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Penn Face: Stigma and Mental Health of Undergraduates at The University of Pennsylvania

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Abstract
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Keywords
mental health, stigmatization, Penn Face, minority, discourse, heterogeneity, vulnerability, culture, norms, college students

Disciplines
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 PENN FACE: STIGMA AND MENTAL HEALTH OF UNDERGRADUATE STUDENTS AT THE UNIVERSITY OF PENNSYLVANIA

By

Rebecca Pels

In

Anthropology

Submitted to the

Department of Anthropology

University of Pennsylvania

Thesis Advisor: Dr. Lawrence Blum

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Abstract

This thesis considers how undergraduate students at the University of Pennsylvania navigate mental health and its related struggles, considering willingness, or lack thereof, to seek help when it is needed. Focused on the nexus of mental health and minority status, the aim is to determine whether certain populations of undergraduates may be particularly reluctant to seek help or to discuss the struggles they are facing, thereby limiting the efficacy of current on-campus mental health resources such as Counseling and Psychological Services (CAPS). “Penn Face” and stigmatization of mental illness are also considered. Data was obtained over the course of three years (2016, 2018, and 2019) by student survey, in addition to five interviews with Penn undergraduates and one interview with the Executive Director of CAPS. Findings suggest that the addition of “mental health advisors” at Penn would be useful in destigmatizing mental health struggles and ensuring that students feel they have access to mental health resources should they need them.

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**Introduction: Mental Health, Stigma, and “Penn Face”**

Mental health is a topic that is often mentioned, but its associated struggles are also often stigmatized nationwide. This stigmatization relates to individual desires to appear “okay” to the outsider in order to comply with the prescribed ideals of the culture in which that person is living. The internal and external meet with a clash and, for some, this event results in pathology. Certain environments, such as that of the University of Pennsylvania, seem to glorify academic and professional successes regardless of what is lost in this pursuit. Because of this, people might feel that in order to survive in such cultures, they need to put on a display of mental fortitude regardless of how they truly feel. So, this begs the question: is it okay to not be “OK”? In the era of “Penn Face,” where putting on the façade that you are perfect and your life is perfect, no matter how pressured you are to keep up with school and a social life, it seems that the acknowledgment of internal, mental struggles is incongruent with the ideals of the external environment of places such as Penn.

Students often feel that they cannot express their struggles because of societal pressures. They would rather stay silent than admit that they are depressed or struggling with other aspects of their mental health that may cause them to appear inferior to their peers. Fear of stigma, of being viewed as weak, become even stronger driving forces than the desire to be open about the struggles one is experiencing. In such cases, silently suffering, sometimes to the point of no return, seems a more appealing option than receiving help. Thus, the problem with the preprofessional culture of Penn is that it can detract from the importance of the mental health of its students. When perfect grades become the normative and academic and professional success are defined as paramount, students who struggle with this competitive atmosphere are left with a severe sense of inadequacy.
The effect of norms perpetuated by culture on the willingness, or lack thereof, of one to express whether he or she is struggling with his mental health is undeniable, and this problem is particularly striking on Penn’s campus. A richly diverse community, many students at Penn are not only subject to the cultural pressures that Penn presents, but are also subject to the norms of their home cultures; what is and is not okay to share, who can and cannot know about one’s struggles. In this sense, Penn Face is amplified because there are multiple levels of cultural norms acting upon the intrapsychic of the individual who is attempting to determine what is socially acceptable. Anthropological theory of culture and group belonging are relevant when considering such topics. The stakes are high in this act of attempting to “belong,” because the potential for what a person can lose is great; what if one’s sense of self, sense of being and happiness, is what is sacrificed in an attempt to appear “OK”? And what if this utter disillusionment results in a desire to end one’s life? Suicide is the ultimate price for one’s inability to reconcile intrapsychic distress, and Penn’s campus has seen far too many of such instances. So, we must consider the reasons why and the mechanisms by which this internal versus external battle occurs in an attempt to find a solution, move forward, and make progress.

The purpose of discussing the relationship between stigma and mental health at the intersection of minority is to determine the degree to which culture, past experiences, and societal norms affect student willingness and/or ability to seek help for mental health struggles. Even if resources such as CAPS are available to students, the persistence of intrapsychic distress remains a barrier to treatment. Parsing out the basis for intrapsychic distress, which creates reluctance to seek help, is equally important as creating new mental health initiatives to increase access to on-campus resources. While the fear of stigmatization might be the basis for some students here which results in “Penn Face,” for others, minority group cultural underpinnings might have an equally convincing role in the decision to refrain from utilizing mental health
resources available on campus. Because for some students, Penn’s culture may not be the reason behind a lack of discourse or a reluctance to seek help regarding mental health struggles. The environments and cultures in which such students grew up might not have considered mental health to be an important facet of their lives. Thus, it was not discussed during early adolescence and did not become a part of their vocabulary or a concept worth heeding, resulting in an unfamiliarity around the topic of mental health. This lack of understanding inhibits discourse and may be the basis upon which the decision, or lack thereof, to seek help for mental health struggles exists, not upon the basis of fear of stigmatization. In such circumstances, intervention and prevention may prove even more challenging if a student is struggling, because he himself may not recognize his struggle as a mental health struggle and be willing to seek help through resources such as CAPS. Particular credence should be paid to such students’ potentially vulnerable status, and efforts should be made to introduce these students, who have not have prior exposure, to the topic of mental health in an attempt to show its importance throughout life and while on Penn’s campus.

Multiple research methods and theoretical frameworks are employed to determine how “Penn Face,” stigma, and mental health struggles are experienced by undergraduate students of various backgrounds at the University of Pennsylvania. Survey and interviews provide first-hand accounts of Penn students and faculty which allows for the consideration and understanding of their opinions and beliefs regarding the environment of Penn, particularly in the context of mental health and its related struggles. Anthropological, psychoanalytic, and sociological elements of this topic are considered. How does the culture in which we are immersed affect the functioning of our psychical processes, and how do these processes affect how we act within society? This paper explores how the culture (anthropology) in which we are immersed affects the functioning of our psychical processes (psychoanalysis) and the decisions we make, and how
these choices affect how we act and portray ourselves within society (sociology). My hope is that addressing this topic and sharing the results of this research will help to show the effect that cultural background and societal pressures can have on the mental health of students. With this in mind, I would propose the addition of mental health advisors to Penn in the future in order to promote awareness and open discourse regarding mental health among its students and faculty by the most preventative measures possible.

**Early Theory: Stigma, Society, and Mental Health from Anthropological, Sociological, and Psychoanalytic Perspectives**

Through studying the interplay of culture and personhood, it becomes possible to better understand the various implications that these influences have on the individual as well as the collective. Positive or negative, identity forming or breaking, the origins and effects of this dyad form the basis upon which theorists of many fields have posited ideas regarding the effect that society has on its members. Anthropology, sociology, and psychoanalysis become enmeshed in an effort to elucidate the profound effect that the collective bears on the individual, specifically in the context of mental health struggles, stigmatization, and help seeking behavior. Stigma is one of the most intense and evident implications of the relationship between a person and the culture in which he lives, because one’s sense of self is often contingent upon a feeling of belonging and acceptance as member of his society. This paper specifically considers the University of Pennsylvania and its pre-professional culture, considering the intrapsychic effect it has on students. I will employ a holistic approach to explore the interaction between the individual and the collective, incorporating multiple perspectives exemplified by theorists including Goffman, Durkheim, and Freud.
Erving Goffman, Canadian-American sociologist, social psychologist, and writer, was one of the first theorists to directly and explicitly consider stigma and its effects. In *Stigma: Notes on the Management of Spoiled Identity* (1963), Goffman considers life as a stigmatized member of society, giving readers a glimpse into what it is like for those not considered to be a “normal,” defined as “we and those who do not depart negatively from the particular expectations” of society (Goffman 1963, 132). Conversely, stigma is used to refer to an attribute that results in othering from aforementioned normals, “defined as a sign of disgrace or discredit, which sets a person apart from others” (Byrne 2000, 65). Once this dichotomy is solidified, it becomes possible to consider stigma’s effect on mental health and the variety of strategies that stigmatized individuals employ to combat and cope with the rejection of others, in addition to the complex images of themselves that they project within their society.

Goffman considers society’s role in categorizing persons, noting that the purpose of doing so is to establish the likelihood of who is to be encountered in certain social settings. This classification is then used to determine who should and should not be considered normal within that context (Goffman 1963, 131). Those who do not comply with these expectations are othered and stigmatized based on the attribute they possess, which renders them different from those who are desirable and do not possess the trait that the stigmatized individuals do. When this difference becomes recognized, the individual is reduced in the minds of normals “from a whole and usual person to a tainted, discounted one” (131). In the context of the highly competitive, pre-professional culture of Penn, a student struggling with his mental health is at odds with this culture, “incongruous with our stereotype of what a given type of individual should be” (132). So, one adapts, often to a fault, in order to conceal the incongruity that could render him as “not quite human” (Goffman 1963, 132), resulting in discrimination and a reduction in his life chances or social opportunities (Brown et al. 2010). At Penn this could mean a variety of things,
spanning from failure to be accepted into a club to receiving job offers. When this possibility of
discrimination is recognized, sufferers initiate a sequence of conscious suppression in order to
mask that which could obstruct their achievement of perceived ideals of success.

Mental health struggle is a “differentness,” a blemish of character, that the sufferer often
believes not to be immediately recognizable by those around him. Thus, a front is put forth, and
while attempting to conceal the attribute which could lead to othering, these people struggle with
Goffman’s (1963) plight of the discreditable (132). In such scenarios, the person who holds the
undesirable trait, the stigma, believes that if he is able to successfully hide his differentness, he
will be accepted, safeguarded from the othering process and “unpleasant situations” that the
exposure of his blemish would create (Dinos et al. 2004; King et al. 2007, 253). This often
intense desire to conceal this “abnormality” emphasizes that “the stigmatized individual tends to
hold the same beliefs about identity that we do” (Goffman 1963, 133). “We” as in those who are
considered normal within society and are not subject to this stigmatization. With this belief, the
stigmatized individual does, “if only for moments…agree that he does indeed fall short of what
he really ought to be” (133). This personal stigma is not directly related to culture and the others
who comprise it in the way that perceived stigma is, but it is similarly influenced by culture,
highlighting the interplay and connectivity between the individual and collective.

“Penn Face” is employed in an attempt to maintain the virtual social identity that is
accepted (collective) and not reveal the actual social identity (individual) which admits a sort of
irregularity in the context of what is expected as a member of this society. If an abnormality is
recognized, someone might be labeled deviant (Durkheim 2006). Deviancy can hold both
positive and negative connotations, and usually “deviance that is gratifying tends to be
continued, and that which is not gratifying is extinguished” (Glaser 1971, 50). This relates to
Freud’s pleasure principle which explains that during the course of development, a child learns
to form conceptions of the external world and to act in ways which produce satisfaction in that world, and not just in the mental world (Bocock 1978, Freud 1955). As it relates to Penn Face, students might have learned throughout their time at Penn that it would be more satisfactory or beneficial to push aside their feelings in an attempt to receive a positive response from members in their society. Psychoanalytically, D.W. Winnicott (1960) builds from Melanie Klein’s Object Relations Theory¹, focusing on the relationship and bond between mother and child during the child’s infancy. While this cannot be used as a direct comparison to adults with fully formed egos, the proposal of development in response to perceived positive or negative outcomes based on action remains applicable in relation to students and their desire to conceal that which could result in othering, and a therefore undesirable experience. Winnicott notes that if the environment in which this mother-child dyad develops is hostile there will be psychical repercussions for the infant throughout life. Through this work, he introduces the notion of selves, in which a “false self”² and “true self”³ develop based on the maternal environment. 

