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Extending the Behavioral Risk Factor Surveillance System Questionnaire to the Bethel College Campus for Assessment of Mental Health and Mental Health Stigma

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Abstract

By using the Behavioral Risk Factor Surveillance System (BRFSS), it was possible to assess the mental health and mental health stigma held by the students of Bethel College. Stigma is expressed in many ways and is a forceful deterrent to those seeking mental health services. Through the analysis of a large data set, this study developed a more complete understanding of who copes with a mental illness and how they experience stigmatization. Twenty percent of the resident student population was solicited for response in a stratified, random sampling during the spring and fall semesters of 2015. Students (31 men & 46 women) completed the section of the BRFSS questionnaire concerning mental health and the Internalized Stigma of Mental Illness questionnaire. BRFSS data from five legislative states were used to form comparisons. Hypothesis 1: That there will be a significant difference between the Kansas data and that of North Carolina, Colorado, New York, and Ohio; indicating better mental health and lower stigma levels among Kansas residents. Hypothesis 1 was confirmed. This difference may be due to state legislation and cultural factors. Hypothesis 2: That there will be a significant difference between the Bethel College students' responses and the BRFSS data on Kansan's ages 18 to 24, with Bethel's scores indicating poorer mental health and higher stigma. Hypothesis 2 was also confirmed. These differences may be due to the unique challenges posed to college students or challenges unique to Bethel College. However, this analysis was not sensitive to the Kansan individuals' status as college students or working professionals. The results of large data analysis, presented in a clear and accessible manner, can provide the information necessary to end mental health stigma and lead to improvements in the quality of life for those Bethel College students diagnosed with a mental illness.

Keywords: Behavioral Risk Factor Surveillance System, Mental Health, Mental Health Stigma

1. Introduction

The following literature review demonstrates that mental health is a serious social concern. The effects of stigma in the personal lives of mentally ill persons and the recovery process is also discussed. Finally, the reliability of the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire in accurate assessment of mental health and stigma is illustrated.

1.1. Mental Health

Many government agencies, non-profit groups, and health care providers realize the importance of good mental health. This is because good mental health results in "a state of well-being in which every individual realizes his or her own

potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[1]. In contrast, poor mental health is a chronic illness that affects mood, thinking, and behavior[2].

A report issued in October 2011 states that, "About one in four adults suffers from a diagnosable mental disorder in a given year"[3]. The specific percentage reported by Pandaya[3] is 26.2 percent, but this succinct evaluation does not account for severity or comorbidity. The National Alliance on Mental Illness gives some perspective to the issue of severity. 2.4 million and 6.1 million American adults have a current diagnosis of schizophrenia and bipolar disorder respectively[4]. Other severe mental illnesses include Post Traumatic Stress Disorder, Major Depressive Disorder, Autism, and many others[5].

Mental illnesses can many consequences in the community. As of 2006, 6.2 percent of the national expenditure on health services was spent on the direct costs of mental healthcare[6]. Direct costs such as outpatient and inpatient care, medications, etc., are easily evaluable. But this evaluation ignores the indirect cost of mental illnesses. Indirect costs of mental illness include loss of earnings, cost of incarceration, and homelessness. According to the "The President's New Freedom Commission on Mental Health Final Report", indirect costs have been evaluated at $79 billion annually[7].

Too often findings from an adult population are simply applied to college students. Though college students are adults, their environment is so drastically different from most other adults' environments, that the comparison is unsubstantiated[8]. Growing the literature base is crucial as the college student population grows. Likewise, if speaking of a traditional age college population, technically some would be best characterized as adolescents given stages of brain development.

According to Hunt and Eisenberg "6% of undergraduates and 4% of graduate students reported having seriously considered suicide in the previous 12 months"[8]. Four out of five college students drink and about half of them binge drink[9]. Such a dangerous pairing as mental illness and substance abuse should cause great concern for the health of our college student population.

1.2. Stigma And Its Universal Effects

Stigma towards those with a mental illness comes in many forms.

