

# ATTITUDES TOWARD MENTAL HEALTH PROBLEMS AND HELP-SEEKING INTENTIONS AMONG COLLEGE STUDENTS

Maria Cecilia L. Pangan

University of Science and Technology of Southern Philippines, Lapasan Highway, Cagayan de Oro City, Philippines

For correspondence: +63 917 773 2647; [cez\\_zil@ustp.edu.ph](mailto:cez_zil@ustp.edu.ph)

Date of publication: 27 July, 2026

**ABSTRACT:** This cross-sectional correlational study examined college students' attitudes toward mental health problems, intentions to seek help, their association, and differences by sex. A proportionally allocated sample of 281 students from five colleges at a private non-sectarian University in Cagayan de Oro City completed the 35-item Attitudes Toward Mental Health Problems Questionnaire and the General Help-Seeking Questionnaire. Descriptive statistics, Pearson correlation, and independent-samples *t* tests were used. Students perceived community attitudes as predominantly negative or very negative (74.02%), while family attitudes were more favorable (53.74% positive or very positive). Intentions were highest for mental health professionals for personal/emotional problems ( $M=4.79$ ) and suicidal thoughts ( $M=4.48$ ), followed by intimate partners and friends. More negative attitude scores were weakly associated with lower help-seeking intentions ( $r=-0.168$ ,  $p=.005$ ). Attitude scores differed by sex ( $t=-1.73$ ,  $p=.043$ ), whereas help-seeking intentions did not ( $t=-0.26$ ,  $p=.798$ ). The findings indicate that willingness to use professional care can coexist with perceived community stigma. Universities should therefore combine confidential, low-threshold counseling and clear crisis pathways with sustained stigma-reduction, peer gatekeeper, family-engagement, and sex-responsive programs. Results are limited by the single-institution, cross-sectional design, unequal sex distribution, and use of intentions rather than verified service utilization.

**Keywords:** college students; help-seeking intentions; mental health; Philippines; stigma

## INTRODUCTION

Mental health is integral to learning, functioning, and social participation, yet mental disorders remain common and undertreated among young people. The World Health Organization estimates that one in seven adolescents experiences a mental disorder and identifies stigma, exclusion, and limited service access as major impediments to care [1]. A 2025 meta-analysis similarly found that only about half of college students with a mental health condition intended to seek help, with actual help-seeking lower than intention [2]. This intention-behavior gap matters in higher education because untreated distress severely comprises attendance, persistence, relationships, and academic performance.

Help-seeking depends on recognizing a concern, accepting assistance, knowing where to go, and trusting that disclosure will be safe. Stigma, self-reliance, limited literacy, cost, confidentiality, and service uncertainty are recurrent barriers, whereas social support, accessibility, and prior helpful care facilitate access [3,4]. Public stigma, internal shame, and reflected or family shame may also diverge: a student can accept counseling personally while anticipating community or family disapproval [5,6].

Republic Act No. 11036 requires educational institutions to promote awareness, support at-risk individuals, and facilitate treatment [7]. Local evidence is needed because international findings cannot simply be assumed to represent Filipino students. The practical gap is whether unfavorable attitudes are associated with weaker help-seeking intentions and whether sex identifies groups requiring differentiated engagement.

Accordingly, this study asked: (1) What are students' attitudes toward mental health problems across community, family, external shame, internal shame, and reflected-shame domains? (2) From whom do students intend to seek help for personal/emotional problems and suicidal thoughts? (3) Are attitude scores associated with help-seeking intentions? and (4) Do attitude and help-seeking scores differ by sex? It was hypothesized that more negative attitudes would be

associated with lower help-seeking intentions and that scores would differ by sex.

## REVIEW OF RELATED LITERATURE

### Mental health needs and the help-seeking gap

The university period coincides with developmental transitions involving autonomy, identity, relationships, financial demands, and career uncertainty. These demands may interact with pre-existing vulnerability, yet service use remains lower than need. Hunt and Eisenberg [12] described a persistent treatment gap among college students even where campus counseling is available. More recent pooled evidence confirms that the gap has not disappeared: Zhao et al. [2] estimated active help-seeking among students with mental-health problems at 28%, compared with an intention rate of 41%. Intention is therefore a meaningful proximal indicator, but it should not be equated with actual access. A student may endorse professional care in a questionnaire and still fail to recognize symptoms, disclose distress, arrange an appointment, afford treatment, or remain engaged.