Similar to an infant adapting in order to survive within the context he lives in relation to his mother, a Penn student acquires a “Penn Face,” or false self, in order to attain the most positive outcome within the relationship of him and his peers. The reality, however, is that these students, who have developed a Penn Face, are putting on a performance in the hopes of being accepted and not stigmatized. Thus, this desire to conceal is perpetuated and often coupled with an element of uncertainty, of “not knowing what the others present are ‘really’ thinking” (Goffman 1963, 136). This area of unknown is where the true self recedes, and in order to avoid

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¹ Object Relations Theory is a theory of relationships between people, in particular within a family and especially between the mother and her child. A basic tenet is that we are driven to form relationships with others and that failure to form successful early relationships leads to psychical problems (changing minds).
² The “false self” is defined as the adaptation that the subject has to make in order to live within his social context.
³ The “true self” is defined as the ‘inherited potential’ of the child which comprises the core of his personality. When supported by the facilitating environment provided by good-enough mothering the true self's continuing development can be established.
feeling incompetent, students, often struggling with their mental health or dealing with depression, adopt a false self in order to survive and conform to the ideals of the environment that is slowly breaking them down. The problematic nature of doing this for an extended period of time, however, is that eventually the true self becomes so elusive that the “Penn Face,” or false self, supersedes the essential self. Students begin to lose sight of who they truly are in an effort to be considered a valued and respected member of their society. A student experiencing this may feel hopeless, existing under the impression that he or she is "not really living" or "sleepwalking through life" (Fennessy 2006). This can cause the true or essential self of a person to become hidden because of the intense social pressures and stigmatization that they fear. The time at which one begins to discourage and dislike himself without even the prompting of others is when shame, or self-stigma (Goffman 1963), sets in, and unremitting uncertainty, guilt, and sense of not belonging takes over. This can lead to extreme self-hate and self-derogation, and in some scenarios, this sense of repugnancy incites a loneliness which can lead to the worst possible outcome: suicide.

In 1897 Émile Durkheim published *Le Suicide*, which was later translated into *On Suicide*. The introduction of this version considers Durkheim’s process of exploration and explanation as “something akin to an archaeological dig” as he sifts through a multitude of factors, such as psychiatry, race, heredity, climate and geography to get at the social core buried beneath suicide (Durkheim 2006, xi). In doing so, Durkheim’s view of social bonds as key structures which lie below the surface of people’s everyday consciousness is emphasized, reminiscent of Freud’s structural theory, in that aspects integral to the person, or society, lie below the surface of consciousness (Freud 1915). Through this work, Durkheim was the first to consider the social dimension of suicide, breaking from the traditional considerations of such an act as a matter of purely individual despair, emphasizing the importance of a balance between the
individual and the communal. He suggests that “instead of trying to resolve these insoluble problems of moral casuistry, [statisticians] should take greater care in recording the social concomitants of suicide” (Durkheim 2006, 155). This relates to changes during the 19th century which involved a shift in belief away from the notion that suicide was confined to “sinners and sensitive soles” (xi). This is because sociological theory, undeniably related to anthropology and the study of culture, was coming into the fold through theorists such as Durkheim who began to explore this new understanding of human emotion that could result in suicide amongst seemingly “normal” people. A different sort of deviant unlike the generalized criminal, suicide represents a deviant behavior that is vastly connected to society and its effect on the individual.

A “talisman of the ‘moral affliction’ of modern society,” suicide is the ultimate consequence of an antagonistic relationship between the individual and collective (Durkheim 2006, xxiii). In regard to suicide that stems from depression or mental health struggle, there is often a deep connection to whether that person feels a sense of belonging within his culture. Durkheim explains that “suicide rates vary inversely with the degree of integration of the social groups to which the individual belongs” (224). Therefore, a connection or attachment to others influences one’s suicidality, and at Penn, people silently struggling with mental health might feel that they do not have the support of, or connection to, their community. Both egoistic⁴ and anomic⁵ suicide, as explained by Durkheim, “come from the fact that society is not sufficiently present for individuals” (284) and is thus the focus for this theoretical framework of the consideration of stigma as it relates to mental health.

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⁴ Egoistic suicide: According to Durkheim, when a man becomes socially isolated or feels that he has no place in the society he destroys himself. This is the suicide of self-centred person who lacks altruistic feelings and is usually cut off from main stream of the society (Bhatt 2012).
⁵ Anomic suicide: This type of suicide is due to certain breakdown of social equilibrium (Bhatt 2012).
This desire to belong to a group in order to form a sense of identity and belonging is exemplified through Durkheim’s considerations of religion and marriage as protective factors against suicide. He emphasizes that people are protected from egoistic suicide only to the extent that they are socialized, but notes that religions can only socialize us to the extent that they deprive us of the right to think for ourselves (Durkheim 2006). However, religion no longer seems to have enough authority over its followers to prevent other cultural elements from innervating one’s sphere of thinking, affecting the intrapsychic stability of individuals. So, it is therefore not through religion that we can count on “holding back the tide” of suicidality (Durkheim, 3006 420). In considering the effect of capitalism, Durkheim notes the professional group or corporation acts as a different group that could have the same effect on one’s sense belonging as religion as long as it has the same cohesion (423). Penn students have an overwhelming desire to get the job, become a part of that company. So much so that their sense of self and identity can be contingent upon successful achievement of this. I have countless friends who have verbally expressed having “severe depression” following an unsuccessful OCR (on campus recruitment) season. What does this say about the culture of Penn?

It means that being “OK” is paramount, idealized, and expected. Despite efforts to promote open discourse, Penn students live within a culture that perceives mental health struggle as weakness. “Penn Wellness Week” and CAPS initiatives attempt to break down this perception, but the reality is that students continue to pretend they are okay, even when they are not. And even more severely, some students come to Penn from cultural backgrounds which have taught them to conceal that they are struggling throughout the duration of their upbringing. In such instances, Penn’s culture may not be the catalyst behind their desires to hide what they are enduring, and destigmatizing mental health struggles as they relate to Penn’s culture will not be sufficient in leading such deviants to believe that their “blemishes” will not result in
stigmatization and a reduction in life chances. Often times, until it is entirely unbearable, students will continue to conceal, ignore, and keep hidden the internal turmoil that impairs their ability to function. Birenbaum (1976) combines Goffman’s notion of the “discredited” individual with that of Durkheim’s notion of “deviance,” resulting in the formation of a “secret deviant,” which seems to encapsulate the experience of students struggling with their mental health at Penn. As considered above, the discredited is only made “found” if he chooses to do so or fails to conceal his nonconformity, as is the case with a secret deviant.

Many secret deviants develop a circle of friends and colleagues who are “in the know” while intermingling with others who are not. Cultural Resource Centers (PAACH, Makuu, La Casa Latina, LGBT Center, etc.) may act as a spaces in which community is promoted and stigmatization appears less potent. In other cases, the secret is so closely kept that no one but the deviant himself knows was he is enduring (Birenbaum 1976). In such circumstances, not even a “safe space” would be enough for the secret deviant to make himself known to others. This desire, to keep secret one’s struggles, stems from an overwhelming fear that “disaster will befall him if his discrediting characteristic becomes known” (Birenbaum 1976, 130). This is only true to the extent that “the rejectee values acceptance,” because this is what is as stake (Glaser 1971, 60). Recognizing this is also vital in acknowledging that stigmatization itself is a social construct, and it is thus the responsibility of the members of each society to remove the potential for such discrediting to occur (Brown 2010). A stake in conformity is what motivates an individual to avoid further deviance or to hide it more carefully (Glaser 1971), but Birenbaum (1976) goes onto flip this notion on its head, explaining that “sometimes the deviance consists in the very fact that it is a secret” (131). Penn administration claims to promote an inclusive and supportive environment, so if students were just more open because they did not have to fear stigmatization, perhaps more efficacious and meaningful help could be given. But as Goffman
(1963) posits, there are undeniable consequences of possessing a stigma that, even if supposedly accepted, leaves a mark.

By studying the anthropological, sociological, and psychoanalytic theory that considers the relationship between an individual and his society, it seems obvious that serious effort should be made to promote open discourse regarding mental health. These considerations by Durkheim, Goffman, Freud, and others outline the very serious implications for the denial or concealment of mental health struggles due to fear of public stigmatization. If people were less fearful of how others might perceive them, perhaps they would be more willing to seek help. As Goffman considers, the social status of people suffering from mental health struggles might be improved through treatments such as psychotherapy, as pioneered by Freud, but they will always have a “record” of that “blemish” (Goffman 1963, 134). Thus, in order for real and substantive changes regarding mental health and stigmatization to occur, discourse must be altered surrounding mental health to promote inclusivity so that a true sense of group acceptance and belonging is felt among students at the University of Pennsylvania.

**Contemporary Contributions: Mental Health and Minorities**

While the theory above suggests that increased inclusivity and more open discourse could help to alleviate the burden of secrecy that many students experiencing mental health struggles face at Penn, this may not be the case for all students. Goffman (1973) considers a desire to hide a discreditable trait for fear of being stigmatized and othered. This would imply that if the fear of public stigmatization did not exist, there would no longer be a reason to conceal such a “blemish,” because it would no longer be considered a trait that if revealed would result in an unpleasant experience. Thus, expressing mental health struggles would be an attribute of a normal, socially accepted and congruent with the norms of Penn’s culture. However, when
considering the cultural norms and societal expectations of certain minority groups, it becomes apparent that the fear of stigmatization or of being othered from a general stance is not the basis upon which matters such as mental health struggles are concealed. For some minority group members, internal struggles are personal, familial, not to be shared with the outside world. In this sense, the acknowledgment of any type of struggle is internally stigmatized on the basis of one’s upbringing, rather than solely mediated by public stigma as it relates to the expression of one’s struggles to others (Brown et al. 2010). In such circumstances, destigmatizing discourse regarding topics such as mental health may not prove to be enough in promoting the utilization of resources and seeking help when it is needed. Considering various cultural underpinnings in the decision, or lack thereof, to seek help for mental health struggles will allow for more productive efforts in improving the mental health of minority students at Penn.

