were investigated. This leads to the following measurement and structural models used for the analyses:

Table 5.

Measurement model of the SEM of HSI

Latent Variable	Manifest Variables
Help-Seeking Intention	GHSQ_Partner + GHSQ_Friend + GHSQ_Parent + GHSQ_Relatives + GHSQ_Internet + GHSQ_Phone_services + GHSQ_Spiritual_support + GHSQ_Counselor + GHSQ_MentalHP + GHSQ_MedicalHP + GHSQ_SelfHelpR
Mental Health Literacy (MHL)	MHL_comprehension + MHL_prevention + MHL_support + MHL_resources
Public Stigma	SSRPH_1P +SSRPH_2P +SSRPH_3P + SSRPH_4P
Self-Stigma	SSOSH_1 +SSOSH_2R +SSOSH_3 +SSOSH_4+ SSOSH_5R +SSOSH_6 +SSOSH_7
Structural Stigma	SSRPH_5E +SSRPH_6E +SSRPH_7E +SSRPH_8E

Note. R indicates reversed items

Table 6.

Structural model of the SEM of HIS (direct effects)

Outcome	Predictor
HSI	~ b*Self-Stigma + e*Public Stigma + c*Structural Stigma + g*MHL
Self-Stigma	~ f*Public Stigma + a*Structural Stigma + h* MHL
Public Stigma	~ d*Structural Stigma + l* MHL
Structural Stigma	~ i* MHL

Note. Paths (a*b) were used to investigate the indirect effect of Structural Stigma on HSI via Self-Stigma, Paths (d*f) were used to investigate the indirect effect of Structural Stigma on Self-Stigma via Public stigma.

Results

Mental health stigma, symptom severity and help-seeking intentions

The hierarchical regression model at hand comprises four steps (for an overview of all the results, see Table 7). The first step includes all demographic covariates and MHL and explains 14.53% of the variance of HIS. Due to small samples across gender, countries of residence and occupation, the significant results cannot be interpreted or used to derive generalized assumptions. However, the covariate MHL was measured in all participants and is a significant predictor of HSI across all blocks. With higher levels of knowledge about MH and MH care, participants show higher levels of help they intend to obtain. When adding stigma covariates in the second step, the model explains significantly more variance compared to the first model (F (2,831) = 14.31; p<.001). Apart from demographic variables and MHL, self-stigma but not public stigma significantly predicts HSI. With higher levels of self-stigma, participants show lower levels of help they intend to obtain. This model explains about 16,51% of the variance in HSI.

The third step serves to evaluate the first hypothesis (i.e., positive relationship between symptom severity and HSI). When adding the variable symptom severity, some demographic variables, MHL and self-stigma remain significant predictors of levels of help they intend to obtain. Additionally, to these variables, the level of education yields significant predictive value. With increasing level of education, participants indicate lower levels of help they intend to obtain. Lastly, symptom severity itself is a significant predictor. With higher level of symptom severity, the intended obtained level of help increases, thus confirming the first hypothesis that both variables have a positive association. Adding symptom severity to the model, improved the prediction of HSI significantly (F (1,830) = 261.13 p <.001***) and explains 36.39% of its' variance. The overall change of the level of help that participants intend to obtain across all symptoms and experimental conditions is visualized in Figure 2. It supports the results and shows that with increasing symptom severity participants intend to seek more formal types of help.

Figure 2.

Mean maximal intended obtained help across all symptoms
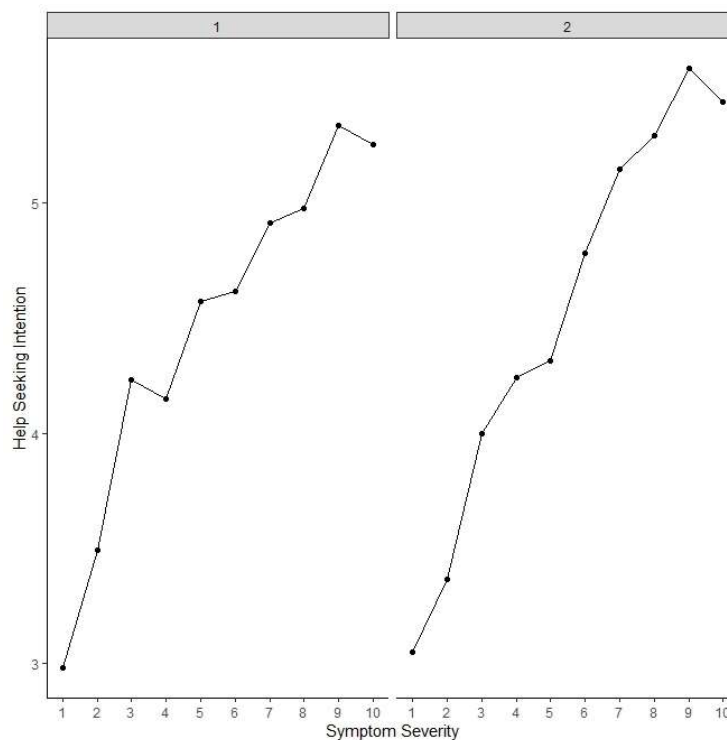
Note. 1= MH stigmatizing hiring condition, 2= MH supporting hiring condition; The figure represents the average of the highest level of help participants intended to obtain. It is separately displayed for the two experimental groups and for each symptom.

This does not, however, account for the second hypothesis. When adding structural stigma variables (i.e., the condition variable and scale variable) in the fourth step, the model does not predict more variance if HSI (F (2,828) =1.53; p=.22, n.s.) and the results for both predictors are not significant. It should be highlighted that the structural stigma scale measurement yields a marginally significant result. Thus, it could be that that with increasing structural stigma perceptions, participants intend to obtain lower levels of help. However, for this sample the second hypothesis (i.e., structural stigma results in less obtained professional help) has to be rejected.

Differences across employer perception

To assess whether participants have differently perceived the description of the employers that were also mentioned in the experimental setting, the scales were compared

with a repeated measures ANOVA. Therefore, three different employer types (i.e., MH supporting, MH stigmatizing and directly MH stigmatizing) were compared in two different measurements of application aspects (i.e., willingness to apply and willingness to declare a MI). When reviewing the descriptive data (see Table 8), the overall willingness to apply and disclose ranges around a mean of 2.2 and 2.6 for the MH supporting employer (1.7 – 2.0 for stigmatizing and 1.5 – 1.6 for directly stigmatizing employers). This indicates an overall tendency to "*probably not*" apply and disclose. The analysis of the main effect employer type yields significant results (F (2,174) =75.81; $p<.001***$). Further post hoc analyses show that participants were more willing to engage in either application aspect in MH supporting employers compared to either stigmatizing employer (see Table 9). They were also more willing to apply and disclose in the stigmatizing rather than the directly stigmatizing employer (see Figure 3 below).

Figure 3.

Overall tendencies in participants to apply to and disclose MH condition at different employers
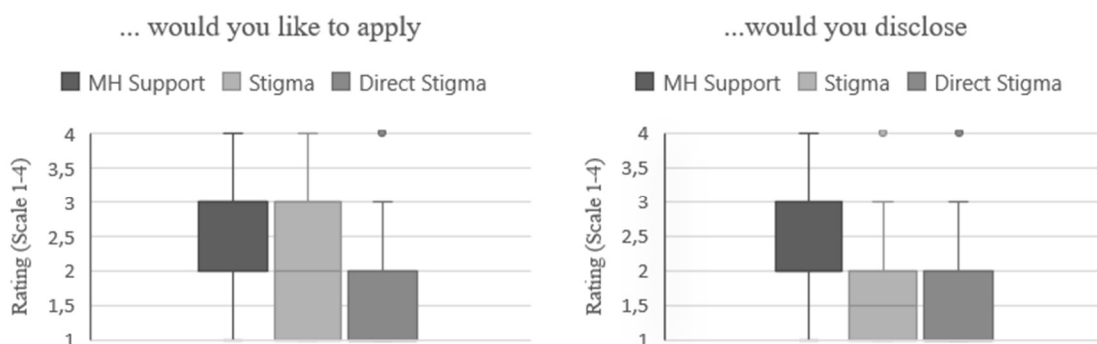
Note. The boxplots depict the three employer types (MH supporting, MH stigmatizing and directly stigmatizing) and the related ratings of the participants and how likely they would apply (left figure) or disclose a MI when there is no record of it (right figure) to them.