The scale of need is supported by large international datasets. In the first stage of the WHO World Mental Health International College Student initiative, Auerbach et al. [13] found that approximately one third of first-year students screened positive for at least one common lifetime mental disorder, with substantial role impairment. In the United States, Lipson et al. [14] documented worsening mental-health indicators from 2013 to 2021, while service use increased but did not fully close the treatment gap. These studies are not directly generalizable to one Philippine university, but they establish that student mental health is a widespread higher-education concern rather than an isolated campus issue.

This distinction is important when interpreting the General Help-Seeking Questionnaire. The GHSQ estimates the likelihood of approaching particular sources under specified problem scenarios [9]. It does not establish whether the respondent presently has a mental disorder, has used a service, or would complete a referral during a crisis. The source-specific structure is nevertheless useful for institutional planning because it identifies possible entry

points into care. If peers and partners are preferred, they can be trained as gatekeepers; if formal providers are preferred but underused, the implementation problem may lie in visibility, accessibility, trust, or confidentiality rather than attitude alone.

#### **Public stigma, self-stigma, and reflected shame**

Stigma is a social process involving labeling, stereotyping, separation, status loss, and discrimination. In help-seeking research, perceived public stigma concerns anticipated reactions from others, while self-stigma occurs when negative social beliefs are applied to oneself. The ATMHP extends this distinction by measuring external shame, internal shame, and reflected shame—the concern that an individual's mental-health problem may damage family standing or that a relative's problem may reflect negatively on the self [8]. The multidimensional structure is important because a low internal-shame score does not imply an accepting social environment. Students may reject stigmatizing beliefs personally while still anticipating gossip, distancing, reputational harm, or family disappointment.

Gilbert *et al.* [8] developed the ATMHP in a cross-cultural investigation and found that cultural background was particularly relevant to external and reflected shame. Subsequent research has used the scale to examine how gender and culture shape shame-focused attitudes. Such evidence cautions against reducing stigma to a single global score. Community attitudes are potential environmental barriers; internal shame is an intrapersonal barrier; and reflected shame connects individual decisions with family and social identity. Each pathway suggests a different intervention—public communication for community norms, psychologically safe counseling for internal shame, and family-sensitive education for reflected shame.

Meta-analytic evidence supports this differentiated interpretation. Clement *et al.* [15] concluded that mental-health-related stigma exerts a small-to-moderate negative influence on help-seeking, with disclosure concerns particularly salient. Schnyder *et al.* [16] likewise found that stigma-related attitudes and intentions are associated with actual help-seeking, although effects vary across stigma dimensions and populations. The implication is not that stigma alone causes non-use, but that it operates with perceived need, service knowledge, accessibility, and trust. This is consistent with the present study's decision to interpret correlation magnitude as well as statistical significance.

#### **Barriers, facilitators, and preferred sources of help**

The systematic review by Lui *et al.* [3] identified self-reliance, stigma, and poor mental-health literacy as the most frequent barriers to seeking help for depression and anxiety among university students. Practical barriers—including cost, time, service availability, uncertainty about eligibility, and concern about confidentiality—can further prevent an intention from becoming behavior. Facilitators include recognizing a need, knowing where services are located, trusting providers, receiving encouragement from others, and having a previous helpful experience. This body of evidence supports a pathway model: attitudes influence openness, but service design determines whether openness can be converted into access.

Cross-national evidence further shows that reluctance can remain high even when students acknowledge a possible

emotional problem. Ebert *et al.* [17] found that many first-year students anticipated handling difficulties alone or were uncertain about treatment effectiveness, while structural barriers remained relevant. Such findings reinforce the need to distinguish unwillingness from inability to obtain care. A university may record low utilization because students avoid disclosure, because services are difficult to navigate, or because both conditions occur simultaneously.