Culture can have a profound effect on what an individual believes, affecting the decisions he or she makes. It informs “right and wrong,” “good and bad,” and regarding medicine, culture affects how illnesses are identified, defined, and made meaningful. In the context of mental health, the experiences, expressions, and responses to mental health struggles have been “a key focus of research in medical anthropology and cultural psychiatry for decades,” because of their relationship to culture (Carpenter-Song et al. 2010, 225). However, among many studies of mental health and its associated stigma which affects help seeking, there is lack in the account of the role of culture. Researchers such as Abdullah and Brown (2011) have attempted to bridge this gap, considering culture’s “critical importance in the variation in stigma experience” (937). Citing studies by Cooper-Patrick et al. (1997), Whaley (1997), and Anglin et al. (2006), Abdullah and Brown (2011) conclude that ethnic minorities express more stigmatizing attitudes than European Americans, which could perhaps suggest that intense internal discomfort is projected outwards as stigma (938). It is clear that varying attitudes have an effect on the
utilization of mental health resources, but this discrepancy in use, despite seemingly equivalent access, begins to consider how beliefs might inform action. Snowden (2001) found that minority populations remain less inclined to use mental health services even when covered by insurance, illuminating the complex underpinnings of differences in access and utilization. This may be attributed to personal beliefs individuals hold regarding illnesses, which are informed by culture.

How one conceives of illness, its basis and potential remedies, affects the ways by which one seeks help, if at all. In a 2010 study, Carpenter-Song et al. found that Euro-Americans participants were most aligned with professional disease-oriented perspectives on severe mental illness, while African-American and Latino participants emphasized non-biomedical interpretations of behavioral, emotional, and cognitive problems. Following these beliefs informed by cultural norms, Euro-Americans “sought the advice and counsel of mental health professionals” while African-American and Latino participants “were critical of mental health services” (Carpenter-Song et al. 2010, 224). Carpenter-Song et al. cited other studies (Alegria et al. 2002; Dobalian & Rivers 2008; Lasser et al. 2002; Wells et al. 2001), which have consistently found that African-Americans and Latinos are significantly less likely than Euro-Americans to use and to receive mental health care. This has a clear affect on one’s willingness, or lack thereof, to seek help if and when it is needed. Interpretations of illness are useful in considering whether certain forms of treatment, such as professional treatment, are valued by members of certain groups. However, stigma also plays a role in the utilization of resources, because while one might see the efficacy in seeking professional treatment, the act of doing so appears overall more harmful than helpful.

Stigma is an equally important facet in the considerations of one’s willingness to seek professional help for mental health struggles, as considered in the previous section. However, in the context of minorities, it is even more important to consider the degree of stigma they face.
While destigmatizing discourse regarding mental health at Penn might prove enough to for some students to seek help, Gary (2005) suggests that “ethnic minority groups, who already confront prejudice and discrimination because of their group affiliation, suffer double stigma when faced with the burdens of mental illness” (979). In this sense, the combination of stigma and membership to an ethnic minority group can impede treatment and well-being, because many members of such groups elect to not seek professional help due to the multilayered stigmatization they face, or are fearful of facing. In addition to ethnic minority groups, it is also important to consider how “double stigma” might affect members of other minority groups, whether that be sexual, religious, or otherwise. Overall, nearly all Penn students fear some degree of stigmatization should they express their struggles with mental health. However, some students appear to be even more vulnerable to stigmatization and even more reluctant to seek professional help for mental health struggles due to their minority group belonging. These concepts are considered below through the use of survey over the course of three years, in addition to personal interviews.

**Three Years, Three Surveys**

In the fall of 2016 I took ANTH309, Psychoanalysis and Anthropology, with Dr. Lawrence Blum and Professor Gregory Urban. It was in this class that I began my research on the mental health of Penn undergraduates. Writing a paper titled The Effect of Words: *Penn Face*, I circulated a survey “Mental Health at UPenn” in order to collect data from Penn undergraduates and received 207 responses. More numerous than I expected and more personal than I could have ever imagined, these responses revealed how strongly Penn students felt about the phenomenon of “Penn Face.”
My research continued in the fall of 2018 when I focused on stigmatization and mental health for my senior capstone project in anthropology. Similarly to 2016, I circulated a survey this time titled “Stigma and Mental Health at UPenn,” which received 70 responses. They again revealed important and meaningful sentiments that many students seemed to share about mental health and its related struggles while at Penn. Notable throughout both of these surveys, however, was the fact that over sixty percent of participants in each survey identified as white. For this reason, I determined to again narrow the scope of my research in order to explore whether there was a correlation between minority group status and heightened reluctance to discuss mental illness and seek help.

For my senior thesis, I decided to consider the nexus of minority and mental health at Penn, which led me to my final survey, circulated in the spring of 2019. The survey, posted in the same manner as the previous two, through posts in the various Facebook groups for each graduating year, was this time titled “Mental Health and Minority Groups on Penn Campus.” It only received 11 responses. Using the same route of access and entry into the student population over the course of three years led to very different response rates despite similarities amongst all three surveys. The main immediate perceivable difference? The title. It appears that as the title gets more specific, students seem to become less willing to share their experiences, perhaps because it then becomes a question of their mental health in relation to something personal about them. Additionally, they might not have felt stigmatized, as considered in the 2018 survey, they might not have felt that their minority status contributed to struggles with mental health, as considered in 2019, or, while they might have felt these things, acknowledging that relationship was too uncomfortable.

Despite the variations in sample size, it is still useful to compare the data across the three surveys because it becomes possible to consider similarities or differences in responses amongst
similarly posed questions. In doing so, it becomes clear that while perhaps fewer people are willing to participate as the title becomes more specific, many sentiments are still carried across the studies. This is relevant in considering what changes might be made going forward in order to elevate and support the mental health of the Penn student population.

**Discourse, Heterogeneity, and Vulnerability**

On April 11th 2019, I participated on the panel of “Suicide on Campus: A Closer Look.” During this discussion I reviewed Penn students’ willingness, or lack thereof, to seek help for mental health struggles and considered findings from the circulated surveys in addition to perspectives acquired through interviews. Discourse in relation to mental health, heterogeneity of the Penn undergraduate population, and vulnerability of certain minority groups whose members may be particularly reluctant to seek help were the focus of my presentation and are acutely relevant to the considerations of my thesis.

**Discourse**

How we talk about things matters. My sophomore year (in 2016), I was focused on “Penn Face,” a term used to connote the desire of students to put on a front that everything is perfect even if one is struggling. I wanted to explore whether having such a term either promotes or inhibits discourse. There appears to be a strong correlation between “buzz words,” such as Penn Face, and increased discourse. Penn has sponsored “wellness weeks” and talks such as “Deconstructing the Penn Face” in which students are given the opportunity to share and discuss their experiences with their mental health while on campus. Given my findings in the 2016 survey (“Mental Health at UPenn”), it seems that approaching mental health from a more general

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stance, and through the use of impersonal terms such as Penn Face, is in fact helpful in promoting conversation for some students. However, this umbrella term, also frustrates other students, thus inhibiting discourse. In an interview that I conducted for my thesis, one student explained that the use of the term “Penn Face” is not helpful. She went onto say that “the word is so trivialized…it’s horrible…who wants to be labeled? Especially in this school” (Interview with Penn Student (A) 2019). For her, “using this term as a blanket statement” only obscures and trivializes what someone is actually enduring. For students like this who are already willing to discuss mental health and its potential struggles, tacking on a term like “Penn Face” in order to generalize experiences becomes not only unnecessary, but unhelpful. Because while someone might be experiencing “Penn Face,” one person’s definition of what that means might be completely different than another person’s definition.

The logical inference seems to be that terms like “Penn Face” both promote and inhibit discourse. Because while there are students who find such a general term unhelpful, it does also help other students to open up and feel comfortable sharing their experiences. This is perhaps because they feel it is relevant to almost everyone, and they are therefore not troubled by having to admit a personal relation to the term. “Penn Face” might thus be understood, in the phrase of psychoanalytic anthropologist Melford Spiro (1965, 104), as a culturally constituted defense mechanism, which helps to connect the internal psychic world of the student and the external influences of Penn’s culture. It facilitates the expression of certain emotional concerns common in a population, while helping to regulate the emotional discomforts associated with it. This supports that we have a dilemma in approaching students about mental health issues: if the approach is too direct, many students may feel uncomfortable and less willing to share their experiences, as shown through the low response rate of my most recent survey. If the approach is too general, certain concessions must be made, because while students may be more comfortable,
it may also be difficult to address specific, important problems. This is particularly relevant in heterogeneous populations where the internal state of individuals varies greatly and is therefore unpredictably affected by external factors.

_Heterogeneity_

Penn is an extremely diverse community comprised of students from various cultures and backgrounds. This heterogeneity, something that Penn is celebrated and known for, has consequences which are extremely relevant in considering whether the current resources available at Penn are ultimately efficacious in helping students who are struggling with their mental health. Some people might be more or less willing to discuss mental health struggles not necessarily upon the basis of whether or not open discourse exists, but based on whether the discussion of mental health was something they were exposed to while growing up. The individual cultures and experiences that people of these heterogenous backgrounds have had affects their willingness to talk about mental health and mental health struggles. Because even with open discourse through events such as wellness weeks and Deconstructing the Penn Face, without the knowledge necessary to engage in such conversations, students might feel reluctant to participate.

If someone does not understand the importance of mental health, do they even recognize their struggle as a _mental health_ struggle? That could be helped through avenues such as CAPS? Or do they feel that whatever they are feeling and experiencing they just need to figure out themselves? What I have found through some of the interviews I have conducted and survey responses I have received throughout my research is that many of the students who do not consider their mental health paramount grew up in environments in which they were told to “buck up and figure it out.” They were told that they were lucky to have the opportunities that they did, and thus the idea of struggling with their mental health was trivialized. If you are of a
background in which mental health was never spoken about during your upbringing, you may not only have difficulty identifying your struggles, but the likelihood that you will see your difficulties as related to your culture or minority group status is diminished. Thus, participating in a survey, such as the one I circulated in 2019, does not seem relevant.

However, when asked directly in one-on-one interviews, students who identified with minority groups began to consider how and if these might be related, which resulted in not only interesting and personal, but extremely relevant findings in the context of mental health, stigmatization, and Penn Face. A student who identifies as Chinese-American explained that prior to coming to Penn, he did not realize the mental health struggles he had suffered throughout high school. He said that “looking back on it, I was just like ‘oh depression…anxiety disorders? That’s not me. That could never be me’” (Interview with Penn Student (B) 2019). And regarding mental illness, he was told that it didn’t exist, or “that doesn’t affect us.” If he tried to have a conversation with his parents about suicide, they would tell him “that's just ridiculous.” To them, such matters were not even concepts worth considering, and it was therefore not until coming to Penn that this student began to even contemplate such topics, let alone openly discuss them, because for most of his life conceptualizing and categorizing what he was feeling felt foreign. For such students, the ability to recognize a struggle as a mental health struggle or to engage in conversations regarding mental illness is compromised, which can affect one’s willingness to get help when he needs it. It is in situations like this that risk seems particularly high, because utilizing resources and getting help seems an impossibility.