1.2.1. public stigma

Public Stigma is defined by Corrigan, Markowitz, and Watson as when the general population endorses prejudice and manifests discrimination towards people with a mental illness[10]. Public stigma is characterized by three primary stereotypes[11]. The first of these beliefs is that people with a diagnosed mental illness are dangerous and unpredictable. Secondly, that these individuals are to blame for their disorder. Lastly, that patients are fully dependent and that all decisions should be made by others.

1.2.2. self-stigma

Self-Stigma according to Lysaker, Roe, and Yanos is "the degree to which a person has internalized societally endorsed stigmatizing beliefs about mental illness"[12]. Patients' absorption and application of society's beliefs means that the three public stigma stereotypes are the dismal view with which these individuals see themselves. One of the most unique qualities of self-stigma is that only those with a mental illness experience it. One cannot apply stigma to oneself if there is an absence of mental illness.

Strong feelings of self-stigma lead to an unwillingness to reveal symptoms (depression, anxiety, psychotic episodes, etc.) and the development of poor coping skills (smoking, decreased exercise, and alcohol abuse)[13]. High levels of internalized stigma lead to low levels of hopefulness and self esteem, decreased confidence in one's future, and poor social functioning[14]. Stigma also leads to an increase in distracting thoughts and anxiety; effects that consume an individual's expendable mental energy. This energy taxation consumes the energy necessary for daily activities[15]. Persistent and prevailing stigma leads to a lack of care seeking on the part of the patient and poor adherence to treatment[16].

1.2.3. personal stigma

Personal Stigma is composed of "the aggregate of each individual's stereotypes and prejudices"[17]. Everyone, not just those with a mental illness, have evaluable personal stigma levels. Unlike self-stigma, personal stigma is not necessarily applied to oneself. As personal stigma is composed of the internalization of public generalizations, it is important for communities centered around common values and ideas, to evaluate the community's view of mental illness.

1.3. Behavioral Risk Factor Surveillance System (Brfss)

The Center for Disease Control (CDC) conducts the BRFSS Questionnaire yearly, by telephone and cell phone, on a national level. The Questionnaire was issued for the first time in 1984 with fifteen states participating[18]. As of 1997, all states were participating[19]. The state of Kansas did not join till 1992[20].

Each state uses a core number of surveys and are then offered the choice of using a variety of auxiliary surveys. The state of Kansas chose to use the auxiliary CDC Module 17: Mental Illness and Stigma, in their 2013 evaluation. The Bethel College data was compared to the Kansas state data and the Kansas data was compared to state data from Colorado, North Carolina, Now York, and Ohio. The states of Massachusetts and New Jersey also issued Module 17, but the data were unavailable for analysis. These seven states were the only ones to select the auxiliary Module 17 as part of their overall survey. It is imperative that the Bethel College data are compared to these large databases as they provide a standard of comparison.

Self-report data can be biased by the individuals' hypotheses about the study, privacy concerns, and misinterpretation. Considering these limitations, self-ratings of mental health should not be treated as less important than physician diagnosis[21]. Both are helpful measures in evaluating the mental health needs of a community. To avoid biases, the BRFSS is reevaluated frequently to assure validity and reliability. A massive overhaul and evaluation was conducted from 2008 to 2011 with the induction of cell phone users[22]. This included improved weighting measures and the inclusion of new variables. Pierannunzi, Hu, and Balluz, researchers independent of the CDC, have compared the BRFSS to other self-report measures of chronic health conditions (including mental health)[22]. The results of their research have shown high consistency between the BRFSS and other self-report measures. It has also been demonstrated that the BRFSS has high test/retest agreement[22]. Research such as this supports the reliability of the BRFSS.

1.4. Rectifying Oversights

It is apparent that extensive research has been put into the three proceeding topics by many institutions and individuals. As stated by Fan, Strine, Jiles, Mokdad, Huang, Murray, and Musingo, "State and local-level data are lacking and may be more helpful (than national data) in planning mental health services for local populations,"[21]. As observed by Hunt and Eisenberg, "Broad population studies involving adolescents have primarily been conducted in other countries"[8]. The United States has a serious deficiency that prevents understanding the mental health needs of the college-age population.