Preferred sources also vary according to perceived problem severity and social context. McCabe *et al.* [4] found that students commonly favor personal contacts, whereas formal providers may become more acceptable as risk or impairment is recognized. Informal support is valuable because it is immediate and relationally safe, but peers and family members may lack the competence to assess suicide risk or severe symptoms. Effective systems therefore do not position informal and professional help as competing options. They build referral bridges through mental-health literacy, gatekeeper training, clear boundaries, and rapid access to qualified care.

#### **Filipino cultural and policy context**

Filipino help-seeking is shaped by relational and structural conditions. Martinez *et al.* [5] found that Filipinos frequently approach family and friends first and may delay formal care until distress becomes severe. Tuliao [11] similarly noted the influence of stigma, service availability, cost, and culturally embedded preferences. Kapwa emphasizes a shared identity and can strengthen social support, but concerns related to *hiya*, family reputation, and being treated as *ibang tao* may constrain disclosure [6]. Culturally responsive intervention should therefore use trusted relationships without making family involvement compulsory or compromising student confidentiality.

Republic Act No. 11036 places educational institutions within the national mental-health response by requiring awareness, support, referral, and protection of rights [7]. The law implies that a university's responsibility extends beyond maintaining a counseling office. Institutions need preventive education, trained personnel, confidential and accessible services, crisis procedures, referral networks, and data for continuous improvement. The present study contributes local evidence by examining several stigma domains together with source-specific help-seeking intentions and sex-based differences. This alignment permits findings to inform both campus service delivery and institutional policy.

#### **Student voice, educational disruption, and institutional support**

Mental-health attitudes develop within students' broader educational experience. Philippine qualitative studies show how instructional conditions, family resources, teacher responsiveness, and institutional flexibility shape strain and adaptation. Abrazado, Namoco, and Dalonos [18] documented demanding distance-learning conditions for special-education teachers, while Cap-atan and Namoco [19] identified resource constraints, independent-learning difficulties, family participation, and adaptive strategies in modular TLE. Namoco and Lesaca [20] further showed that persistence among at-risk technical-vocational learners was supported by families and schools rather than individual resilience alone. In Malaysia, Namoco, Thien, and Kho [21] linked school-life satisfaction with emotional contentment, achievement, environmental safety, and development

opportunities. These studies did not measure mental-health help-seeking, but they justify participatory planning that examines whether the educational environment is safe, supportive, accessible, and responsive.

## MATERIALS AND METHODS

### Research design and setting

A quantitative, cross-sectional correlational design was used because the questions required estimation of current attitudes and help-seeking intentions, examination of their linear association, and comparison of scores between sex groups without manipulating an exposure. The design supports description and association but not causal inference. Data were collected during academic year 2022–2023 at a private non-sectarian university in Cagayan de Oro City. The setting included students from science, technology, engineering, computing, and teacher-education programs, allowing perspectives from academically diverse disciplines.

### Population, sample, and participant selection

The accessible population consisted of 1,647 students enrolled across five colleges. Proportionate stratified random sampling was used, with each college treated as a stratum. The required sample of 312 students was allocated proportionately to the enrollment of each college to ensure adequate representation and prevent the over- or underrepresentation of particular colleges. Within each stratum, eligible students were randomly selected and invited to participate.

A total of 281 students submitted usable responses, representing a 90.1% response rate relative to the target sample. The respondents were distributed as follows: College of Science and Technology Education, 67; College of Science and Mathematics, 16; College of Technology, 6; College of Engineering and Architecture, 102; and College of Information Technology and Computing, 90. The sample included 67 males (23.84%) and 214 females (76.16%).

Eligible respondents were required to be currently enrolled participating colleges, have access to an institutional email account, provide informed consent, and submit a sufficiently complete questionnaire. The research instruments were administered through Google Forms, and survey invitations were sent to the department heads. The department head, upon their formal approval, subsequently sent the questionnaire to the qualified student-respondents through their institutional email addresses and/or Facebook accounts.