Participants were also more inclined to apply at either company than to disclose a potential MI (F (1,87) = 11.52; p = .003**). Lastly, the interaction of both conditions was significant as well (F (2,174) = 12.07; $p<.001***$) and additional post hoc tests show, that participants are the least inclined to apply to a company that shows explicit forms of

employment discrimination, followed by the indirect stigma (i.e. the stigma condition of the scenario) and lastly the employer with the MH supporting condition (see Table 10). This order also applies to the willingness of participants to disclose an MI if they have not had an MHR. If participants evaluate employers based on their hiring conditions and the way they use MH information during application processes, they are most likely to apply and disclose any potential MH condition to MH supporting employers. Compared to that, they are decreasingly likely to apply and disclose to stigmatizing and directly stigmatizing employers.

Structural Equation Model of Stigma on HSI

To understand the abstract and general relationships between the different forms of stigma and the other covariates, Pearsons r correlations and a structural equation model (SEM) were administered. These aim to analyze the third hypothesis and understand the different influence of the distinct sources of stigma on each other and HSI.

Firstly, zero order correlation analyses show that all scales correlate significantly with general HSI (measured with GSHQ). All stigma scales negatively correlate with general HSI, indicating that higher stigma scores are associated with lower HSI. Among the stigma scales, only the self-stigma scale (measured with SSOSH) and structural stigma scale (measured with SSRPH-E) did not correlate (see Table 11 below). Whenever stigma scales correlate, there is a positive association, which indicates that higher scores on one scale are associated with higher scales on another stigma scale. Lastly, the covariate MHL correlated positively with general HSI but not with any stigma scale.

Table 11.

Pearsons r correlation of all stigma scales, MHL and GSHQ

Variable	*M*	*SD*	1	2	3	4	5
1.GHSQ	4.03	0.95	1				
2.SSOSH	1.99	0.73	-.29**	1			
3.SSRPH-P	2.07	0.61	-0.24*	.31**	1		
4.SSRPH-E	2.93	0.69	-.27**	.11	.47***	1	
5. MHL	3.51	.79	.27**	-.17	-.03	-.09	1

Note. N = 88; *p < .05, **p < .01, ***p < .001 (two tailed correlation)

Prior to forming the SEM, three participants were excluded, as they were identified as outliers with the mahalanobis distance of multivariate data analysis. Further Shapiro-Wilk univariate normality tests and Mardia multivariate normality tests all yielded significant results, thus violating the normality assumption. Therefore, the MLM estimation method in R (based on maximum likelihood estimations, 'MLM' estimator in 'lavaan',(Rosseel et al., 2023)) is applied to create a model that is more robust to the non-normal data distribution. The final model includes data from N=85 participants and has no missing values.

When testing the model's goodness of fit, the analyses show a reasonable but not good model fit. The Satorra-Bentler scaled chi-square was calculated to account for the non-normal data and yields a significant result ($X^2(395) = 573.52$; p<.001) indicating that the implied model differs significantly from the covariance matrix of the data. Considering the guidelines of RSMEA, the present model shows a reasonable fit with an RSMEA estimation of .073 (90% CI=.06, .086), which is confirmed by the non-significant test of whether the RSMEA is higher than .08 with p=.22. Other goodness-of-fit analyses show that the model is not a conventionally considered good fit. That is, the Tucker-Lewis index results in TLI = .75 (where TLI > .95 is considered good), the comparative fit index in CFI = .78 (scale from 0-1 with .95 conventionally considered as good) and standardized root mean residual SRMR = .1 (SRMR <= .08 is accounted as a good model on a scale from 0-1). Nonetheless, all analyses considered, the model does structure the data in a meaningful way and is presented in Figure 4 below.

Figure 4.

Structural model of Help-Seeking Intention

Public Stigma

-..62

Structural Stigma

-.39

-.39

.67

Mental Health Literacy

-.38

Self-Stigma

Help-Seeking Intention

-.48
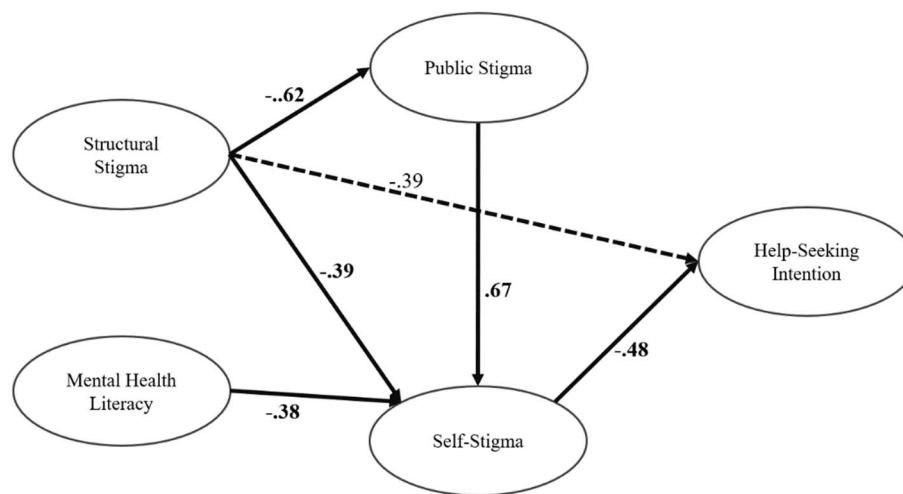
Note. Represented are the different latent variables and their direct relationships. Interrupted arrow connections indicate marginally significant estimates; Bold and full arrow connections indicate significant (p<.05) estimates; all related results of the SEM are presented in Table 12-14.

The proposed structural model shows that public stigma is negatively associated with structural stigma (beta= -.62; *p*<.001) but not with MHL (beta= -.07; *p*=.59). Self-stigma is influenced by all the variables that were entered into the related model. That is, MHL negatively affects self-stigma (beta= -.38; *p*=.016*), indicating that higher levels of MHL lead to lower levels of self-stigma. Public stigma has a positive relationship with self-stigma (beta=.67; *p*=.001**), indicating that higher public stigma correlates with higher self-stigma. Although the total effect of structural stigma on self-stigma is not significant (.03, p=.87, n.s.), there is a negative direct effect (beta= -.39; *p*=.04*) and a positive indirect effect (.42; p=.02*) via public stigma. The direct effect indicates that perceiving employers as highly stigmatizing relates to lower self-stigmatization. Conversely, the indirect effect indicates an inconsistent mediation. Mediated via a negative relationship with public stigma, structural stigma has a positive relationship with self-stigma.

The outcome variable of interest in this model is HSI. In this model it is only directly influenced by self-stigma (beta= -.48; *p*=.004**), thus higher stigma scores are associated with lower HSI. The total effect of structural stigma on HSI is not significant (-.2; p=.33).