It has been the author's goal to support these areas of psychological research and literature. First, every single participant in this study had to be a current, residential student at Bethel College. Second, Bethel College students were compared to Kansas residents in the same age group. The hope was to make an informative contribution to the literature concerning college students and local/state-level community health.

1.5. Summary

Mental illness can be devastating, not only to the individual but to their family, friends, and community. It is imperative that changes are implemented in our communities that preserve mental health. One of the changes proposed here is decreasing the stigma of mental illness.

Education and exposure are monumental steps towards eradicating personal stigma. If mentally healthy and unhealthy persons could view mental illness as any other illness, the strength of self stigma would be greatly decreased. As self stigma is one of the strongest deterrents from successful treatment, either by decreased help-seeking or bruised self-esteem, exponential change would be seen if only it could be eradicated.

To make these changes, it is necessary to understand the needs of the community and the stigma with which the unhealthy are perceived. This can be done through the use of the Behavioral Risk Factor Surveillance System. Though national data is important, local and state data enable communities to make more effective changes.

2. Methodology

2.1. Subjects

Out of 130 people solicited, there were 77 respondents (59.23%). 31 men and 46 women responded out of the 65 solicited in each group (47.69% and 70.76%). Average age across groups was 20. The population was divided into five different racial groups, White, African American, Hispanic, Asian, and Mixed Race. The Bethel College population consists predominantly of students from White or Caucasian descent. The three largest groups were White (79.22%), African American (3.896%), and Hispanic (5.194%). Several religious groups were represented, including Mennonite, Catholic, Protestant, Methodist, Baptist, Lutheran, Pentecostal, and an Other Christian group. Atheists and Agnostics were also represented. The three largest groups were Mennonites (35.06%), Other Christian (23.37%), and Catholics (12.98%).

All participants were residential students of Bethel College. Only 20% of the population was selected for surveying so as to avoid oversampling. In the spring semester, there were 308 residential students and 60 students were selected. In the fall semester, there were 362 residential students and 70 were selected. All students selected in the spring semester were exempt from the fall semester's pool.

Students were selected according to their residence hall. Bethel College has three halls: Warkentin Court, Voth Hall, and Haury Hall. Each student, by residence hall, was given a unique number. Using a random number generator (random.org) the correct number of students were selected[23]. These steps were taken to gather a truly random sampling. Table 1 is composed of the data on student solicitation. Table 2 breaks down the spring responses by gender and residence hall. Table 3 includes the same variables as Table 2 but for the fall responses.

Table 1. Spring and Fall Housing Distribution - The table below easily breaks down the percentage of students housed in each hall (Percentage), the number of students selected (Number), and the selection rate of men and women. It was possible to select students by gender in a fifty-fifty split. The equal gender selection was not proportional to the actual population.

Residential Representatives	Percentage of Population - Spring	Percentage of Population - Fall	Number of Students Selected - Spring	Number of Students Selected Fall	Men/Women - Spring	Men/Women - Fall
Haury Hall	30.8%	36.18%	18	25	9/9	13/12
Voth Hall	24.35%	21.82%	15	15	7/8	7/8
Warkentin Court	44.8%	41.98%	27	30	14/13	15/15

Table 2. Spring Response Distribution - Women more reliably responded than men, so the results cannot be generalized across genders as readily as once hoped. The majority of responses were from Warkentin Court, and as in the case of gender, it is not possible to generalize across housing.

Residential Represen-tatives	Male - Frequency	Male - Percentage	Female - Frequency	Female - Percentage	Frequency Response Total	Percentage Response Total	Frequency Non-Response Total	Percentage Non-Response Total	Row Totals (response + non response)
Haury Hall	0/9	0%	4/9	44.44%	4/18	22.22%	14/18	77.77%	100%
Voth Hall	1/7	14.28%	5/8	62.5%	6/15	40.0%	9/15	60.0%	100%
Warkentin Court	6/14	42.85%	11/13	84.61%	17/27	62.96%	10/27	37.04%	100%

Column Totals	7/30	23.33%	20/30	66.66%	27/60	45.0%	33/60	55.0%	

Table 3. Fall Response Distribution - Female residents of Haury and Voth halls were more likely to respond than their male counterparts. In contrast, male Warkentin Court residents were more likely to respond than the women. Though gender differences are less pronounced here, it is still difficult to generalize across residence halls. Though Voth Hall and Warkentin Court had similar response rates, they heavily outstripped Haury Hall.