### Research instruments

The Attitudes Toward Mental Health Problems (ATMHP) Questionnaire is a 35-item self-report instrument developed by Gilbert et al. [8]. Items are rated from 0 (do not agree at all) to 3 (completely agree). Its content covers perceived community attitudes (items 1–4), perceived family attitudes (items 5–8), external shame or anticipated negative evaluation (items 9–18), internal shame or negative self-evaluation (items 19–23), reflected shame concerning the impact of one's problem on the family (items 24–30), and reflected shame concerning the impact of a relative's problem on the self (items 31–35). Higher values represent more negative or shame-focused attitudes. Domain-level analysis was retained because the instrument was designed to distinguish socially and psychologically different forms of stigma.

The General Help-Seeking Questionnaire (GHSQ) measures intention to seek assistance from a range of sources under specified scenarios [9]. The present study used personal/emotional problems and suicidal thoughts. For each scenario, respondents rated sources such as partner, friend, parent, relative, mental-health professional, physician, helpline, and religious leader from 1 (extremely unlikely) to 7 (extremely likely). The option 'I would not seek help from anyone' represents avoidance rather than help-seeking; it should be reverse-scored if a total help-seeking score is computed. Source-specific means were emphasized because they retain actionable information and avoid obscuring divergent preferences.

### Instrument validity and reliability

Validity was addressed at two levels. First, use of established instruments supported content relevance to the constructs. The ATMHP was explicitly developed to capture community, family, external, internal, and reflected-shame dimensions [8], while the GHSQ was designed to measure source- and problem-specific help-seeking intentions [9]. Second, five experts reviewed the adapted survey for clarity, relevance, cultural appropriateness, and correspondence between items and study variables. The supplied study record did not include item-level content-validity indices; expert validation should therefore be understood as qualitative content review rather than quantified evidence of content validity.

The research instruments were pilot-tested with 30 respondents to assess their reliability. The analysis yielded Cronbach's alpha coefficients of 0.93 for the 35-item ATMHP and 0.88 for the 20-item GHSQ, indicating high internal consistency for both instruments.

### Data-collection procedure

The researcher first sought permission from the relevant university and college authorities. Eligible students received an institutional-email invitation containing the study purpose, voluntary-participation statement, electronic informed-consent form, and Google Forms link. The survey required approximately 5–10 minutes. No face-to-face collection was required. Participants could omit participation or discontinue before submission without academic or administrative consequence. The researcher remained available to clarify procedural questions but avoided influencing item responses. Submitted questionnaires were screened for eligibility and completeness, coded without direct identifiers, and prepared for statistical analysis.

### Data analysis and statistical assumptions

Frequencies and percentages described respondent sex and the distribution of ATMHP domain categories. Arithmetic means ranked help-seeking sources separately for personal/emotional problems and suicidal thoughts. Pearson's product-moment correlation tested the direction and strength of the association between attitude and help-seeking scores. Independent-samples *t* tests examined whether the mean attitude and help-seeking scores differed by sex. Tests were evaluated at  $\alpha=.05$ , and two-tailed interpretation was used unless the original analysis explicitly specified otherwise.

Pearson correlation assumes paired continuous or approximately continuous scores, independent observations, a linear relationship, absence of influential bivariate outliers, and approximate bivariate normality for significance testing. The independent-samples *t* test assumes independent groups,

an approximately continuous outcome, no extreme within-group outliers, approximate normality within groups, and homogeneity of variance when the pooled-variance form is used. In a complete analysis, linearity and outliers should be inspected with scatterplots; normality with histograms, Q-Q plots, skewness/kurtosis, or Shapiro-Wilk tests; and variance equality with Levene's test. If homogeneity fails, Welch's *t* test should be reported; if distributions are severely non-normal or ordinal-score behavior dominates, Spearman correlation and Mann-Whitney *U* may be used as sensitivity analyses. The supplied manuscript did not contain raw data, diagnostics, degrees of freedom, or group means and standard deviations, so these assumptions could not be independently verified and effect sizes could not be reconstructed.

### Ethical considerations

The study applied the principles of respect for persons, beneficence, nonmaleficence, and confidentiality. Consent information described the purpose, procedures, voluntary nature of participation, right to stop, anticipated minimal risk, and intended academic use of data. No penalty was attached to refusal or withdrawal. Because the questionnaire included suicidal thoughts, the survey information identified available university counseling support and allowed respondents to discontinue if distressed. Data were coded, access was restricted to the research team, and results were reported in aggregate to reduce re-identification risk.