Both the direct and indirect influences of structural stigma on HSI are only marginally significant (direct: beta= -.39; *p*=.096; indirect via self-stigma: .19; *p*=.09). As neither influence reaches the level of significance, the hypothesis that the relationship between structural stigma and HSI could be mediated by self-stigma, must be declined. Structural stigma has direct and indirect relationships with other stigma types but in this model and for this sample it has no significant association with HSI.

Discussion

This study was designed to investigate the effect of structural stigma on young adults' HSI. Along with the aim to implement a more differentiated and ecologically valid method of understanding help-seeking, a scenario-based help-seeking decision method was created. Across ten serially worsening symptom descriptions, participants responded to the same set of questions regarding their HSIs. This scenario-based help-seeking decision measurement allowed to investigate and confirm the first hypothesis that symptom severity is positively related to HIS. With the data from this and additional scale-based measurements (i.e., different stigma perceptions scales and a general help-seeking intention scale), a hierarchical regression and a structural equation model was administered. Both analyses show that public stigma and structural stigma do not pose significant predictors or influencing factor of HSI. As structural stigma shows neither direct nor indirect effects (i.e., mediated via self-stigma) on HIS, hypothesis 2 and 3b are disconfirmed. Among the stigma sources only self-stigma yields a significant and negative relationship with HSI. Further examinations of the relationship between the stigma sources confirm previous research and find public and self-stigma to be positively associated. Structural stigma has associations with both public and self-stigma, which confirms hypothesis 3a. However, as these results are inconsistent, they should be perceived as preliminary findings. Given the limitations of this study the findings require further discussion as well as research.

HIS and symptom severity

When participants are placed in scenarios with increasingly worsening symptoms and asked which help they would intend to seek, they tend to choose more formal sources of help the worse the symptoms become. Although participants were in a hypothetical scenario, the results are in line with prior longitudinal and qualitative research (Broglia et al., 2021; Martínez-Hernáez et al., 2014; Nagai, 2015). Additional findings show the need for further research of help-seeking decision processes in relation to psychopathology. For instance, as

represented in Figure 2, the mean HSIs across symptoms show a decline for the last symptom, which would make it interesting to understand the underlying processes and motivations. Already in the study from Nagai (2015), people show different reactions related to the increasing constraints of the symptoms. They are either concerned and therefore motivated to seek help or they are restrained by the MI itself. The qualitative data collected in this study shows similar and even more tendencies. In total eighteen participants explained the help-seeking decision that they made for the last symptom. Some of them acknowledged the constraints of the symptomatic and thought of them as too restraining as that they would be able to obtain help. Some would intend to seek formal help, but would need an external motivator (e.g., someone that looks out for them or a critical incident that helps them realize the extent of their MI). Others are indifferent about the situation and would do nothing. Another valuable insight was that informal help was considered less helpful. Participants state that it could not provide them with the appropriate help they needed or that they would feel ashamed if friends or family would see them in such a state of MH. With such different perceptions of the MH help-seeking decision at hand and the changes of HSI participants present across all symptoms, the value of investigating help-seeking with specified psychopathologies and with clearly defined environments becomes apparent (Rickwood & Thomas, 2012).

HIS and structural stigma

The second hypothesis of this study was set up to understand the relationship between structural stigma and help-seeking decisions. Besides the comparison of the two hiring condition groups and their scenario-based help-seeking decisions, this analysis also includes a survey-based assessment of structural stigma perceptions. To assess participants' general perception of stigma deriving from employers, an existing scale that measures perceptions of public stigma was transformed. An implemented explorative factor analysis validates that these two scales measure different constructs, thus this study puts forth a new psychometric measurement to assess structural stigma. This scale-based structural stigma perception measurement and the comparison of the experimental groups were used to investigate whether structural stigma has a negative effect on formal help-seeking. The results show that the general structural stigma perception scale (i.e., SSRPH-E) yielded marginal significance in the hierarchical regression of HSI. That this result was not significant, could be related to the low sample size and therefore an underpowered study. The experimental group variable, i.e., the experimental manipulation of structural stigma in the scenario-based measurement,

yielded a non-significant prediction of HSI. Opposed to the hypothesis, participants that were placed in structurally stigmatizing hiring conditions did not show less formal help-seeking. Therefore, the manipulation did not work, and the two descriptions of the hiring conditions elicit no distinct help-seeking decisions. When reviewing the "perception of employers"-scale, the results did show that participants were significantly more willing to apply and disclose to the MH supporting employer. However, the overall answer tendency related to the MH supporting employer was "*probably not*" to apply and disclose. Further qualitative data related to this question shows that the fact that the MH supporting employer asks for records leads to distrust of their intentions. Across the distinct types of employers, the qualitative data indicates that the request of MHR induces a feeling of filtering, invasion of privacy as well as stigma. Regarding the question if participants would disclose non-recorded MI during an application process, the results are in line with previous research (Clement et al., 2015; Lettieri et al., 2022; Martínez-Hernáez et al., 2014). Many participants associate disclosure with employment disadvantages and would therefore conceal any MI. This is stated in relation to either employer type but intensified the more stigmatizing the employers' hiring conditions are. Therefore, future research should implement a similar method and compare hiring conditions that alter if MHR are required or not during hiring procedures. To make this method even more ecologically valid and useful for interventions, hiring procedures from existing employers could be conceptualized and used as experimental conditions.

Covariates and their influence on HSI

The additional results of the hierarchical regression on HSI show that the inclusion of covariates is important to gain a holistic understanding of structural stigma and the influence on HSI. A review of the demographic covariates indicates the need for a larger sample to allow for generalized interpretations. For instance, gender, certain countries of residence as well as occupations yielded significant results, but the subgroups only included between one and fourteen participants. The covariate education level also yields significant predictive value and indicates lower HSI with increasing level of education, which would confirm prior research and the idea that higher social status could relate to lower HSI (see Benuto et al., 2020; disconfirms Gonzalez et al., 2011 and; Leaf et al., 1987). However, as the distribution of education level is skewed in this sample with the majority of participants having a Bachelor's or Master's degree, these results should be interpreted with caution. Apart from that, MHL and the stigma covariates show predictions similar to prior research. For instance, higher MHL shows to be associated with higher HSI (Broglia et al., 2021; Furnham & Swami,

2018; Schomerus et al., 2019). The covariate self-stigma was negatively related to HSI and as stated by previous studies able to explain more variance in HSI than demographics (Cheng et al., 2018; Mackenzie et al., 2019; Vogel et al., 2017). Public stigma indicates a negative relationship with HSI but does not yield significant predictive value in the model. This supports the idea that self-stigma rather than public stigma influences peoples help-seeking decisions (Mackenzie et al., 2019; Nohr et al., 2021) and disconfirms the idea that public stigma leads to label and treatment avoidance (Corrigan & Bink, 2016; Corrigan et al., 2014). As discussed before, symptom severity also accounts for an important variable in explaining the HSI that participants deployed across the different symptom scenarios. Therefore, it should be included as a covariate in future research.

HIS and stigma sources

To understand hypothesis 3b, i.e., whether the influence of structural stigma on HSI is mediated by self-stigma, an SEM was administered. The model generally shows that among the three types of stigma only self-stigma has a negative influence on HSI, which confirms the results of the hierarchical regression and is in line with prior research (Cheng et al., 2018; Mackenzie et al., 2019; Vogel et al., 2017). Despite correlational analyses showing that all sources of stigma relate negatively to HSI, both structural and public stigma yield non-significant results in the SEM. This also confirms the results of the hierarchical regression. Nonetheless, as prior research indicates that public stigma is negatively associated with HSI either directly or indirectly via self-stigma, it is unexpected that public stigma has no influence in this sample (Benuto et al., 2020; Mackenzie et al., 2019; Nohr et al., 2021; Vogel et al., 2017; Wodong & Utami, 2023). In comparison to that there has been little quantitative research on the effect of structural stigma on HSI. Prior research has only hypothesized a negative relationship (Hatzenbuehler & Link, 2014; Nohr et al., 2021; Peterson et al., 2008). The hypothesis at hand builds upon other stigma research and explored whether self-stigma could have a mediating role in the relationship between structural stigma and HSI. However, as structural stigma has neither a direct nor an indirect association with HSI, hypotheses of prior research and this study have to be disconfirmed. For this sample, the quantitative data shows that structural stigma resulting from employers does not influence HSI.