Residential Represen-tatives	Male - Frequency	Male - Percentage	Female - Frequency	Female - Percentage	Frequency Response Total	Percentage Response Total	Frequency Non-Response Total	Percentage Non-Response Total	Row Totals (response + non response)
Haury Hall	6/13	46.15%	6/12	50%	12/25	48%	13/25	52%	100%
Voth Hall	4/7	57.14%	8/8	100%	12/15	80%	3/15	20%	100%
Warkentin Court	14/15	93.33%	12/15	80%	26/30	86.66%	4/30	13%	100%
Column Totals	24/35	68.57%	26/35	74.28%	50/70	71.42%	20/70	28.57%	

2.3. Instruments – Spring & Fall

The survey sent out in the spring of 2015 was composed of the BFRSS Mental Illness and Stigma Module and demographic questions. 2013 BRFSS data, script, and supporting documents were obtained through the CDC website[24]. The first six questions of the Mental Illness and Stigma Module are the Kessler 6 Scale[25]. The Kessler 6 (K6) is used to determine Serious Psychological Distress (SPD). The K6 is composed of questions concerning states of nervousness, hopelessness, restlessness, depression, worthlessness, and feelings of everything being an effort. The seventh question evaluates Frequent Mental Distress (FMD). FMD is evaluated by the number of days in a month in which one's mental health was not good. The eighth question determines psychiatric medication use. SPD, FMD, and medication usage are all pieces of information used to evaluate the mental health of a population. The last two questions of the module pertain to stigma. Question nine relates to the usefulness of treatment. The last question, number ten, relates to society's general treatment of people with mental illnesses.

The survey sent out in the fall of 2015 was composed of the Mental Illness and Stigma Module, five questions modelled after the Internalized Stigma of Mental Illness (ISMI) survey, and various demographic questions. Questions from the ISMI were added to more directly assess stigma towards specific populations. These questions were included for future analysis and extension.

At the end of both modules, several demographic questions were included. These included age, gender, race, religious affiliation, education, residence hall, and the participants' thoughts about the study. This information is helpful in determining factors that would influence mental health and stigma.

The state of Kansas provides access to the interviewer's script used in the phone surveys. With slight modification, it was possible to write the Module 17 questions into a Google Form for electronic distribution and data compilation. Students received an e-mail including a link to the survey during the months of April and September 2015. To represent each residence hall and gender fairly, a stratified random sampling within residence hall-gender groups was used.

2.2. Study Design

The survey was sent as a Google Form to all randomly selected students. Reminders were sent out periodically in hopes of gaining more responses. It was left as an option for the student to speak with the school counselor, Joanna Bjerum, or professor of psychology, Paul Lewis, in case they had any questions or concerns.

The first ten questions (BRFSS - module 17) remained constant from spring to fall. One demographic question (year in college) was exempted from the fall survey. This question showed no helpfulness once the individual's age was gathered. Five questions modeled after the ISMI (Internalized Stigma of Mental Illness) were added to the fall survey for additional stigma evaluation[26]. Students solicited in the spring semester were exempt from the second round of

randomized sampling in the fall. This second sampling was intended to account for graduated seniors and new freshmen specifically.

3. Data Analysis

During the summer of 2015, the BRFSS data was cleaned and sorted. This included removing extraneous variables, weighting the data according to CDC standards, and removing other states' data beside Colorado, Kansas, North Carolina, New York, and Ohio[27]. R Statistical Software was used to conduct all data analysis[28].

The cleaned five-state data was then narrowed to consist solely of response data from participants ages 18 to 24. This was to ensure the closest comparison to Bethel College. It was then possible to compare the BRFSS question responses across five states and Bethel College. As the ISMI questions had not been asked in the spring, no comparison could be made. Sampling in both the spring and fall, which includes such dramatic upheavals in the student populace as graduation and incoming freshman, made it possible to determine whether the findings were replicated across semesters with consistency or inconsistency.