## RESULTS

**Table 1. :Distribution of attitudes toward mental health problems (N=281)**

| Domain                          | Very positive n (%) | Positive n (%) | Negative n (%) | Very negative n (%) |
|---------------------------------|---------------------|----------------|----------------|---------------------|
| Community                       | 20 (7.12)           | 53 (18.86)     | 91 (32.38)     | 117 (41.64)         |
| Family                          | 59 (21.00)          | 92 (32.74)     | 64 (22.78)     | 66 (23.49)          |
| External shame/stigma awareness | 109 (38.79)         | 172 (61.21)    | 0 (0.00)       | 0 (0.00)            |
| Internal shame                  | 145 (51.60)         | 136 (48.40)    | 0 (0.00)       | 0 (0.00)            |
| Reflected shame—family          | 61 (21.71)          | 86 (30.60)     | 98 (34.88)     | 36 (12.81)          |
| Reflected shame—self            | 49 (17.44)          | 96 (34.16)     | 87 (30.96)     | 49 (17.44)          |

Table 1 shows a marked domain-specific pattern. Nearly three fourths of respondents perceived community attitudes as negative or very negative (74.02%); only 25.98% placed community attitudes in the two positive categories. Family perceptions were more favorable: 53.74% were positive or very positive, although 46.27% remained negative or very negative. The difference suggests that immediate family may be perceived as more accepting than the broader community, but support cannot be assumed for all students.

All respondents fell within positive categories for the external-shame/stigma-awareness and internal-shame scoring bands. This should be interpreted as low endorsement of the relevant shame statements under the study's categorization, not as proof that stigma has been eliminated. Reflected shame was substantially more divided: 47.69% reported negative or very negative family-related reflected shame, and 48.40% reported negative or very negative self-related reflected

shame. Students could therefore maintain a relatively accepting personal view while worrying about reputational consequences for themselves or their families. This result directly answers the first research question and demonstrates why separate domain scores are more informative than one undifferentiated attitude label.

**Table 2: Mean help-seeking intention by source and problem type**

| Potential source                 | Personal/emotional | Suicidal thoughts |
|----------------------------------|--------------------|-------------------|
| Mental health professional       | 4.79               | 4.48              |
| Intimate partner                 | 4.65               | 4.19              |
| Friend                           | 4.29               | 3.91              |
| Doctor/general practitioner      | 3.95               | 3.59              |
| Phone helpline                   | 3.12               | 3.21              |
| Parent                           | 3.21               | 2.85              |
| Other relative/family member     | 2.41               | 2.20              |
| Minister/religious leader        | 2.28               | 2.16              |
| Other source                     | 2.69               | 2.55              |
| Would not seek help from anyone* | 4.01               | 3.89              |

\*This item is a non-help-seeking option and should be reverse-scored if included in a total. Scale: 1=extremely unlikely to 7=extremely likely.

Mental-health professionals were the highest-ranked source for personal/emotional problems (*M*=4.79) and suicidal thoughts (*M*=4.48), followed by intimate partners (*M*=4.65 and 4.19) and friends (*M*=4.29 and 3.91), respectively. These values lie near the 'likely' portion of the seven-point response continuum and indicate comparatively favorable intentions, not confirmed help-seeking. Physicians occupied an intermediate position, while relatives and religious leaders received lower means. The ordering suggests that students distinguish between trusted relational support and specialized care, with both functioning as plausible entry points.

Most source means declined when the scenario changed from personal/emotional difficulty to suicidal thoughts. For example, intention to approach a parent decreased from 3.21 to 2.85, and intention to approach a mental-health professional decreased from 4.79 to 4.48. A higher helpline mean for suicidal thoughts (3.21 versus 3.12) was the principal exception. The relatively high 'would not seek help from anyone' means (4.01 and 3.89) indicate meaningful avoidance and are clinically important. They also make an uncorrected overall mean psychometrically ambiguous; conclusions therefore emphasize source-specific values. The second research question is answered by the ranking and scenario-specific pattern rather than by a single composite mean.