Relationships between stigma sources

In regard to the remaining hypothesis 3a, thus the exploration of the relationships between the stigma sources, the administered SEM indicates some unexpected results. The

relationship between public and self-stigma is in accordance with prior research and indicates that higher public stigma relates to higher self-stigma (Corrigan et al., 2014; Corrigan & Rao, 2012; Corrigan & Watson, 2002, Vogel et al., 2017). The model also confirms that structural stigma is related to public and self-stigma. However, the effects in the structural model differ from zero-order correlational analyses. When reviewing the zero-order correlations, the stigma sources all have a positive association, thus they seem to reinforce themselves. In the SEM, the direct relationships between macrolevel structural stigma and the microlevel public as well as self-stigma become inverted. Therefore, the results of the model suggest that high structural stigma is associated with lower public stigma perceptions as well as with lower levels of self-stigma. An interpretation of these and further indirect effects is not possible at this point due to the lack of theory and research. It needs to be investigated whether the effects are merely statistical or if they reflect real-life occurrences. Future research could for instance investigate whether there are variables that lead to a positive or negative association between the stigma sources. A possible moderator of the relationship between structural and self-stigma could be reactance. For instance, one participant expressed feelings of anger regarding stigmatizing hiring conditions. If the experience of structural stigma elicits reactance, individuals might oppose the presented stigma and deploy more positive attitudes towards oneself. This in turn could decrease self-stigma (for further reactance research see Brehm, 1966).

Limitations

Despite the insights and foundations for future research that this study has provided, it is not without limitation. The limitations of this study concern the sample selection, limitations resulting from ethical considerations and the scenario-based method.

Regarding the sample selection, the limitation to people with a current involvement in an education was supposed to ensure two things. Firstly, the sample should be likely in the stage of emerging adults, as students or apprentices are in transition to a degree and employment and therefore usually financially dependent on parents or the government. Secondly, as students and apprentices aim for employment, they can include their own emotions and considerations into the prospective hiring situation that they are placed in within the scenario-based measurement. Compared to that, employed adults of same age might show retrospective biases when being placed in that scenario and are less likely to share the perspective of an emerging adult. In the end, this study only assessed participants age and

educational level. It did not however administer any control questions related to employment status or any specific assessment of the criteria of an emerging adult. Therefore, employment and the importance of financial independence to the individual is unknown and should be included in further research. Assessing employment status could also be relevant as employment during studies or working for an employer during an apprenticeship might mitigate the effect of structural stigma on HSI. Previous or current employment experiences could also influence expectations regarding employers and hiring processes and therefore change the way people responded to the conditions. Furthermore, this study did not assess participants' perception of their social support system. On the one hand, better social support systems might lead participants to be more likely to seek informal help. As previous research has indicated it might also lead individuals to seek less formal help, as partners, friends or family suffice for help (Broglia et al., 2021). On the other hand this variable is considered to moderate the relationship between the subjective need for help and subsequent HSB (Nagai, 2015). Participants with greater social support systems were more likely to seek help when they perceived a subjective need for help. Thus, with increasing symptom severity individuals might be more willing to seek help, if they have a good and supportive social support system.

Due to ethical considerations, this study did not assess the MH state of the participants nor include a clinical sample. A potential reason for the non-significant results in this study could be that participants have no prior experience with MH stigma and are therefore less affected by stigmatizing scenarios (Toth & Dewa, 2014). Being an unstigmatized individual that is placed in a scenario with a stigmatizing environment might not provoke the same experiences that individuals with MI make in their social environment. Further this study chose to describe symptoms and the development of a depression in a stereotypical way to enable participants to have an easier understanding of the scenarios. However, individuals have different schema of MI and for instance include non-clinical symptoms into their conceptualization of a depression (Heim et al., 2005). Thus, participants might not interpret the symptoms as a depression or experience it as less severe. Also, depending on the way a vignette presents symptoms (e.g., *Charlie's friend sees that Charlie has symptom X,* rather than *Charlie has symptom X*) participants' perception of symptom severity changes. Therefore, it could be that presenting participants with non-clinical symptoms from an outsider's perspective (e.g., "What would you do if your friend tells you that you seem to have …") could induce a greater perception of symptom severity and also change HSI.

Overall, more research is needed to understand the mechanisms of stigma on HSI and how to investigate it experimentally.

Future directions

Future research can continue with implementing more nonlinear and pattern-oriented analyses to account for the heterogeneity among samples and in their HSI. This could also deepen the understanding of how participants deploy different sources of help and if there are any internal variables or critical scenarios that attract certain help-seeking decisions. It could also be useful to implement the scenario-based method in qualitative research. Through that, research could gain a deeper understanding of the different help-seeking processes and influencing variables. Apart from that, the scenario-based method could be used in a more general sample. This could show whether the perceptions regarding stigmatizing employers differ depending on age or other demographics and it could help making general inferences about processes between structural stigma, public stigma, and self-stigma. Conversely, research could also include a more specific sample such as with individuals that are affected by stigmatizing hiring procedures (i.e., individuals aiming to work for the public or government, or German students in law, police academies or education). It could be that individuals that experience or are aware of structural stigma employ different help-seeking decisions. Lastly, the concept of public stigma needs further research as well. It could be that participants respond differently depending on the social group that questionnaires refer to. For instance, in this study the distinction between "employers" and "people" could have shifted participants perception of their social environment and might have influenced who they consider as "people" in their evaluation of public stigma.

Conclusion

In conclusion, this study indicated that there are processes apart from public and self-stigma that could influence individuals in the perception of their social environment and might affect their help-seeking. The fear of employment discrimination and disadvantages resulting from MI stigma at workplaces was not found to significantly influence HSI. However, the perception of disadvantages based on MI was stated in qualitative data and is represented in the overall low score of the structural stigma scale. Its' presence reflects a societal issue where there is no singular person but rather an entire self-sustaining system causing the stigma (Phelan et al., 2008). Therefore, it is society and research that needs to take

matters into hand and understand as well as work against such limiting prospects for individuals.

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Tables

Table 1.

Descriptive data of age and self-rated level of gender identification in both experimental groups and the total sample

Group		N	Missing	*M*	*SD*	Skewness	Kurtosis	Range
Stigma	Age	46	1	25.89	5.30	2.82	10.25	(20-50)
	Gender ID	46	1	4.83	0,53	-3.94	18.19	(2-5)
MH Support	Age	41	0	24.95	4.78	2.50	8.82	(19-46)
	Gender ID	41	0	4.56	0,84	-2.48	7.39	(1-5)
Total	Age	87	1	25.45	5.06	2.66	9.29	(19-50)
	Gender ID	87	1	4.70	0,70	-3.04	10.84	(1-5)

Note. M= Mean; SD= Standard Deviation; Range includes minimum and maximum of the value; Gender ID relates to the item: "How much do you identify with your entered gender identity?" with a 5-point Likert-scale (1-"Not at all"; 2-"Slightly"; 3-"Moderately"; 4-"Mostly"; 5-"Completely").