**Vulnerability**

Vulnerability is another key component in assessing how students might best benefit from mental health resources while attending Penn. There may be particular hesitations to seek help and particular vulnerability for students who are from minority populations. My survey
results and interviews with individual students led me to believe that students may be especially vulnerable when one or more of the following factors are present: A situation in which there is a collectivist feeling of being representative of the family, such that admitting that one is struggling reflects poorly on one’s family or makes one appear weak. Very high academic ambition is also a factor, and may be particularly problematic when there is low Socioeconomic Status, putting even further pressure on the individual to succeed. So, there are high expectations and demands of success, and high expectations and demands that there be no problems that might interfere with particular notions of a successful college career and therefore future. Additionally, there is extra embarrassment if there should be any need for help with mental health struggles, because this was a topic that was often trivialized during upbringing.

It is important to note that in addition to the possible factors already mentioned, there are many others that are relevant, including whether or not one feels that he or she will be understood when receiving help. Members of minorities tend to be particularly concerned that they will be understood and feel included, and not further marginalized through asking for help. So, while I was mainly focused on geographic and ethnic minorities throughout my interviews, that concern, and therefore vulnerability, may perhaps apply to members of all types of minority groups, whether that be ethnic, sexual, religious, or otherwise. Because regardless of what minority or minorities that students might identify with, reluctance to seek help might exist for fear that they will be further marginalized or misunderstood. Finally, highly competitive, pre-professional environments, like Penn, may both increase the need for help and decrease the comfort with seeking it, which is an additional factor that must be considered regarding all Penn students. Results from the 2016, 2018, and 2019 surveys, as well as one-on-one interviews, considered below show the importance of discourse, heterogeneity, and vulnerability when
considering stigma, Penn Face, and mental health, particularly as it pertains to students who identify with various minority groups.

**Survey Results and Theory**

The ability to ground findings such as the ones of this survey in anthropology, sociology, and psychoanalysis provides validity and backing to the claims being made. The “most humanistic of the sciences and the most scientific of the humanities” (Wolf, 1964), anthropological theory allows broad responses to be analyzed and synthesized in a way that provides understanding beyond any one individual response. While each response is vital for the formation of these connections, together and with the framing of theoretical proposition they become even stronger when considering the implications of society’s influence on the individual. The results of this survey in their entirety can be found in the appendix. In this section, significant findings from the results and their connections to theory will be considered.

Many of the figures below combine results from questions that remained similar across all three surveys in order to compare results spanning the three years. In such instances, the results from the 2016 survey “Mental Health at UPenn” are first (top), followed by the results from the 2018 survey “Stigma and Mental Health at UPenn” (middle), and finally the results from the 2019 survey “Mental Health and Minority Groups on Penn Campus” (bottom). Some images combine questions similar across the 2018 and 2019 surveys; in such cases the 2018 results will be first (top), followed by the 2019 results. Additionally, questions unique to the 2019 survey will be considered separately in order to study more thoroughly results related to minority group status and willingness, or lack thereof, to seek help when it is needed.
These questions were included across all surveys to attain a general concept of the participant pool of each. **Year: (figure 1)** In 2016 there was a disproportionately high number of sophomore participants, which is what I was at the time this survey was circulated. This might allude to researcher bias in that more of my immediate peers who knew my name were willing to participate in my survey. This seems to be less of the case in the 2018 and 2019 surveys where response rate among each year is more equal. **Gender: (figure 2)** Proportions remain relatively constant across all surveys with a disproportionately high number of female participants relative to their male counterparts. This suggests that male students might be more reluctant to engage in discourse regarding mental health, but that is not the primary focus of my research. **Undergraduate School: (figure 3)** While each school (CAS, Wharton, Engineering, and Nursing) is represented throughout each survey, there is a higher rate of participation amongst the College of Arts and Sciences students. This might be attributed to its overall larger size in comparison to the other schools, but considerations of whether the other schools have increased competition or stigma associated with mental health struggles should be made.
Conclusive data percentages were difficult to amass for this question because it was open-ended, meaning that someone who identifies as white could have written “white,” “White,” or “Caucasian,” and someone who identifies as black could have written “black” or “African-American.” Across all three surveys, however, it is easily determined that there is a disproportionately high response rate amongst students who identify as white, which was the basis upon which I decided to pursue research specifically pertaining to minority groups at Penn.
These charts show the vast majority of students across all surveys report having known someone who has struggled with his or her mental health while at Penn, and/or have themselves experienced struggles with their mental health at Penn. Even though 70, or even 11, participants does not seem like many students in relation to the Penn undergraduate student body at large, findings such as these should not be taken lightly. It only takes one student deciding that he or she does not have the support he needs or ability to ask for help to render him hopeless and wanting to end his life. While Penn administration has made a concerted effort over recent years to improve access to mental health resources on campus, responses to other questions that will be considered show an apparent disconnect between these efforts and students actually feeling
This gap is what desperately needs to be bridged in an effort to save and better lives of the young adults at Penn who are on the often painstaking path of self-discovery.

**Do you feel that Penn does a good job of destigmatizing mental health issues?**

Across all surveys, only 27-29% of students indicated that “Yes,” they do feel that feel that Penn does a good job of destigmatizing mental health issues. In 2016 and 2018, over half of participating students chose a definitive “No.” While there is a marked decrease in “No” for the 2019 survey, responses still indicate a lack of clarity amongst students for this question, with multiple responses written in as “unsure.” And for one student in 2019, a simple “No” was not
enough to express his sentiments, and he chose to write in “Looooool no.” The overall decrease of a simple “No” in 2019 perhaps means that Penn administration has improved efforts in the past few years to destigmatize discourse around mental health struggles, but it is also important to consider how the smaller sample size of 2019 as compared to 2018’s or 2016’s could affect how the data is interpreted. Regardless, there is clearly still a noticeable gap between initiatives to destigmatize mental health struggles and student perceptions of whether this has been successful, indicating that potential improvements remain.

If you answered "no" to the above question, what problems do you think there are?

*Figure 7: Student opinions on problems associated with efforts to destigmatize mental health issues at Penn.*

As a follow up to “Do you feel that Penn does a good job of destigmatizing mental health issues?” this question was posed. In 2016, 94 out of 207 participants responded (45.5%), in 2018, 38 out of 70 responded (54.3%), and in 2019, 3 out of 11 responded (27.3%). Examples of the results for each year are as follows:

**2016 Responses**

- “Student health and CAPS are not sufficient resources for students with health problems, physical and mental, and have become the punch line of jokes on campus because of it. There's also a pervasive stigma associating mental health with ‘not being able to handle the pressure’. My friends in discussing this have said things like, ‘It just takes a certain type of person to be able to handle Penn,” and I think that's widely agreed upon on campus. There's a misconception that people who openly struggle with mental health issues just aren't cut out for this pressurized environment.”
“I think that Penn is afraid of admitting that it creates an environment that endangers students' mental health and as a result tries to brush things under the rug. Not admitting that students are struggling makes students feel more alone.”

“At this point I think Penn has a lot of initiatives in place to preserve mental health, but it's so difficult to get into Penn that most students have to develop unhealthy coping mechanisms/are driven to develop mental illnesses during high school, and then arrive at Penn having been self-stigmatizing or avoiding seeking help for years already.”

“My entire freshman year, ‘Call CAPS’ was a joke made whenever someone was being sensitive.”

“I feel like while there are initiatives being created, they need to be more preventative instead of reactive. The initiatives only come about after there are major issues, instead of beforehand to prevent them. I think having long-term programs for each class would ensure that the stigma starts to fade.”

2018 Responses

“I think that there is a stigma of going specifically to CAPS, like they’re not real psychologists”

“Some of their solutions seem to not really address the underlying problems. Making events with dogs or candy and changing Huntsman's hours do not really do much. That said, I think talking about the issue (which they do) is the first step and an important one.”

“People typically do lip service to destigmatization without actually trying to change anything, including students, faculty, and admin. Mental health resources
are atrocious and you can’t get a CAPS appointment if you’re not ‘depressed enough,’ something I personally experienced when I was first seeking help for my depression.”

• “I haven’t had trouble personally speaking up about my mental health conditions. But I’ve met many students who are really struggling and won’t even admit it to themselves, let alone their friends or family members. Whether this is due to Penn not doing enough or due to the ways in which depression changes one’s view of themselves is hard to say, but it’s probably both.”

• “Penn face” and a constant need to be the best. Extreme competition only makes it worse. No one wants to be viewed as weak here.”

• “One thing that perpetuates the stigma in my opinion is jokes about serious mental disorders ie suicide jokes, they trivialize mental illnesses and make them seem like an otherworldly problem that we - or at least some of us- don’t have to deal with but some of us do.”

2019 Responses

• “I think a lot more time could be put into resources and events dedicated to mental health so that it doesn’t seem like it just helps at a ‘surface level’.”

• “Too much damn work and not enough value.”

• “More student voices are needed. Also fix the caps website it’s confusing and intimidating.”
These results indicate that the majority of students, across all surveys from three years, would seek help under the pretense of hopelessness. It is my belief that no student should be pushed to this point before being willing to consider seeking help and making use of the resources available to them. The desire to appear strong, or “perfect,” supersedes one’s struggles.
It appears that for many students it is not until all hope seems gone, all hope of “fixing” whatever one is struggling with himself, that taking the step to get help from others seems a possibility.

**Are you aware of the mental health services available to Penn students?**

![Chart showing awareness of mental health services among Penn students.]

While nearly all Penn students who participated in these surveys seem to be aware of, or believe that they are aware of, the mental health services available to them on campus, responses to other questions indicate that most students do not feel that Penn administration has done enough to make students feel supported. This is particularly concerning in the context of minority students, because even if they are aware of the available mental health services, they can do nothing to help these students if they are reluctant to seek help.
Despite the fact that this question received 70 responses in 2018 and only 11 in 2019, there are still striking similarities amongst responses regarding “negative connotations” and stigma.

2018 Responses

- “A negative connotation or stereotype of a condition, group of people, or culture.”
- “Stigma refers a negative connotation associated with some concept or issue. For me, stigma usually causes a subject to become taboo and people to avoid addressing the subject.
- “To me, stigma means that there are negative connotations associated with suffering from mental health issues. These could be conscious or subconscious. They make people less likely to talk to their friends and loved ones when they are suffering from such issues.”

2019 Responses

- “Stigma refers to a negative connotation in a certain cultures norms. To me, stigma is when some people unnecessarily look down on others for some behavior or some part of their identity.”
- “I think it means negative connotation.”

When students feel that something about them might have a negative connotation in society, it might then be stigmatized. At a competitive, preprofessional school such as Penn, getting bad grades are stigmatized. And for some students, they feel that their mental health struggles might
be stigmatized and viewed as a weakness, perceived as an opportunity by their peers to “get ahead.” One student in 2018 responded:

- “It means that I feel like when I take time off to focus on me rather than rampant pre-professionalism, my friends look down on me and take my “weakness” as an opportunity to get ahead. It means my teachers don’t believe me when I tell them it’s hard to get out of bed in the morning because I don’t show that. **It means that it’s not normal to not be OK here.**”

In 2018, 81.4% expressed a belief that stigma, Penn Face, and mental health, are either completely or very related. Additionally, 15.7% reported that they are at least somewhat related. In 2019, 81.8% reported that stigma and mental health are either completely or very related, and

Figure 11: Relationship between stigma, Penn Face, and mental health.