The first analysis was a comparison between Kansas state residents and residents of Colorado, North Carolina, New York, and Ohio. The final analysis was between the Kansas data and the combined spring and fall Bethel College data. To target assessments of mental health and stigma, analysis was limited to the Kessler Six and stigma questions.

4. Results

BRFSS data was obtained and analyzed with little difficulty. As for the Bethel data, reminder e-mails, public announcements, and personal appeals were made to gain responses. Only one individual verbally refused to respond. They gave no reason for their unwillingness or inability.

4.1. Kansas Vs. Four State Group

It was possible to compare college age residents of Kansas to those in the other four states (New York, Ohio, North Carolina, and Colorado) by using the four state group as population levels in a chi-square goodness of fit test. In the cross-tabulation with the four state group, Kansas scored significant p-values in five of the six Kessler categories and one stigma category. A significant difference is indicated by a p-value lower than 0.05. Statistical summaries, including p-values and degrees of freedom, can be found Table 4.

The Kessler Six and stigma questions are as follows[24]:

K6 - Nervous – "About how often during the past 30 days did you feel nervous?"

K6 - Restless – "During the past 30 days, about how often did you feel restless or fidgety?"

K6 - Worthless – "During the past 30 days, about how often did you feel worthless?"

K6 - Depressed – "During the past 30 days, about how often did you feel so depressed that nothing could cheer you up?"

K6 - Effort – "During the past 30 days, about how often did you feel that everything was an effort?"

K6 - Hopeless – "During the past 20 days, about how often did you feel hopeless?"

Stigma 1 – Caring – "People are generally caring and sympathetic to people with mental illness."

Stigma 2 – Treatment – "Treatment can help people with mental illness lead normal lives."

Answers to the Kessler Six questions are measured on a seven-point scale:

All – Most – Some – A Little – None – Not Sure – Refused

Answers to the stigma questions are also measured on a seven-point scale:

A. Str. (Agree Strongly) – A. Sl. (Agree Slightly) – Nor (Neither Agree nor Disagree) – D. Sl. (Disagree Slightly) – D. Str. (Disagree Strongly) – Not Sure – Refused

Table 4. Kansas Significance Tests: Chi-Square Goodness of Fit – Kansas scores vary significantly from the four state group in the following categories: Nervous, Hopeless, Effort, Depressed, Restless, and Treatment. Kansas scores do not vary significantly from the four state group in the Worthless or Caring categories.

Questions (n=503)	Kansas – X-Squared	Kansas – df	Kansas – p-value
K6 - Nervous	26.7336	6	0.0001624
K6 - Restless	23.038	6	0.0007838
K6 - Worthless	6.3169	6	0.3886
K6 - Depressed	1791.523	6	<2.2e-16
K6 - Effort	42.9506	6	1.193e-07
K6 - Hopeless	1006.629	6	<2.2e-16
Stigma - Treatment	12.2417	6	0.05679
Stigma - Caring	10.7102	6	0.09776

The differences between Kansas and the other states was less pronounced than the difference between Bethel College and the state of Kansas. This evaluation is the most statistically reliable due to the large sample sizes: Kansas (n=503) & 4 States (n=1006).

4.2. Bethel Combined Vs. Kansas

It has been seen that Kansas data is different, but in a limited way, from the four other states' data. In conclusion, Kansas will be kept as a separate comparison group. A combined Bethel group (both spring and fall being considered one group) will be compared to the state of Kansas.

This comparison can be done by using the data from college age residents of Kansas as population levels for a chi-square goodness of fit test. In the cross-tabulation with the state of Kansas, Bethel scored significant p-values in all Kessler Six and stigma categories. See Table 7 for statistical summaries.

Table 7. Bethel Significance Tests: Chi-Square Goodness of Fit – Bethel scores vary significantly from Kansas in every category.