Table 2.

Frequencies of gender, educational level, country of residence and occupation in the MH stigma group (N=47), MH supporting group (N=41) and the total sample (N=88)

	Stigma			MH support			Total	
	n	Valid %	%	n	Valid %	n	Valid %	%
Gender								
Female	39	82,98		30	73,17	69	78,41	78,41
Male	4	8,51		10	24,39	14	15,91	15,91
Non-Binary	3	6,38		0	0,00	3	3,41	3,41
Undefined	1	2,13		1	2,44	2	2,27	2,27
Education level								
High School	4	8,70	8,51	5	12,20	9	10,35	10,23
Apprenticeship	2	4,35	4,26	7	17,07	9	10,35	10,23
Bachelor	30	65,22	63,83	22	53,66	52	59,77	59,09
Master	10	21,74	21,28	7	17,07	17	19,54	19,32
Missing	1	-	2,13	0	0,00	1	-	1,14
Residence								
Azerbajian	0	0,00	0,00	1	2,44	1	1,15	1,14
Denmark	0	0,00	0,00	1	2,44	1	1,15	1,14
France	1	2,17	2,13	0	0,00	1	1,15	1,14
Germany	18	39,13	38,30	17	41,46	35	40,23	39,77
Hong Kong	1	2,17	2,13	0	0,00	1	1,15	1,14
Hungary	1	2,17	2,13	1	2,44	2	2,30	2,27
India	2	4,35	4,26	1	2,44	3	3,45	3,41
Luxemburg	0	0,00	0,00	1	2,44	1	1,15	1,14
Malta	1	2,17	2,13	0	0,00	1	1,15	1,14
New Caledonia	0	0,00	0,00	1	2,44	1	1,15	1,14
Phillipines	0	0,00	0,00	1	2,44	1	1,15	1,14
Portugal	0	0,00	0,00	1	2,44	1	1,15	1,14
Saudi Arabia	1	2,17	2,13	0	0,00	1	1,15	1,14
Slovenia	0	0,00	0,00	1	2,44	1	1,15	1,14
Sweden	18	39,13	38,30	11	26,83	29	33,33	32,96
UK	3	6,52	6,38	2	4,88	5	5,75	5,68

	Stigma			MH support			Total		
	n	Valid %	%	n	Valid %	n	Valid %	n	%
USA	0	0,00	0,00	2	4,88	2	2,30		2,27
Missing	1		2,13	0	0,00				1,14
Occupation [a]									
2	7	15,22	14,89	2	4,88	9	10,35		10,23
3	2	4,35	4,26	0	0,00	2	2,30		2,27
4	0	0,00	0,00	1	2,44	1	1,15		1,14
5	3	6,52	6,38	1	2,44	4	4,60		4,55
6	2	4,35	4,26	3	7,32	5	5,75		5,68
7	1	2,17	2,13	0	0,00	1	1,15		1,14
8	1	2,17	2,13	5	12,20	6	6,90		6,82
9	11	23,91	23,40	15	36,59	26	29,89		29,55
11	2	4,35	4,26	2	4,88	4	4,60		4,55
12	2	4,35	4,26	1	2,44	3	3,45		3,41
13	1	2,17	2,13	0	0,00	1	1,15		1,14
14	3	6,52	6,38	2	4,88	5	5,75		5,68
16	1	2,17	2,13	2	4,88	3	3,45		3,41
18	10	21,74	21,28	5	12,20	15	17,24		17,05
19	0	0,00	0,00	2	4,88	2	2,30		2,27
Missing	1		2,13	0	0,00	1			1,14

Note. n= Size of the subsample.

[a]   2=Administration, Business, Human Resources and Management
3=Agriculture, Animal, Horticulture and Natural Resource
4=Architecture, Construction and Design
5=Arts, Advertising, Communications, Media and Public Relations
6=Education and Training
7=Electrical and Electronics
8=Government, Defence and Protective Services
9=Health and Community Services
11=Information and Communication Technology
12=Legal and Insurance
13=Manufacturing
14=Marketing, Real Estate, Sales
16=Personal Services
18=Science, Technology, Engineering, and Mathematics
19=Transportation, Distribution, and Logistics.

Table 3.

Zero order correlation between GSHQ items and the mean help-seeking intentions of each source across all scenarios

Variable	GSHQ 11	GSHQ 5	GSHQ 1	GSHQ 2	GSHQ 3	GSHQ 4	GSHQ 6	GSHQ 7	GSHQ 8	GSHQ 10	GSHQ 9
1. DoNothing	-.17	-.21*	-.02	-.17	-.23*	-.10	-.26*	-.08	-.19	-.29**	-.39***
2. Internet	.11	**.50***	.02	.14	.03	.13	.15	.08	.26*	.05	.01
3. Informal Help	.32**	.001	**.54***	**.35***	**.22***	**.17**	-.02	-.08	.11	.07	.13
4. Formal Help nR	.16	.46***	.10	.20	.12	.04	**.40***	**.36***	**.51***	.003	.17
5. Medical HP	.21*	.29**	.13	.20	.05	.19	.35***	.18	.34***	**.54***	.39***
6.Psychological HP	.20	.21*	.03	.21*	.09	.11	.34**	.08	.37***	.40***	**.57***

Note. nR= no Records; HP= Health Professionals; Bold are all correlations between conceptually corresponding items. Conditioned on Hiring Condition, * p < .05, ** p < .01, *** p < .001; Variables relate to the scenario-based Help Seeking Intention measurement (see Appendix A3); GSHQ relates to the corresponding items of the General Help Seeking Questionnaire (Wilson et al., 2005a; see Appendix A5).

Table 4.

Results from the exploratory factor analysis on the alternated Stigma Scale of Receiving Psychological Help (SSRPH) items

Item	Factor Loading	
	1	2
Factor 1: Structural Stigma		
5. Employers see it as a sign of personal weakness or inadequacy if a person sees a psychologist for emotional or interpersonal problems.	**0.87**	0.01
6. Employers will see someone in a less favorable way if they come to know that the person has seen a psychologist.	**0.90**	-0.07
7. It is advisable for a person to hide the information from employers that they have seen a psychologist	**0.45**	0.17
8. Employers tend to prefer those less, who are receiving professional psychological help.	**0.73**	-0.05
Factor 2: Public Stigma		
1. People see it as a sign of personal weakness or inadequacy if a person sees a psychologist for emotional or interpersonal problems.	0.02	**0.69**
2. People will see someone in a less favorable way if they come to know that the person has seen a psychologist.	0.02	**0.71**
3. It is advisable for a person to hide the information from people that they have seen a psychologist.	-0.04	**0.64**
4. People tend to like those less, who are receiving professional psychological help.	-0.004	**0.63**

Note. $N = 88$. The extraction method was principal axis factoring with an oblique (Promax with Kaiser normalization) rotation. Factor loadings above .30 are in bold. All included items present KMO values above 0.7 and the Bartlett's test of sphericity is significant ($X^2(28) = 332.20, p < .001$); Factor 1 has an Eigenvalue $= 3.7$ and Factor 2 $=1.33$. Items were adopted from Komiya et al., 2000b.

Table 7.