In 2018, 81.4% expressed a belief that stigma, Penn Face, and mental health, are either completely or very related. Additionally, 15.7% reported that they are at least somewhat related. In 2019, 81.8% reported that stigma and mental health are either completely or very related, and
not a single participant stated that these facts are not very related at all. If this is the case, should Penn, and its students, be making a concerted effort to destigmatize differences on campus in an attempt to improve mental health? You would think that the obvious answer is yes, but society and its culture, once established, can be extremely pervasive as well as difficult to change.

Figure 12: Stigma’s role in the acknowledgement of and seeking help for mental health struggles (yes or no).

Following the above question, there was a staggering near unanimity amongst that students of both surveys that “Yes,” stigma plays a role in one’s willingness to acknowledge mental health struggles and seek help for them. While this is important information to have, findings throughout this research, particularly pertaining to members of minority groups, show that destigmatization of mental health struggles is not enough to prompt open discourse or willingness to seek help for some students. Self-advocation can prove a near impossible in an effort to seek help.
If you answered "yes" to the above question, what role do you believe it plays?

Figure 13: Stigma’s role in the acknowledgement of and seeking help for mental health struggles (open-ended).

2018 Responses

- “The stigma that surrounds mental health here is essentially that if you have mental health **problems you are weaker or incapable of being successful**. This makes people who struggle feel like nothing they’re feeling is valid and that it’s all because they’re just being **weak**
- “…I do not discuss my mental illness with anyone (aside from my therapist and psychiatrist) **due to fear of being stigmatized**.”
- “It prevents **people from seeking help**. Fear of what people think of you plays a large role, as one might view it as a reflection of your character in a bad light, or that you are lesser than. Especially in some **cultures**”
- “It’s quite hard to open up and talk about your challenges when people make lighthearted **jokes** about them every day and there’s a general atmosphere on campus that **taking care of yourself in any capacity is weak**. (I have heard my classmates say that taking less than five classes or sleeping through the night is pathetic & weak.)”
- “It makes some people scared of **the societal consequences of “coming out”** as mentally ill etc”
- “People here only value people they see as successful. **There’s a culture here where people don’t think mental illness and success can coexist**.”
- “I believe it makes people feel isolated in how they are feeling, and that it creates an environment where people feel they **need to hide** or not express
emotions and be honest, creating what we call “penn face” and a generalized environment that it is weak somehow to feel any form of emotions”

A more tailored question was asked in the 2019 survey which read: “If you answered "yes" to the above question, what role do you believe stigma plays, and is your minority group status a contributing factor? If you answered "no", what else might play a role?” Responses to this question will be considered in the next section.

2019: “Mental Health and Minority Groups on Penn Campus”

This survey was circulated in an effort to collect data for a more specific question: is there a relationship between minority group status and mental health which results in an even stronger reluctance to seek help for mental health struggles? Posted in the University of Pennsylvania Class of 2019, 2020, 2021, and 2022 Facebook groups, it included questions unique from those of the 2018 and 2016 surveys whose results are analyzed below.

Have you participated in either of the following surveys: "Mental Health at UPenn" (2016) or "Stigma and Mental Health at UPenn" (2018)

11 responses

Figure 14: Student participation overlap across various surveys.

The first question asked showed that the majority of students who participated in this survey (6/11) had not responded to either of my other two surveys, while two had responded to
both, and the final three could not remember whether or not they had. This means that for the six students that had not previously responded, something about the specificity of the question I was asking perhaps prompted them to participate. However, given the over lower sample size, it would seem that the notion, as previously considered, of asking particular questions can decrease willingness to participate. This might be attributed to students either being too uncomfortable to acknowledge the relationship between their minority group status and mental health, or because they do not see the relevance of such a question.

### Which minority group(s) do you identify with?

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<tr>
<th>11 responses</th>
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<tbody>
<tr>
<td>LGBTQ</td>
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<tr>
<td>lgbtq+</td>
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<tr>
<td>None</td>
</tr>
<tr>
<td>Jewish (not really a minority at penn though)</td>
</tr>
<tr>
<td>Low income</td>
</tr>
<tr>
<td>Black, mixed race, female, LGBTQ+</td>
</tr>
<tr>
<td>Women, Asian</td>
</tr>
<tr>
<td>None.</td>
</tr>
<tr>
<td>Indian and Jewish</td>
</tr>
<tr>
<td>Jew</td>
</tr>
<tr>
<td>Hispanic, LGBT, low income</td>
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*Figure 15: Minority group identification.*

The results of this question were very interesting, because the majority of students who participated identified with sexual or religious minority groups rather than ethnic minority groups. While my thesis aims to consider *all* minority groups and how they might affect one’s willingness, or lack thereof, to seek help for mental health struggles, much of my research has been primarily focused on the effect that membership to an ethnic minority group might have, on
the pretense that the culture associated with this group affected students’ upbringings and familiarity with topics surrounding mental health. The fact that only four of the participants included ethnic minority groups, coupled with the fact that each of these were people identify as *intersectional* minority group members, further promotes the notion that for many people establishing a correlation between *ethnic* minority group belonging and mental health was not something they were willing to do.

**Have you been hesitant to seek help for a mental struggles? Why or why not?**

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<tr>
<th>Response</th>
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<tr>
<td>Yes, because I did not find them helpful in the past, literally cannot find time w nursing workload and instructors will pass off stress as “preparing you for the real world”</td>
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<tr>
<td>I have been hesitant, but not because I am worried – more because I feel as if I am comfortable taking to friends and dealing with it on my own. Has not been much of a problem for me.</td>
</tr>
<tr>
<td>Yes. Hard to admit to myself that I need help</td>
</tr>
<tr>
<td>Not thinking anyone could help. Also not having time for it (even though it should be priority)</td>
</tr>
<tr>
<td>Yes; I felt that I would not be given help in a timely manner or that it would be very time consuming and cause me to miss out on other opportunities</td>
</tr>
<tr>
<td>I have been hesitant to seek help for mental struggles only because I did not know how to articulate my struggles into words, and oftentimes did not know whether I should “solve the problem myself” or ask someone for resources/advice.</td>
</tr>
<tr>
<td>I don’t think I’m good at asking for help with anything (homework, physical illness), so asking for mental health help is much harder.</td>
</tr>
<tr>
<td>Yes because it comes in waves so I get better for a bit then don’t feel the need to seek preventative mental health care.</td>
</tr>
<tr>
<td>Yes, afraid of showing weakness</td>
</tr>
</tbody>
</table>

*Figure 16: Hesitation to seek help for mental health struggles.*

Additionally, the majority of participants *are* hesitant to seek help. Whether it is because they do not think “anyone could help,” or are “afraid of showing weakness,” the idea of seeking preventative care for mental health struggles does not seem to be worth the time or effort it would take to engage campus resources such as CAPS.
This question was posed directly following the one considered above, and shows a desire to feel *cared* for. There is a difference between knowing that resources exist and feeling that someone is capable of understanding one’s struggles and will offer guidance in a helpful manner. To ask students what they “imagine” calling would feel like relates to psychoanalysis in that it asks students to introspectively reflect and consider how a situation might make them feel if it were to occur. One student expressed that “considering this makes me even more depressed because asking for help and not receiving it would confirm that no one cares.” If Penn’s mental health initiatives were working to the degree that they are meant to, no student should have to, for a second, contemplate whether or not he would be cared about if he needed help for mental health struggles. Again, there appears to be a gap between the aims of current initiatives and student sentiment.
If you answered "yes" to the above question, what role do you believe stigma plays, and is your minority group status a contributing factor? If you answered "no", what else might play a role?

11 responses

<table>
<thead>
<tr>
<th>Stigma plays a role because when we (low income students) got here, we weren't supposed to have emotional baggage. Somehow I wasn't supposed to be torn up by my parents' homelessness or the fact that I can't afford textbooks. Stigma is when my wealthy classmates don't understand that when I decline going out to dinner, it isn't out of lack of social interest but simply inability to participate.</th>
</tr>
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<tr>
<td>Stigma stops people from asking for help because they think they'll be looked down on or judged for doing so, or they have their own misconceptions of the process of asking for help. Being in a minority group (several) has helped me see that there is so much pressure from so many angles to be successful &quot;despite&quot; one's minority status that contributed to people's hesitance to be open.</td>
</tr>
<tr>
<td>Stigma plays a role because it mediates how conversation occurs; stigma sometimes stonewalls conversations because they are thought of as &quot;too difficult.&quot; As a result of these conversational barriers, people tend to want to place their troubles on the backburner, feeling like if no one talks about it, something is wrong with them or that help is otherwise unnecessary. Minority group status is a factor for many others, but not for me specifically.</td>
</tr>
<tr>
<td>People don't want the consequences of seeking help and being seen as subnormal.</td>
</tr>
<tr>
<td>My minority's group status doesn't contribute to stigma for me but for others, w especially Asian communities, cultural stigma plays a role</td>
</tr>
<tr>
<td>Barely anything to me</td>
</tr>
<tr>
<td>Stigma means that I couldn't ask people that were my peers for help or advice. Also Hispanic families don't often take mental health concerns seriously</td>
</tr>
</tbody>
</table>

Figure 18: Minority group status contribution to stigma associated with one’s willingness, or lack thereof, to acknowledge mental health struggles and seek help for them.

In 2019, this question was included following “Do you believe stigma plays a role in one's willingness to acknowledge mental health struggles or seek help for them?” which was also asked in 2018 (comparison considered in above section). For some participants, their minority status was not a contributing factor in their willingness to seek help for mental health struggles. However, specific minority groups, such as low SocioEconomicStatus, Asian, and Hispanic are mentioned as factors that might affect such willingness to seek help. Students of these minority groups, and others, are particularly vulnerable and at higher risk of not feeling as though the current resources available at Penn will be helpful to them. This is when personal factors affect the internal psychic state of individuals, because regardless of an understanding that resources exist there is a barrier to seeking treatment based on past experience.
If your minority group status is a contributing factor, how has your home culture affected (or not affected) this?

4 responses

| I am closeted at home so a huge part of my stress about my minority group factors into slipping up or what to do should I begin a relationship with someone of the same sex. |
| My home culture is pretty standard American poverty, I have no parental support and that has been a contributing factor. Ethnically I'm Jewish and the hardworking/self sacrificing culture has definitely contributed to my ability to get here (Penn) but also negatively to my mental health |
| My home culture hasn't really affected this. |
| My mental health was bad in high school but my parents just told me to get over it |

Figure 19: Home culture and acknowledgement of mental health struggles.

For the participants who explained how their minority group is a contributing factor of their willingness, or lack thereof, to seek help for mental health struggles, there is an apparent feeling of being unsupported. Whether that is due to their sexuality and fear will not be accepted by their family, as in the first response, or a general feeling of having to “get over it,” as in the last response, these students have been conditioned to conceal their struggles and not address them in a way that could be productive through the help of others.

Do you believe that Penn should tailor its mental health services for students of specific minority groups, or are the services provided by CAPS and Cultural Resource Centers sufficient?