Questions (n=77)	**Bethel Combined – X-squared**	**Bethel Combined – df**	**Bethel Combined – p-value**
K6 - Nervous	38.6378	4	8.276e-08
K6 - Hopeless	48.3343	5	3.038e-09
K6 - Effort	124.5462	5	<2.2e-16
K6 - Depressed	Inf	5	<2.2e-16
K6 - Restless	Inf	5	<2.2e-16
K6 - Worthless	43.0267	4	1.022e-08
Stigma - Treatment	9.6909	4	0.04597
Stigma - Caring	38.5754	5	2.891e-07

Though the statistical reliability is not as high in this analysis as the Kansas to other state comparisons, the results are informative. The statistics can only indicate that there is a difference between Bethel College students and Kansas residents. It is important to observe the direction of the differences. The differences are best observed in graphical representations. Figures 1 and 2 depict how Bethel College students are responding in ways that indicate frequent experiences of psychological distress and more extreme stigmatization.

An example of the differences is in the K6 category Nervous. KS residents' responses peak at "None", indicating zero days during the past thirty days in which they felt nervous. Bethel College students' responses, in contrast, peak at "A Little". This indicates more frequent mental health distress.

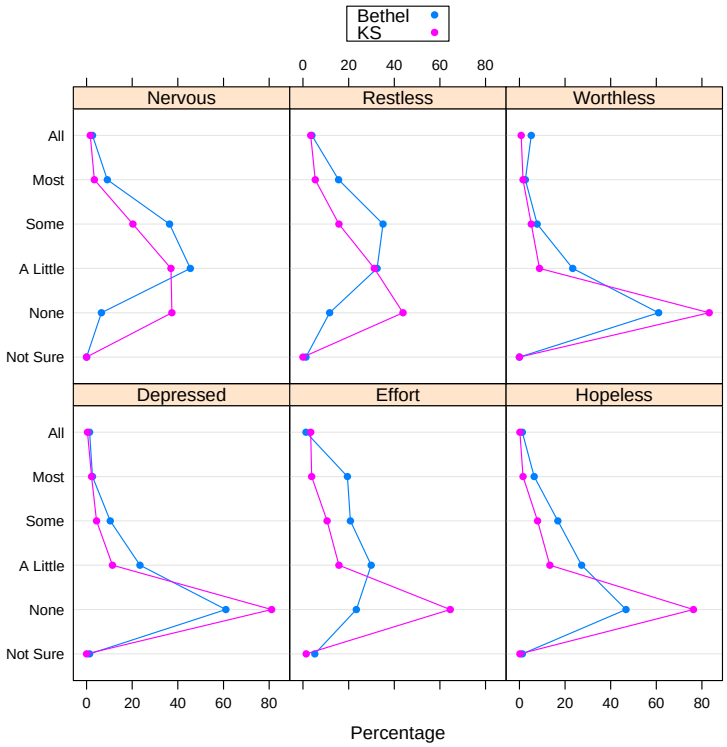

Figure 1. Each category represents one of the Kessler Six questions and percentages are charted against a six-point scale. In the Nervous, Restless, and Effort categories, Bethel College responses are peaking higher on the scale than Kansas responses. In categories Worthless, Depressed, and Hopeless, Bethel College and Kansas responses peak at the same point on the scale, but Bethel responses are more evenly spread across the scale than Kansas responses.

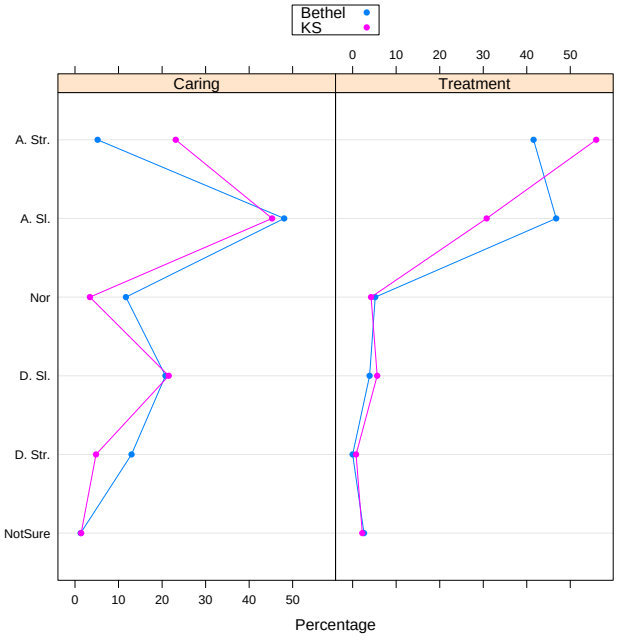

Figure 2. Each category represents a BRFSS stigma questions and percentages are charted against a six-point scale. In the Caring category, Bethel students' responses and Kansas residents' responses are peaking at the same point on

the scale, but the Bethel responses are spread across the scale in a more extreme pattern. In the Treatment category, Bethel College students are less likely to respond Agree Strongly than Kansas residents of the same age.