Four step hierarchical regression predicting the level of help participants intended to obtain

		Estimate	SE	95% CI		p
				Lower	Upper	
STEP 1:	**Intercept**	3.834	.998	1.870	5.790	<.001***
	Age	.001	.014	-.028	.029	.964
	Gender					
	Male	.446	.218	.017	.875	.041*
	Non-Binary	.140	.332	-.512	.792	.673
	Other	.397	.517	-.618	1.410	.442
	Residence					
	France	-2.642	.925	-4.460	-.827	.004**
	Hungary	-1.295	.846	-2.960	.367	.126
	Luxemburg	-2.723	.882	-4.460	-.992	.002**
	Saudi Arabia	.619	.927	-1.200	2.440	.505
	Education Level	-.077	.086	-.247	.093	.374
	Occupation					
	4 [a]	-2.128	.583	-3.270	-.984	<.001***
	6 [b]	-.508	.343	-1.180	.165	.139
	MHL	.439	.098	.247	.630	<.001***
STEP 2:	**Intercept**	6.033	1.094	3.890	8.180	<.001***
	Age	-.011	.014	-.039	.017	.441
	Gender					
	Male	.256	.223	-.182	.695	.252
	Non-Binary	-.055	.331	-.705	.595	.869
	Other	.582	.514	-.426	1.590	.257
	Residence					
	France	-2.576	.920	-4.380	-.771	.005**
	Hungary	-1.707	.854	-3.380	-.030	.046*
	Luxemburg	-2.837	.886	-4.580	-1.100	.001**
	Saudi Arabia	1.150	.955	-.725	3.020	.229
	Education Level	-.160	.088	-.332	.012	.069.
	Occupation					
	4 [a]	-1.964	.578	-3.100	-.830	<.001***
	6 [b]	-.589	.339	-1.250	.077	.083.
	MHL	.376	.097	.185	.568	<.001***
	Stigma					
	SSOSH	-.354	.093	-.537	-.171	<.001***
	SSRPH_P	-.190	.137	-.460	.080	.167
STEP 3:	**Intercept**	4.616	.959	2.730	6.500	<.001***
	Age	-.011	.013	-.036	.014	.379
	Gender					
	Male	.255	.195	-.128	.638	.192

	Estimate	SE	95% CI		p
			Lower	Upper	
Non-Binary	-.069	.289	-.636	.499	.812
Other	.582	.448	-.298	1.460	.195
Residence					
France	-2.581	.803	-4.160	-1.000	.001**
Hungary	-1.711	.746	-3.170	-.247	.022*
Luxemburg	-2.840	.773	-4.360	-1.320	<.001***
Saudi Arabia	1.144	.834	-.492	2.780	.170
Education Level	-.160	.077	-.310	-.010	.037*
Occupation					
4 [a]	-1.966	.504	-2.960	-.976	<.001***
6 [b]	-.590	.296	-1.170	-.009	.047*
MHL	.376	.085	.209	.543	<.001***
Stigma					
SSOSH	-.355	.081	-.514	-.195	<.001***
SSRPH_P	-.189	.120	-.424	.047	.117
Symptom Severity	.258	.016	.227	.289	<.001***
STEP 4: **Intercept**	4.976	1.000	3.010	6.940	<.001***
Age	-.015	.013	-.041	.010	.236
Gender					
Male	.354	.212	-.062	.769	.095.
Non-Binary	-.046	.293	-.621	.529	.875
Other	.551	.453	-.338	1.440	.224
Residence					
France	-2.598	.803	-4.170	-1.020	.001**
Hungary	-1.546	.751	-3.020	-.071	.040*
Luxemburg	-2.580	.788	-4.130	-1.030	.001**
Saudi Arabia	1.418	.850	-.251	3.090	.096.
Education Level	-1.530	.077	-.303	-.003	.046*
Occupation					
4 [a]	-1.765	.517	-2.780	-.751	<.001***
6 [b]	-.456	.306	-1.060	.144	.136
MHL	.358	.086	.190	.526	<.001***
Stigma					
SSOSH	-.338	.082	-.499	-.177	<.001***
SSRPH_P	-.109	.136	-.376	.157	.421
Symptom Severity	.258	.016	.227	.289	<.001***
Structural Stigma Condition [c]	-.091	.126	-.337	.156	.470
SSRPH_E	-.179	.107	-.389	.031	.094.

Note. Bold are all significant results; N=87 (One participant had no data on demographics and their data was therefore excluded for this analysis), 95% CI = 95% confidence interval; SE B = standard error of estimates; p = significance level; Out of overview purposes only those

residence and occupation demographics are listed that turn significant throughout the hierarchical regression (the following demographics were not included: Azerbaijan, Denmark, Germany, Hong Kong, India, Malta, New Caledonia, Philippines, Portugal, Slovenia, Sweden, UK, USA; all Occupations apart from 4 and 6); MHL=Mental Health Literacy; SSOSH= Self Stigma of Seeking Help (Brenner et al., 2021); SSRPH_P= Stigma Scale of Receiving Psychological Help with public stigma (based on Komiya et al., 2000b); SSRPH_E= Stigma Scale of Receiving Psychological Help with structural employer stigma (based on Komiya et al., 2000b); . p< .10, * p < .05, ** p < .01, *** p < .001.

[a] 4- Architecture, Construction and Design; N=1.

[b] 6 – Education and Training; N=5.

[c] 1= Stigma condition, 2=MH supporting condition.

Table 8.

Descriptive data on the perception of employers

Application Influence	Employer Type	*M*	*SD*
Applying	MH Support	2.67	0.89
	Stigma	2.05	0.92
	Direct Stigma	1.61	0.85
Declaring	MH Support	2.22	0.86
	Stigma	1.71	0.83
	Direct Stigma	1.52	0.88

Note. N=88; M= Mean; SD= Standard Deviation.

Table 9.

Post Hoc Comparisons of the Employer Perception Scale main effects

		Mean Diff.	SE	t	p_{holm}
Employer Type [a]					
MH Support	Stigma	0.57	0.07	7.88	< .001***
	Direct Stigma	0.88	0.07	12.13	< .001***
Stigma	Direct Stigma	0.31	0.07	4.26	< .001***
Application Influence [b]					
Applying	Declaring	0.30	0.10	3.05	0.003**

Note. P-value adjusted for comparing a family of 3; SE = Standard Error ; *** p < .001; ** p < .01.

[a] Results are averaged over the levels of: Application Influence.

[b] Results are averaged over the levels of: Employer Type.

Table 10.

Post Hoc Comparisons of the Employer Perception Scale Interaction effects (Employer Type ✻ Application Influence)

		Mean Diff.	SE	t	p_{tukey}	p_{holm}
MH Support, Applying	Stigma, Applying	0.63	0.08	7.67	< .001***	< .001***
	Direct Stigma, Applying	1.06	0.08	12.98	< .001***	< .001***
	MH Support, Declaring	0.46	0.11	4.28	< .001***	< .001***
	Stigma, Declaring	0.97	0.12	7.88	< .001***	< .001***
	Direct Stigma, Declaring	1.15	0.12	9.36	< .001***	< .001***
Stigma, Applying	Direct Stigma, Applying	0.43	0.08	5.30	< .001***	< .001***
	MH Support, Declaring	-0.17	0.12	-1.39	0.73	0.50
	Stigma, Declaring	0.34	0.11	3.21	0.02*	0.008**
	Direct Stigma, Declaring	0.52	0.12	4.26	< .001***	< .001***
Direct Stigma, Applying	MH Support, Declaring	-0.60	0.12	-4.91	< .001***	< .001***
	Stigma, Declaring	-0.09	0.12	-0.74	0.98	0.79
	Direct Stigma, Declaring	0.09	0.11	0.86	0.96	0.79
MH Support, Declaring	Stigma, Declaring	0.51	0.08	6.28	< .001***	< .001***
	Direct Stigma, Declaring	0.69	0.08	8.51	< .001***	< .001***
Stigma, Declaring	Direct Stigma, Declaring	0.18	0.08	2.23	0.23	0.11

Note. SE= Standard Error * p < .05, ** p < .01, *** p < .001.