11 responses

Figure 20: Student opinions regarding whether mental health services at Penn should be tailored.
Prior to this question, the question “Do you believe that Penn should tailor its mental health services for students of specific minority groups, or are the services provided by CAPS and Cultural Resource Centers sufficient?” was asked (Figure 20). 36.4% of participants responded, “No, services at CAPS and the Cultural Resource Centers are sufficient.” 9.1% of participants responded, “Not sure.” 54.5% of participants responded, “Yes, services should be tailored. For those who answered “Yes,” this question was asked so that students would have a space to consider what they believe would be helpful. There was a consensus that past experiences should be considered when providing help to students, because one method will not work for everyone. That is not to say CAPS does not already make an effort to do this, because its staff does. However, for students who are worried that they may not be understood, this can affect their willingness to seek help because it may not feel that the effort or time they put forth will be worthwhile.
On March 7th 2019, I met with Dr. Kumar, Executive Director at CAPS (Counseling and Psychological Services). She recounted her struggles upon coming to the United States from India in her twenties to pursue a graduate degree, calling it “a traumatic experience in some ways” (Kumar 2019). Yet, despite the psychical struggles she was facing, discussing this internal battle with her parents was an impossibility at times. She explained that India is “such a collectivist society. You do things for your family, you do things to make them happy,” and to tell them that she was having doubts about the choice she had made to leave home would only cause them distress.

When I asked Dr. Kumar whether she felt it was possible to discuss the struggles she was facing during her transition here with her parents, she explained “I could talk to them about the homesickness part of it, but… the other part of it was that they [her parents] didn’t really have the capacity to understand much of this [her mental health struggles]. So it’s sort of like you’re stuck a little bit.” Stuck. I imagine many students who identify with minority groups at Penn feel this way; a need for and wanting of assistance, while simultaneously being unsure of how to ask for it, wondering whether or not they will be understood or accepted if they do. Furthermore, they are left questioning whether or not doing so would be helpful or cause further damage. These are the internal struggles that many minority students struggle with, open discourse aside.

In our meeting, Dr. Kumar explained a new initiative that has been introduced at Penn: ICARE. “An interactive gatekeeper training for students, faculty, and staff that builds a caring community with the skills and resources to intervene with student stress, distress, and crisis” (https://www.vpul.upenn.edu/caps/icare). While this is a great step towards creating awareness about the types of mental health struggles students might face and equipping various members on Penn Campus to have the capacity to intervene in challenging situations, this is only effective so far as students are willing to go out of their way to discuss what they are enduring internally. For
many, this choice to talk is the ultimate battle. Doing so goes against what many minority students’ cultures have taught them to do if they are struggling. What if this choice to talk, a sort of middle man in the process of struggling and getting help, was removed? This is my proposition for preventative action to ensure that students feel they have access to resources without having to choose to utilize them.

**Looking Forward: The Era of “Mental Health Advisors”**

“I feel like while there are initiatives being created, they **need to be more preventative** instead of reactive. The initiatives only come about after there are major issues, instead of beforehand to prevent them. I think having **long-term programs for each class** would ensure that the stigma starts to fade.” -Anonymous Penn Student, 2016 survey response

This was a student’s answer in response to “If you answered ‘no’ to the above question, what problems do you think there are?” The “above” question was “Do you feel that Penn does a good job of destigmatizing mental health issues?” A preventative, long-term program is what I propose through the addition of mental health advisors.

When I began this research, I considered whether Cultural Resource Centers (PAACH, La Casa Latina, Makuu, LGBT Center, etc.) could begin to serve as spaces in which topics surrounding mental health would be discussed with and introduced to students of backgrounds and cultures that did not consider the topic of mental health during upbringing. My thought was that perhaps in these safe spaces it would be easier to become comfortable with something they were not used to discussing, something that was therefore inherently **uncomfortable**. The reality, however, is that very few students who participated from my survey identify with a CRC on campus, let alone use such spaces as a means by which to seek help should they need it.
While, granted, the sample size of this survey is small and perhaps not indicative of the number of Penn students who actually utilize these spaces for discussions regarding mental health, this still did not seem like the prevention solution I was looking for.

The act of seeking help, of going “out of one’s way,” to confess one’s struggles with mental health, is often taboo and incredibly difficult to do. I don’t know that it is practical, but my proposed solution to this conundrum of reluctance to seek help is as follows: the addition of “mental health advisors” at Penn. All students have academic advisors, and until you declare your major you have to meet with your academic advisor to get taken off of academic hold to
register for classes. Because each student is required to see his or her academic advisor, it is completely destigmatized; there is no fear that peers might conclude that you are struggling academically because of this meeting and therefore stigmatize you for it, because, regardless of academic success, or lack thereof, everyone must go. I believe that having students see their academic advisor freshman and sophomore year not only destigmatizes these meetings, but also opens the door for your junior year and senior year to keep checking in. You have gotten into the routine of going, so perhaps you will continue to do so because it feels safe and comfortable.

While I understand that Penn is a highly competitive, preprofessional school, and that grades matter, I am still left wondering: why, if we have academic advisors, can't we have mental health advisors? Perhaps it is only mandatory for freshman year, but say freshman year, for 10 minutes or so a semester, everyone had to meet with a mental health advisor whose job it is to see how students are adjusting to the transition into college, to learn how they are actually doing, classes and academics aside, and to guide them through the mental health resources available on campus should they feel that they need them. In having everyone go, the stigmatization around getting help that students often feel when going to CAPS is removed, because it is not as if one is going because he is necessarily struggling with his mental health, he is going because everyone has to go. And if a student is struggling, he has a safe space, unattached from his academics, to learn about the resources that could be helpful to him.

When asked “How are you doing?” by his mental health advisor, there might be a student who exclaims “I'm fine! I'm loving it. College is great,” and he might genuinely mean it. There could be another student who sits in the meeting and says “uhhh, yeah, I’m fine! Things are going well.” And while he might not actually feel that way or believe it, he is not comfortable talking about it, which is also fine. And then there also might be a student who looks at his mental health advisor and for the first time feels genuinely cared about, self reflects, and says
“actually, you know, I'm not doing too well.” Even if the final scenario is only 1 in 500 students, someone has just received intervention much sooner than they likely would have. And in the case of the second situation, even if a student is not comfortable in that moment sharing what he or she is struggling with internally, at least he is aware that there is someone who cares about his mental wellbeing and is now familiar with the resources available should he decide to use them. When asked about this idea in one-on-one interviews, these were some of the sentiments that Penn undergraduates of various genders, ethnicities, and years shared:

A sophomore female in the College of Arts and Sciences who identifies as Hispanic communicated that it would be helpful to have a separation between “academics and the mental,” as she put it. She explained that, “as Penn students, and how academically driven we are, the thought of telling our academic advisor, who’s clearing us for making these schedules can be very intimidating. So, having someone who is not here to tell you what classes you can and cannot take based on what you just said about your mental health would be useful.” Also, regarding available resources, she noted that having to search online can be a deterrent in seeking help. She explained, “Nobody’s actually going to do that. Unless it's this dire, dire need. But if you have somebody telling you ‘this is what we have,’ somebody who takes the time to tell you and show you, that could help.”

A senior male in the School of Engineering who identifies as white and Hispanic explained, “Yeah, I think that's a great idea. I think I would have 100% gotten help a lot quicker. I think your idea is awesome. I totally agree. I think that would be dope. And it would have completely helped my issue a lot earlier on. I also think that another issue is, I didn’t want to think financially either, I didn’t want to deal with insurance or any of that stuff. And I think if I had to meet with someone who had laid out all the information in front of me, without me having to think about it, that would be very helpful too. Because it's not something I like to think about.”
A senior male in the College of Arts and Sciences who identifies as Chinese-American said, “I think it’s worth it. Honestly, I agree with you…I definitely agree there are a lot of people who are, you know, just so subsumed by campus culture, which I think to an extent silences these issues, right? You work as hard as you can, you know, ‘work hard play hard’ and there’s no space for complaining I think. Like, just grit your teeth and, you know, do it right. I think that's actually, that's a concept in Chinese culture too. To basically like bite your teeth. Or like ‘to eat bitterness’ is actually what it’s called in Chinese…but that's not something we talk about. We never put health first.”

A senior female in the College of Arts and Sciences who identifies as African-American and Hispanic responded, “I think that's like a really good idea because even though there are so many resources that are already around, having it [mental health advisor meetings], like you said just be a thing that everyone does, and everyone has to do. And just checking in, I think would be really helpful for students. Especially those who don't have much experience with talking about their feelings, or just what they're going through. Because just having like, I think adding mental health professionals into the lives of anyone, but especially students, like younger students in particular is, I think, really beneficial. Yeah, so it think it’s a really good idea.”

Overwhelmingly positive opinions from each of these students, my belief that this initiative could be helpful to Penn students was only amplified. Conversations such as these highlight the importance of helping students to understand and believe how invested Penn, the administration, the professors, are in not only the academic success of students, but also in their mental health experiences while attending Penn. Mental health advisors could serve as the general basis upon which to ensure that all students do and feel that they do have access to resources meant help with mental health struggles. Because as I have considered, findings
suggest that students are usually more comfortable approaching topics in a general fashion that feels relatable to their peers.

**Conclusion**

Mental health is a topic that has been stigmatized throughout history and its related struggles will not be destigmatized in the near future. However, the survey responses show a desire by students to move towards a more supportive environment with the hope of fostering a community in which asking for support for mental health struggles is not viewed as a weakness. If this hope becomes a reality, those struggling with their mental health will feel comfortable enough to speak about what they are going through and seek help before it is too late.

While my research focuses on the stigmatization of mental health on Penn’s campus and the term “Penn Face,” it is important to realize that this is not an issue specific to Penn. Mental health is stigmatized globally, and there are countless people who feel the need to put on the façade of being okay when in reality they are not. Recognizing this universality emphasizes the importance of addressing such topics and fostering an open discourse that does not immediately result in stigmatization that affects life chances and opportunities. The fear of not being treated in the same manner as one’s peers or of not conforming to one’s cultural ideals is often the reason behind why one attempts to mask what he is enduring. Until mental health struggles cease to be regarded as a brand of weakness, people will continue to hide and silently suffer in an attempt to conform to the culture in which they live.

Through conducting research and sharing its results, my goal is to advance changes around campus to stop student suicide, promote inclusivity, and ensure that if someone feels that he needs help he is able to receive it. As considered, certain groups of students at Penn, particularly those of minority backgrounds in which mental health was not a concept during upbringing, are particularly vulnerable in the context of mental health struggles and their
willingness, or lack thereof, to seek help when it is needed. The role of culture in this barrier to treatment cannot be undermined, because without its consideration the most efficacious action to providing resources will not be achieved. It is the responsibility of Penn Administration, Penn’s faculty, its students, and the families of its students alike to make an effort to change the toxic environment in which many students feel that they are forced to live.

Considerations through the lens of anthropological, sociological, and psychoanalytic theory grounds the topics of mental health and stigma in conversations that have been occurring for hundreds of years. And while there is still work to be done, these discussions have experienced a marked shift in discourse from the time of Freud, Lévi-Strauss, Durkheim and others. So, while there remain barriers within the Penn community to achieving open discourse and willingness to seek help for mental health struggles, it is the duty of those interested in culture and social theory to use their knowledge to buttress considerations surrounding these topics.
Appendix 1: “Mental Health at UPenn” (Fall 2016 Survey)

Below are all of the questions included in the survey in addition to the breakdown for each question. Total Participants: 207.