5. Discussion

Hypotheses for this study included the following: 1. There will be a significant difference between the Kansas 2013 BRFSS data and the 2013 BRFSS data of North Carolina, Colorado, New York, and Ohio. 2. There will be a significant difference between the Bethel College students' responses (both spring and fall) and the Kansas 2013 BRFSS data. Both hypotheses were confirmed.

With the size of the state data sets, it was possible to establish statistical validity. Generally, Kansas scores proved to be significantly different than the four state conglomerate. The few exceptions were the Worthless and Caring categories in which Kansas was not significantly different. With this being the case, it was not possible to combine data sets without confounding the analysis by skewing the data towards one state or another.

Bethel College data were significantly different than the state of Kansas in every K6 and stigma category. Bethel students were more likely to score in such a way that indicated symptoms of mental illness, psychological distress, and stronger mental health stigma, than the state of Kansas. It is imperative that the Bethel College community recognize the student body's poor mental health status and take action.

Three factors need to be addressed for their possible influence on the data, producing biases or skewed responses. These factors are self-selection bias, finals, and incoming freshman. Though a random stratified sampling is a good step to limit these biases, it is not a sure fix.

The final responses are determined by such factors as who checks their e-mail with the highest frequency, the authors relationship to the individual respondents, and maybe even worries about confidentiality. The spring collection occurred at the beginning of April and continued into May, and ended right before finals week. The proximity to finals may have influenced the number of responses received in the spring semester. The fall semester has its own challenges, specifically incoming freshmen adjusting to life away from home, the end of summer, and a new schedule. Attempting to limit these fall effects, surveys were not sent out till the beginning of September.

6. Conclusion

Mental health is an important factor in the health of our communities. There is clear evidence that the Bethel College community is not exempt. If Kansas is taken as a baseline, Bethel students are showing more pronounced signs of mental health distress.

This data should be viewed as an indicator of the current mental health of Bethel College students. Though this data is not sufficient to determine causality, it is important to consider the possible causes. The state of Kansas and Bethel College have such disparate scores that one is led to disregard state-level factors. In conclusion, there may be some characteristic or characteristics of Bethel College or college communities that are causing these differences.

Why these levels of poor mental health are being observed could be due to a number of things. Bethel, a four-year private college, is well known for its rigorous academic standards. In a small college, societal stressors can escalate when every student knows every other student. In the small town of North Newton, there are few entertainment options beyond drug and alcohol use. A school with a strong religious heritage can prove to be a challenging environment for those outside the particular belief system. These are a few characteristics that may prove to be causative forces alone or in combination.

The literature concerning the mental health of college students is lacking. The resources to make comparisons from one university to another are not currently available. It is not possible to compare potential causative factors to those of another college. It is hoped that this will be the beginning of comparative research among universities and colleges, both public and private, in the state of Kansas.

There will be no improvement if changes are not put into place. This may mean first determining what stressors are leading to such a difference between Bethel and other college age residents of Kansas. Once it is determined which stressors need to be addressed, action must be taken.

These changes must also address issues of stigma. Administrative and policy changes can be made, but they can only make slow progress as long as the ideas of the population go unchallenged. High stigma levels have been observed in the Bethel College populace. One cannot see positive change in mental health without the same positive change occurring in matters of public prejudice, stigma, and stereotyping.

The reality of mental health and stigma in the Bethel College community is apparent. Members of the community must be unflinching and ready to face these issues again and again, until they are resolved. The effects of research cannot end here. Every individual plays a role in making the community a more responsible, tolerant, and caring place. For the betterment of the community, every individual must care for each other community member no matter their mental health status and in spite of the stigmatizing ideas we all hold.

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