Table 12.

Measurement model loadings

Latent Variable	Manifest variable	Estimate	SE	z-value	95% CI		p
					Lower	Upper	
Public Stigma							
	SSRPH_1P	.55	.09	5.92	.37	.74	.00
	SSRPH_2P	.48	.07	6.41	.33	.62	.00
	SSRPH_3P	.36	.08	4.73	.21	.51	.00
	SSRPH_4P	.37	.09	4.03	.19	.54	.00
Structual Stigma							
	SSRPH_5E	.72	.07	10.67	.59	.85	.00
	SSRPH_6E	.64	.07	8.82	.50	.78	.00
	SSRPH_7E	.45	.10	4.39	.25	.64	.00
	SSRPH_8E	.51	.10	5.10	.31	.70	.00
Self-Stigma							
	SSOSH_1	.52	.07	7.93	.39	.64	.00
	SSOSH_2R	.52	.08	6.87	.37	.67	.00
	SSOSH_3	.39	.07	5.45	.25	.52	.00
	SSOSH_4	.62	.08	8.12	.47	.77	.00
	SSOSH_5R	.40	.07	5.94	.27	.54	.00
	SSOSH_6	.57	.08	7.37	.42	.73	.00
	SSOSH_7	.53	.11	5.04	.33	.74	.00
HSI							
	GHSQ_Partner	.33	.12	2.71	.09	.56	.01
	GHSQ_Friend	.69	.15	4.59	.39	.98	.00
	GHSQ_Parent	.41	.18	2.30	.06	.77	.02
	GHSQ_Relatives	.38	.17	2.22	.04	.72	.03
	GHSQ_Internet	.84	.23	3.72	.40	1.29	.00
	GHSQ_Phone	.89	.18	5.06	.54	1.23	.00
	GHSQ_Spiritual	.36	.11	3.12	.13	.58	.00
	GHSQ_Councelor	.96	.17	5.79	.64	1.29	.00
	GHSQ_MentalHP	1.00	.18	5.64	.65	1.35	.00
	GHSQ_MedicalHP	.61	.18	3.38	.26	.97	.00
	GSHQ_SelfHelpR	.39	.17	2.29	.06	.73	.02
MHL							
	MHL_comprehension	.53	.10	5.24	.33	.73	.00
	MHL_prevention	.84	.10	8.36	.64	1.04	.00
	MHL_support	.68	.12	5.58	.44	.93	.00
	MHL_resources	.62	.11	5.71	.41	.83	.00

Note. SE= Standard Error; 95% CI= 95% Confidence Interval; Manifest Variables relate to the scales: SSRPH (Komiya et al., 2000b; see Appendix 6 and 7 for subscales), SSOSH (Brenner et al., 2021; see Appendix A8), GSHQ (Wilson et al., 2005a; see Appendix A5) and MHL (Jorm et al., 2007, Moll et al., 2017; see Appendix A9).

Table 13.

Structural Model with direct and indirect effect estimations

Outcome	Predictor	Estimate	*SE*	z-value	95% CI Lower	95% CI Upper	*p*
Direct Effects							
HSI							
	Self-stigma (b)	-.48	.17	-2.87	-.81	-.15	.00
	Public Stigma (e)	.25	.22	1.16	-.17	.68	.25
	Structural Stigma (c)	-.39	.23	-1.66	-.85	.07	.10
	MHL (g)	.20	.18	1.08	-.16	.55	.28
Self-stigma							
	Public Stigma (f)	.67	.20	3.34	.28	1.06	.00
	Structural Stigma (a)	-.39	.19	-2.09	-.76	-.02	.04
	MHL (h)	-.38	.16	-2.40	-.69	-.07	.02
Public Stigma							
	Structural Stigma (d)	.62	.18	3.49	.27	.97	.00
	MHL (l)	.07	.13	.54	-.18	.32	.59
Structural Stigma							
	MHL (i)	-.12	.12	-.97	-.35	.12	.33
Indirect Effects							
HSI	Structural Stigma via Self-Stigma	.19	.11	1.70	-.03	.41	.09
Self-Stigma	Structural Stigma via Public Stigma	.42	.17	2.42	.08	.76	.02
Total Effects							
HSI	Structural Stigma	-.20	.20	-.98	-.59	.20	.33
Self-Stigma	Structural Stigma	.02	.15	.17	-.27	.31	.87

Note. SE= Standard Error; 95% CI= 95% Confidence Interval; in parentheses are the specified path names used in Table 6.

Table 14.

Residual variances of the included variables in the SEM

Variable	Estimate	SE	z-value	95% CI Lower	95% CI Upper	p
.SSRPH_1P	.33	.08	3.92	.16	.49	.00
.SSRPH_2P	.26	.06	4.11	.14	.38	.00
.SSRPH_3P	.37	.05	7.44	.27	.47	.00
.SSRPH_4P	.42	.07	5.87	.28	.55	.00
.SSRPH_5E	.11	.06	1.98	.00	.22	.05
.SSRPH_6E	.14	.05	2.68	.04	.24	.01
.SSRPH_7E	.65	.11	6.13	.44	.86	.00
.SSRPH_8E	.41	.11	3.83	.20	.62	.00
.SSOSH_1	.54	.13	4.14	.28	.79	.00
.SSOSH_2R	.70	.17	4.04	.36	1.04	.00
.SSOSH_3	.42	.09	4.77	.24	.59	.00
.SSOSH_4	.42	.09	4.56	.24	.60	.00
.SSOSH_5R	.25	.06	4.44	.14	.35	.00
.SSOSH_6	.29	.06	4.94	.17	.40	.00
.SSOSH_7	.81	.11	7.29	.59	1.03	.00
.GHSQ_Partner	1.25	.19	6.48	.87	1.63	.00
.GHSQ_Friend	1.87	.32	5.90	1.25	2.49	.00
.GHSQ_Parent	2.56	.35	7.44	1.89	3.24	.00
.GHSQ_Relatives	2.49	.28	8.74	1.93	3.04	.00
.GHSQ_Internet	2.69	.50	5.39	1.71	3.66	.00
.GHSQ_Phone	1.84	.34	5.48	1.18	2.49	.00
.GHSQ_Spiritual	1.36	.28	4.92	.82	1.91	.00
.GHSQ_Councelor	1.80	.34	5.35	1.14	2.46	.00
.GHSQ_MentalHP	1.68	.31	5.43	1.07	2.28	.00
.GHSQ_MedicalHP	2.27	.30	7.48	1.67	2.86	.00
.GSHQ_SelfHelpR	2.55	.38	6.65	1.80	3.30	.00
.MHL_comprehension	.87	.16	5.65	.57	1.18	.00
.MHL_prevention	.28	.12	2.32	.04	.51	.02
.MHL_support	.67	.17	3.99	.34	1.01	.00
.MHL_resources	.76	.17	4.50	.43	1.10	.00
.Public Stigma	1.00			1.00	1.00	
.Structural Stigma	1.00			1.00	1.00	
.Self-Stigma	1.00			1.00	1.00	
.HSI	1.00			1.00	1.00	
MHL	1.00			1.00	1.00	

Note. SE= Standard Error; 95% CI= 95% Confidence Interval; (.) in front of a variable indicates endogenous variables.

Appendix A

Survey Material

A1. Scenario text material

Overall Scenario description:

Currently, you are studying for your degree. Once you finish, you hope that you can land your dream job. You're almost done with all of your classes and tests but getting there has also been quite stressful. Luckily, you have some great people around you, who you can turn to for support and who've had your back throughout difficult times. You know you could have turned to professional counseling services and support groups if you needed to, and you know that there are health care experts. They could have provided you with qualified help and treatment, which they keep a record of for future references. So far however, you've been doing okay without them.