**A selection of “open-ended” responses will be considered here for reference; some are expanded upon more thoroughly within the body of the paper.**

1. **Year**
   - Freshman: 1.9% (4 responses)
   - Sophomore: 58% (120 responses)
   - Junior: 7.2% (15 responses)
   - Senior: 32.9% (68 responses)

2. **Undergraduate School** (multiple choice) (required)
   - CAS: 58.5%
   - The Wharton School: 18.4%
   - Penn Engineering: 16.4%
   - School of Nursing: 6.8%

3. **Intended Major** (short answer)
   - Conclusive data percentages were challenging to amass because it was a written in answer (i.e. PPE could also be written in as Philosophy, Politics, and Econmoids”)

4. **Gender** (M/F/other)
   - Female: 72%
   - Male: 28%

5. **Race** (short answer)
   - Conclusive data percentages were challenging to amass because it was a written in answer (i.e. someone who is white could have written “white,” “White,” or “Caucasan,” or someone who is black could have written “black” or “African-American.” Even though for the purpose of my data these would be grouped together the survey did not do this.
   - Important takeaway: Over 50% of the responses came from white participants.

6. **“Have you known someone who has struggled with mental health at Penn?”** (Y/N) (required)
   - Yes: 95.7% (198 responses)
   - No: 4.3% (9 responses)

7. **“Have you struggled with mental health at Penn?”** (Y/N/I’d rather not share) (required)
   - Yes: 79.3% (153 responses)
   - No: 24.6% (51 responses)
   - I’d rather not share: 1.4% (3 responses)

8. **“Have you heard of the term ‘Penn Face’?”** (Y/N) (required)
   - Yes: 95.7% (198 responses)
   - No: 4.3% (9 responses)
9. “If you answered ‘yes’ to the above question, what does it mean to you?” (open ended)
   • 178 responses where Penn undergrads explained what “Penn Face” means to them.
   • “It means pretending like everything's ok to look better to others”
   • “It means working while ignoring the feelings of exhaustion and pointlessness because other people seem to function similarly.”
   • “Acting like everything is okay when it's really not”
   • “A facade to hide struggling”
   • “Covering up depression”
   • “The front Penn students put on to appear as if they are perfect and have everything under control”
   • “Pretending to have it all under control while secretly struggling, comparing yourself to your successful peers, etc”
   • “trying to seem perfect while dying on the inside”
   • “Penn student in some sort of distress but doesn't let their exterior show it so they aren't judged by other students in a very preprofessional and competitive environment.”
   • I means the tendency for Penn students to pretend nothing is wrong out of fear of judgment”
   • "Penn Face" is the idea that you have to be okay all the time. There is this relentless pressure to be good at everything and to do a million things. Literally sometimes I feel bad if I don't have work for a night because of the glorification of being busy. For some reason, the culture here is such that you are supposed to spend all your time keeping busy, and if you aren't constantly busy (or at least acting like you always have so much to do) there's something wrong with you.”

10. “Do you think having a term like ‘Penn Face’ helps to create an open discourse about mental health at Penn?” (Y/N/Other) (required)
    • Yes: 42.5%
    • No: 43.5%
    • Other: 14%

11. “Do you feel that Penn does a good job of destigmatizing mental health issues?” (Y/N/Other) (required)
    • Yes: 29.5%
    • No: 56%
    • Other: 14%

12. “If you answered ‘no’ to the above question, what problems do you think there are?” (open ended)
    • In other words, what are the problems at Penn that lead to mental health stigmatization? 94 people responded to this question.
    • “Because we all put on Penn Face, none of us really have open, unbridled conversations about mental health issues.”
• “There are not enough resources for students to get help with their mental health and the hyper-competitive, image heavy environment makes students unable to show any kind of weakness”
• “You can be taught again and again to not stigmatize mental health but as long as the glorification of unhealthy lifestyles continues so will the glorification of mental health issues.”
• “My entire freshman year, "Call CAPS" was a joke made whenever someone was being sensitive.”
• “This is still a very competitive, pre-professional school so no matter how much Penn talks about mental health issues, it all seems pretty fake if they're still allowing for students to be taking multiple exams in one day. There have also been 12 suicides at Penn in the last four or so years so there's still a big problem.”
• “I wouldn't feel comfortable telling a friend I was ‘depressed.’”
• “normalization of Penn face”
• “students are aware of mental health issues on campus but they cannot really escape them because of the inherently competitive/unwelcoming atmosphere on campus. Also CAPS is not as efficient as it should be”

13. “If you were concerned about yourself, you would seek help if you” (can select multiple choices) (required)
  • felt stressed: 21.7% (45 responses)
  • couldn't focus: 21.7% (45 responses)
  • had increased sensitivity: 13% (27 responses)
  • felt hopeless: 68.6% (142 responses)
  • felt alone: 47.3% (98 responses)
  • I would not seek help on campus for my mental health: 25.1% (52 responses)
  • Other: 7.2% (15 responses)

14. “Are you aware of the mental health services available to Penn students?” (Y/N/Other) (required)
  • Yes: 92.3% (191 responses)
  • No: 3.4% (7 responses)
  • Other: 4.3% (9 responses)

15. “Is there anything you would like to share about your experience with mental health at Penn?” (open ended)
  • 74 responses
  • “I've struggled with my mental health many times and have never reached out to any of the resources at Penn because I've heard they are incredibly insufficient and do not help.”
  • “Penn is an unforgiving place to be recovering from a mental health disorder. While conversation does occur, often it normalizes behavior that should be highlighted and should be addressed. I have struggled with depression/anxiety since high school and knew what I was getting into when I came to Penn, but at every turn, no matter how ready I feel, it is always harder than I expect. As much as I know amazing loving and caring people at Penn, there is a competitive environment deeply engrained. That mixed with constant high stress demands make it a difficult place for someone with an illness (of
ANY kind) to succeed. I returned to school this fall after a brief stay at a psych hospital this summer much more stable than I had been but still in the fragile stages of recovery, and I honestly feel like I am being tested and pushed to my limits most days.”

- “I couldn't get an appointment with CAPs when I needed it because of a weeks long wait list”
- “I've found CAPS to be the antithesis of helpful - in fact, I feel as though CAPS actually made things worse”
- “My aunt asked me over break if I was under enough pressure to kill myself, because Penn has had so many suicides due to academic pressure.”
- “Penn's isolating and high-stress culture definitely exacerbated my situation, but I learned a lot from it and was able to find the silver lining. If I were to do it over again, I don't think I would come to Penn. I am not pre-professional and not fitting in with the culture has been quite harmful. I will be looking for different culture post-grad.”
Appendix 2: “Stigma and Mental Health at UPenn” (Fall 2018 Survey)

Below are all of the questions included in the survey in addition to the breakdown for each question. Total Participants: 70.

**A selection of “open-ended” responses will be considered here for reference; some are expanded upon more thoroughly within the body of the paper.

1. **Year** (required) (multiple choice)
   - Freshman: 24.3% (17)
   - Sophomore: 14.3% (10)
   - Junior: 35.7% (25)
   - Senior: 25.7% (18)

2. **Undergraduate School** (required) (multiple choice)
   - CAS: 60% (42)
   - The Wharton School: 12.9% (9)
   - Penn Engineering: 14.3% (10)
   - School of Nursing: 11.4% (8)
   - Other: 1.4% (1)

3. **Intended Major** (open-ended short answer)
   - Conclusive data percentages were difficult to get for this question because it was a written-in answer (i.e. someone could have written “BBB,” “Biological Basis of Behavior,” or “Neuroscience”), so while for the purpose of my results these data would be grouped together, the survey algorithm does not do this.

4. **Gender** (multiple choice)
   - Female: 68.6% (48)
   - Male: 30% (21)
   - Other: 1.4% (1)

5. **Race** (open-ended short answer)
   - As was the case of the “Intended Major” question, data for this was difficult to conclusively get percentages for because it was also a written-in answer (i.e. someone who is white could have written “white,” “White,” or “Caucasian,” or someone who is black could have written “black” or “African-American”).
   - Important takeaway: majority white participants

6. **Have you known someone who has struggled with mental health at Penn?** (required) (multiple choice)
   - Yes: 92.9% (65)
   - No: 7.1% (5)

7. **Have you struggled with mental health at Penn?** (required) (multiple choice)
   - Yes: 82.9% (58)
   - No: 15.7% (11)
   - I’d rather not share: 1.4% (1)

8. **Please explain what ‘stigma’ is and what it means to you.** (required) (open-ended short answer)
“Stigma is the negative association by members of society about a specific identity. In this case, this negative energy is associated with mental illness or psychological distress, perhaps especially for those who seek out help or are diagnosed. It places them along the spectrum of societal norms as deviants, which although might be true, is not always viewed positively or with support.”

9. “To what degree do you think stigma and mental health are interrelated?”
   (required) (multiple choice)
   - Completely Related: 27.1% (19)
   - Very Related: 54.3% (38)
   - Somewhat Related: 15.7% (11)
   - Not Very Related: 2.9% (2)
   - Not Related at All: 0% (0)

10. “Do you believe stigma plays a role in one’s willingness to express mental health struggles?”
    (required) (multiple choice)
    - Yes: 98.6% (69)
    - No: 1.4% (1)

11. “If you answered ‘yes’ to the above question, what role do you believe it plays?”
    (open-ended short answer)
    - “…I do not discuss my mental illness with anyone (aside from my therapist and psychiatrist) due to fear of being stigmatized.”
    - “It prevents people from seeking help. Fear of what people think of you plays a large role, as one might view it as a reflection of your character in a bad light, or that you are lesser than. Especially in some cultures”

12. “Do you feel that Penn does a good job of destigmatizing mental health issues?”
    (required) (multiple choice)
    - No: 52.9% (37)
    - Yes: 28.6% (20)
    - Other: 18.5% (13)

13. “If you answered ‘no’ to the above question, what problems do you think there are?”
    (open-ended)
    - In other words, what are the problems at Penn that lead to mental health stigmatization?
    - “I think that people want to put their best self out there, and so mental health issues take the back burner usually. People aren't open!”
    - “Honestly, I don't know what else Penn can do as an institution, but there is clearly a culture at Penn that glorifies de prioritizeing self-care in favor of academic/professional success.”
    - “Stigma is so ingrained in the culture of Penn.”

14. “Why do you think these problems exist?”
    (open-ended short answer)
    - “Extreme SES gaps, lack of knowledge regarding mental health in general, hyper competitive cultures.”
    - “It is hard to change something so widespread and prominent in Penn's culture.”
    - “Society.”
• “The problem exists because we inherently yearn for a sense of meaning, whether it be in our accomplishments (academic, professional, social, etc.) and contributions to society. Our concept of self can be very fragile, and healing is not something that we can expect from the university.”

• “The desire to project happiness and positivity at all times.”

  i. Desire to showcase your “best” and “strongest” self... you have to be okay → Penn Face.