Now that you're looking for jobs that you really want, you're getting pretty excited! You've found out that some employers check mental health records when hiring. Especially in your field of work,…

Mental health stigmatizing:	Mental health prevention/support:
…they do it to make sure they're creating a **highly productive work environmen**t for everyone. You've heard that when employers care about mental health, they usually aim to have **resilient and stress-tolerant employees**, which in turn creates a better workplace. Considering mental health records helps them understand **job applicant's qualities and limitations better and predicts future functionality and performance**. Overall, it seems like these employers care about that their workers **fit with the demands of the positions** they hire for and want to make sure **everyone maintains a high work capacity**.	…they do it to make sure they're creating **a good working environment** for everyone. You've heard that when employers care about mental health, they usually aim to have **happier and motivated employees**, which in turn creates a better workplace. Mental health records help them understand **job applicant's individual qualities and limitations better and enable them to provide any necessary support**. Overall, it seems like these employers **really** care about that their workers **fit with the positions** they hire for and want to make sure **everyone feels supported in their roles**.

Note. Bold text marks the conceptual differences between the two conditions.

A2. Mental Health Series

"What would you do if you experience the following?"

1. You went to bed last night and had trouble falling asleep. You ended up having a restless night with only 3h of total sleep. When you woke up in the morning you had a hard time getting up.
2. You had a few restless nights and felt like you had little energy for the day. To get some more rest you ended up staying at home for most of the day.
3. You slept unwell and had little energy for almost a week. You struggle to find something meaningful to do, and don't find pleasure in the things that you normally like to engage in. In your indecisiveness you end up laying down to rest.
4. You experienced sleep issues, low levels of energy and indecisiveness for a week. Then, while at home, you start to cry for no reason and feel like you could not control it.
5. You started noticing that after about two weeks of sleeplessness, fatigue and feeling down, your weight is changing. After reflecting on your eating habits from the last weeks you realize you've not been eating well.
6. You had trouble sleeping for more than two weeks. You wake up almost every night and although you are tired all the time you seem to take a long time in the evenings to fall asleep.
7. You were tired and restless for some weeks, but you also haven't had the energy to do your everyday tasks. You have not cleaned or done laundry and you rarely have energy to make food.
8. Your home has been falling into disrepair for some weeks and you are barely able keep up with it, while your friends keep asking if you want to do something. You keep cancelling them and you seldom leave your bed or home unless you need to.
9. You were mainly at home trying to find some rest from your meanwhile one month of intermittent sleep. Your situation seems to become worse as the work piles up and your motivation to do something remains low. You have noticed that you start feeling lonely and cannot shake off this persistent sadness. You try to understand what is going on, but your feelings are not really tied to anything.
10. Although you knew that your' eating habits have been bad for about a month, you cannot help it. You stay at home most of the time and keep feeling alone and sad. You have no energy to leave your bed or do anything in particular, which leads you to keep wearing the same clothes for multiple days in a row and stop showering or brushing your teeth.

A3. Help-seeking intention Scale

(Theurel & Witt, 2022) original scale	Final scale
Item 7: I'm waiting the problem would get better by itself	I'm waiting for the situation to get better by itself.
Item 6: I am looking for information that can help me on the internet	I'm looking for information on the internet that can help me.
Item 1: I talk to a friend about it Item 2: I talk to someone in my family about it	I talk about it with a person that is close to me (i.e. friend, family, partner).
Item 5: I call a hotline (e.g. Fil santé jeunes)	I seek help from an anonymous help service (e.g., help hotline, spiritual/religious support, communal counseling services).
Item 3: I talk to my GP about it	I seek help from a health care professional (e.g., primary care/general practitioner).
Item 4: I seek help from a mental health professional (psychologist/psychiatrist)	I seek help from a mental health professional (i.e. psychologist/psychiatrist).

Open Help-seeking question**: "What is your reasoning for your decision (if any)?"**

A4. Employer perception scale

On a scale from 1- "Definitely not", 2 – "Probably not", 3 – "Probably yes" to 4 – "Definitely yes"

1. Mental health fostering employer: "If you found out that an employer you would consider working for in the future asks for mental health records to assess job applicants' individual qualities and limitations in order to provide applicants with any necessary support…"
2. Implicit stigmatizing employer: "If you found out that an employer you would consider working for in the future asks for mental health records to assess job applicants' qualities and limitations in order to predict their future functionality and performance..."
3. Explicit stigmatizing employer: "If you found out that an employer you would consider working for in the future asks for mental health records to assess job applicants' performance capacity and uses them to exclude applicants with mental health issues..."

a. ... would you like to apply for a job at this company?
b. ... and if you had mental health issues that were not recorded by a professional, would you truthfully declare your mental health issues during the application process of such a company?

A5. General Help seeking scale

"If you were having an unusual personal or emotional problem that you can't overcome on your own for more than two weeks, how comfortable would you feel seeking help from the following people or sources?" with a scale from 1 –"completely uncomfortable" to 7 – "completely comfortable

1. Partner (e.g., spouse, significant boyfriend or girlfriend)
2. Friend (not related to you)
3. Parent
4. Other relative / family member
5. Online information platforms
6. Phone help services (e.g., Lifeline, Kids Help Line)
7. Spiritual / Religious support services
8. Communal / organizational counseling services (e.g. from the municipality or educational facility)
9. Mental health professional (e.g. psychologist, psychiatrist)
10. Family doctor / General Practitioner

Additional self-help question: "If you were having an unusual personal or emotional problem that you can't overcome on your own for more than two weeks, how comfortable would you feel NOT seeking help from <u>any person or source</u>?" with a scale from 1 –"completely uncomfortable" to 7 – "completely comfortable.

A6. Public Stigma Scale

"Please rate how much you agree or disagree with the following statements."

Scale from 1 – "strongly disagree" to 4 – "strongly agree"

1. People see it as a sign of personal weakness or inadequacy if a person sees a psychologist for emotional or interpersonal problems.
2. People will see someone in a less favorable way if they come to know that the person has seen a psychologist.
3. It is advisable for a person to hide the information from people that they have seen a psychologist.
4. People tend to like those less, who are receiving professional psychological help.

A7. Structural Stigma Scale

"Please rate how much you agree or disagree with the following statements."

Scale from 1 – "strongly disagree" to 4 – "strongly agree"

5. Employers see it as a sign of personal weakness or inadequacy if a person sees a psychologist for emotional or interpersonal problems.
6. Employers will see someone in a less favorable way if they come to know that the person has seen a psychologist.
7. It is advisable for a person to hide the information from employers that they have seen a psychologist.
8. Employers tend to prefer those less, who are receiving professional psychological help.

A8. Self-Stigma Scale

" People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please rate the degree to which each item describes how you might react in this situation. "

Scale from 1 – "strongly disagree", 2 – "disagree", 3 – "agree/disagree equally", 4 – "agree" to 5 – "strongly agree"

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. It would make me feel inferior to ask a therapist for help.
5. I would feel okay about myself if I made the choice to seek professional help.
6. If I went to a therapist, I would be less satisfied with myself.
7. I would feel worse about myself if I could not solve my own problems.

A9. Mental Health Literacy scale

"The following vignette features a situation that you might encounter with a person you know. You are asked to rate your knowledge about how to identify and address the situation."

"John is a 21-year-old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him."

Scale from: 1 – "very low", 3 – "moderate" to 5 – "very high"

Rate your level of knowledge regarding...

1. ...what might be happening with the person
2. ...how you could prevent the situation from becoming worse
3. ...what you should say or do in the situation
4. ...resources or services that might be helpful