15. “If you were concerned about yourself, you would seek help if you” (required)
(checkboxes: can select multiple choices)

  • felt stressed: 22.9% (16)
  • couldn't focus: 24.3% (17)
  • had increased sensitivity: 15.7% (11)
  • felt hopeless: 61.4% (43)
  • felt alone: 41.7% (33)
  • I would not seek help for my mental health: 12.9% (9)
  • I would not seek help *on campus* for my mental health: 25.7% (18)
  • Other: 8.5% (6)

16. “Are you aware of the mental health services available to Penn students?” (required) (multiple choice)

  • Yes: 90% (63)
  • No: 5.7% (4)
  • Other: 4.2% (3)

17. “If you feel comfortable, please share your experience with mental health and stigmatization at Penn.” (open-ended)

  • “As I’ve mentioned throughout the above questions, I am someone who has dealt firsthand with mental illness and feared stigmatization while at Penn. I don’t blame Penn at all for my depression as it has been a long term struggle, but I am angry and disappointed for the way that Penn refuses to supply CAPS with even close to the bare minimum to provide care for students. In a drop in assessment there last fall when I was first seeking help, I was told to “think positively,” which is not really a helpful treatment for Major Depressive Disorder and left me feeling like a failure for not being able to be happy. I also was unable to book an appointment within three months, even though I mentioned that I had been dealing with escalating self harm throughout the semester. I am fortunate enough to have the financial resources to pay for private therapy and psychiatric services, so I am doing much better now. However, I still struggle with stigma and am so scared of what people will think that I have not told anyone (even my parents or brothers) about my mental illness. Especially at Penn, people value being strong and being able to go 100% on everything you do, so mental illness is still seen by many as a weakness.”

  i. I decided to include this response because its length shows the amount of time students were willing to put forth to express their experiences regarding mental health and stigma while attending Penn. This is important because it is not a lack of effort or wanting to share, it is a fear of being looked down upon or nonconforming of
cultural norms of being “okay” that prevent people from sharing their struggles.

- “I've found that within certain communities I've been in, **what holds interactions/ relationships together is the idea of being efficient and functional.** Thus, it is difficult for others to go beyond small talk or comments about what you've accomplished or what your goals are, to discuss emotional matters (let alone struggles with terrible memories, fears about the future, etc.).”

18. **“Is there anything you would like to add?”** (open-ended)

- **“The culture is toxic** and the institutions that are supposed to care for us are making us afraid.”
- “Thanks for **giving me a place to tell my story**, and I hope it can give some insight into an experience.”
- “Six penn students committed **suicide** from 2013-2014 and all penn has done is close huntsman earlier bye”
Appendix 3: “Mental Health and Minority Groups on Penn Campus” (Spring 2019 Survey)

Below are all of the questions included in the survey in addition to the breakdown for each question. Total Participants: 11.

**A selection of “open-ended” responses will be included for questions not discussed more thoroughly in the body of the paper.

1. **Have you participated in either of the following surveys: "Mental Health at UPenn" (2016) or "Stigma and Mental Health at UPenn" (2018) (multiple choice)**
   - Yes, "Mental Health at UPenn": 0%
   - Yes, "Stigma and Mental Health at UPenn": 0%
   - Both: 18.2% (2)
   - Neither: 54.5% (6)
   - I can't remember: 27.3% (3)

2. **Year** (multiple choice) (required)
   - Freshman: 27.3% (3)
   - Sophomore: 18.2% (2)
   - Junior: 18.2% (2)
   - Senior: 36.4% (4)

3. **Undergraduate School** (multiple choice) (required)
   - College of Arts and Sciences: 36.4% (4)
   - The Wharton School: 18.2% (2)
   - Penn Engineering: 27.3% (3)
   - School of Nursing: 18.2% (2)

4. **Intended Major** (open-ended)
5. **Gender** (multiple choice) (required)
   - Male: 27.3% (3)
   - Female: 72.7% (8)
   - Other: 0%

6. **Race/Ethnicity** (open-ended)
   - Asian/Chinese: 22.2% (2)
   - Black/Mixed Race: 11.1% (1)
   - Hispanic/White: 11.1% (1)
   - White: 55.5% (5)

7. **Which minority group(s) do you identify with?** (open-ended) (required) (*some students are intersectional and are considered in multiple groups)
   - LGBTQ: 36.4% (4)
   - Jewish: 27.3% (3)
   - Female: 18.2% (2)
   - Low Income: 18.2% (2)
   - None: 18.2% (2)
   - Indian: 9.1% (1)
   - Black/Mixed Race: 9.1% (1)
   - Hispanic: 9.1% (1)
8. **When did you begin to identify with this group(s)?** (open-ended) (required)
   - I always have: 36.4% (4)
   - Elementary/Middle School: 9.1% (1)
   - High School: 9.1% (1)
   - At Penn: 27.3% (3)
   - Other: 18.2% (2)

9. **What factors are you aware of that have influenced your identification(s)?** (open-ended)
   - “primarily just lgbtq+ peers”
   - “I’m from a place with few Jews”
   - “Being on free/reduced lunch, being nearly homeless several times”
   - “Social media, friends, representation on campus”
   - “n/a”
   - “Being biracial”
   - “My family and their income”

10. **Which (if any) Penn Cultural Resource Centers do you associate with?** (multiple choice) (required)
    - Pan-Asian American Community House (PAACH): 0%
    - The Center for Hispanic Excellence (La Casa Latina): 9.1% (1)
    - The Black Cultural Center (Makuu): 0%
    - Lesbian, Gay, Bisexual, Transgender Center (LGBT Center): 18.2% (2)
    - None: 72.7% (8)
    - Other: 9.1% (1)

11. **Have you known someone who has struggled with mental health at Penn?** (multiple choice) (required)
    - Yes: 90.9% (10)
    - No: 9.1% (1)

12. **Have you struggled with mental health at Penn?** (multiple choice) (required)
    - Yes: 81.8% (9)
    - No: 18.2% (2)
    - I'd rather not share: 0%

13. **Have you been hesitant to seek help for a mental struggles? Why or why not?** (open-ended) (required)

14. **What do you imagine it would be like to call and ask for help? And what sort of feelings arise when you consider this?** (open-ended) (required)

15. **Please explain what "stigma" is and what it means to you.** (open-ended) (required)

16. **Please explain what "Penn Face" is and what it means to you.** (open-ended) (required)

17. **To what degree do you think stigma, Penn Face, and mental health are interrelated?** (multiple choice) (required)
    - Completely Related: 18.2% (2)
    - Very Related: 63.6% (7)
    - Somewhat Related: 18.2% (2)
• Not Very Related: 0%
• Not Related at All: 0%
• Other: 0%

18. Do you believe stigma plays a role in one's willingness to acknowledge mental health struggles or seek help for them? (multiple choice) (required)
   • Yes: 100% (11)
   • No: 0%

19. If you answered "yes" to the above question, what role do you believe stigma plays, and is your minority group status a contributing factor? If you answered "no", what else might play a role? (open-ended) (required)

20. If your minority group status is a contributing factor, how has your home culture affected (or not affected) this? (open-ended) (required)

21. Do you feel that Penn does a good job of destigmatizing mental health issues? (multiple choice) (required)
   • Yes: 27.3% (3)
   • No: 9.1% (1)
   • Other: 63.6% (7)

22. If you answered "no" to the above question, what problems do you think there are? (open-ended)

23. Have any of Penn's Cultural Resource Centers helped you in navigating any mental health struggles you have experienced as a student? (multiple choice) (required)
   • Yes: 9.1% (1)
   • No: 81.8% (9)
   • Other: 9.1% (1)

24. How have they helped or not helped? (Feel free to be broad and/or specific here; e.g., group meetings with people who you feel can relate to your experiences, therapy sessions with a member of your minority group, a safe space to be open, etc.) (open-ended) (required)
   • “I have not felt a compulsion to use these resources.”
   • “I've just never sought it out, I identify as LGBTQ+, but don't explore the community much”
   • “Have not sought help”
   • “Haven't tried to use them”
   • “I saw a first generation/low income therapist at CAPS. It helped that she was familiar with some of my experiences”
   • “Safe space to be open, place to just hang out when I need it and where I know there are people who care about me”
   • “I have never really turned to these organizations for help; I find that while I identify with minority groups, their personal values are rather different from mine and I derive satisfaction and joy from other sources of identity.”
   • “Haven't really found a space”
   • “NA”
   • “Eh”
   • “Haven’t asked”
25. You would seek help if you: (multiple choice) (required)
   - felt stressed: 27.3% (3)
   - couldn't focus: 27.3% (3)
   - had increased sensitivity: 27.3% (3)
   - felt hopeless: 72.7% (8)
   - felt alone: 63.6% (7)
   - I would not seek help for my mental health: 18.2% (2)
   - I would not seek help *on campus* for my mental health: 9.1% (1)
   - Other: 9.1% (1)
     o  “felt unable to cope.”
26. If you checked "I would not seek help *on campus* for my mental health" please elaborate if you feel comfortable doing so. (open-ended)
   - “I’ve heard horror stories about CAPS and would only get help as a last resort if I was going to hurt myself or others”
27. Are you aware of the mental health services available to Penn students? (multiple choice) (required)
   - Yes: 100% (11)
   - No: 0%
28. If you answered "yes" to the above question, what services are you familiar with? (open-ended)
   - “https://www.vpul.upenn.edu/caps/”
   - “caps, peer benjamins”
   - “Familiar with CAPS, phone number to reach them”
   - “Caps, penn bens, reach a peer helpline, penn wellness, chaplains office”
   - “CAPS, SIS, clubs such as Penn Benjamins”
   - “CAPS, SHS”
   - “CAPS, VPUL, Student Intervention Services, Penn Benjamins, RAP Hotline, etc.”
   - “Caps , reach a peer”
   - “CAPS”
   - “Caps, benjamins”
   - “Caps”
29. Do you believe that Penn should tailor its mental health services for students of specific minority groups, or are the services provided by CAPS and Cultural Resource Centers sufficient? (multiple choice) (required)
   - Yes, services should be tailored: 54.5% (6)
   - No, services at CAPS and the Cultural Resource Centers are sufficient: 36.4% (4)
   - Other: 9.1% (1)
30. If you answered "yes" to above question, in what ways do you believe services should or could be tailored? How and why would this be helpful? (open-ended)
31. If you feel comfortable, please share your experiences with mental health and/or its stigmatization at Penn. (open-ended)
   - “The groups most vulnerable to mental health issues are the very ones that believe it is a big problem. I believe the causality runs both ways.”
• “There's a lot to type from shs thinking nothing of laxative use to peer harassment about mental health, not being taken serious about sexual assault, and I have lots of feelings on the sexual assault climate survey that Penn sent out.”
• “I have a mental health condition called misophonia in which the sound of chewing gives me panic attacks (google it!) and i encounter many people who don’t believe me or make fun of me because the issue is relatively unknown”

32. **If you would be willing to be interviewed personally to provide more qualitative data for my study, please include your name, phone number, and email below.** Thank you! (open-ended)

33. **Is there anything you would like to add?** (open-ended)
References Cited