**Table 3. : Association and sex-based comparisons**

| Research question                 | Statistic        | p    | Decision        |
|-----------------------------------|------------------|------|-----------------|
| Attitude-help-seeking association | <i>r</i> =-0.168 | .005 | Significant     |
| Attitude score by sex             | <i>t</i> =-1.73  | .043 | Significant     |
| Help-seeking score by sex         | <i>t</i> =-0.26  | .798 | Not significant |

Attitude and help-seeking scores were weakly but statistically significantly related ( $r=-.168$ ,  $p=.005$ ). Because higher ATMHP values represent more negative attitudes, the negative sign has a clear substantive meaning: students with more negative or shame-focused attitudes tended to report lower intentions to seek help. Squaring the coefficient gives  $r^2=.028$ , indicating only about 2.8% shared variance. The null hypothesis of no linear association was rejected, but the small magnitude prevents the relationship from being described as strong or determinative.

Attitude scores differed by sex ( $t=-1.73$ ,  $p=.043$ ), whereas help-seeking scores did not ( $t=-0.26$ ,  $p=.798$ ). The attitude test therefore rejected the null hypothesis at  $\alpha=.05$ , while the help-seeking test did not. Statistical significance alone does not show which sex reported more negative attitudes or whether the difference was practically important. Group means, standard deviations, degrees of freedom, confidence intervals, and an effect size such as Cohen's  $d$  were absent from the supplied record. The result should consequently be reported as evidence of a difference requiring clarification, not as proof that one sex is more stigmatizing or less receptive to care.

## DISCUSSION

The principal finding is not simply that stigma was present, but that its location differed. Students reported little internal shame while perceiving substantial community negativity and mixed reflected shame. This pattern supports a multilevel view of stigma: personal acceptance can improve before perceived social norms and reputational concerns change. Similar divergence has been observed when students possess mental health knowledge but remain uncertain about disclosure because of anticipated judgment [3]. In the Filipino context, relational obligations may intensify concern about how a problem reflects on one's family even when the individual accepts mental health care [5,6]. Campus programs should therefore measure and address public, self, and family-related stigma separately rather than treating 'attitude' as a single undifferentiated construct.

The contrast between community and family ratings has practical meaning. Family can act as a protective source of emotional and logistical support, yet almost half of respondents still perceived negative family attitudes. A universal message that simply instructs students to 'talk to the family' may therefore be helpful for some but unsafe or discouraging for others. Services should assess the student's preferred support person and seek family participation only with informed consent, except where lawful emergency procedures apply. Community-level communication should use contact-based and recovery-oriented messages rather than one-time information drives, because factual awareness alone may not change social distance or anticipated judgment.

Professional providers ranked first for both scenarios, which is encouraging and differs from literature in which students primarily prefer informal contacts [2–4]. However, intimate partners and friends were also strongly preferred, confirming that trusted peers are central entry points. The finding should not be read as evidence of actual service use: intentions frequently exceed behavior [2], and a sizeable mean for seeking help from no one indicates residual avoidance. The lower intentions reported for suicidal thoughts are especially consequential because acute risk requires rapid escalation. Universities need a visible, rehearsed pathway from peers and

faculty to qualified professionals, emergency services, and crisis support rather than relying on awareness campaigns alone.

Although helplines did not rank highly, their mean increased slightly for suicidal thoughts, possibly reflecting immediacy and anonymity. Universities should publish verified crisis contacts and define when emergency escalation, qualified risk assessment, and follow-up are required.

The weak negative correlation is theoretically coherent: as stigma becomes more negative, willingness to seek help decreases. Yet attitude scores explained only 2.8% of the variation in intention, indicating that policy focused solely on changing beliefs will be insufficient. Accessibility, cost, confidentiality, service knowledge, perceived need, waiting time, and prior experiences also shape help-seeking [3,5]. The sex difference in attitudes, alongside no difference in intentions, may mean that sex influences beliefs more than stated behavioral readiness in this sample. Because females constituted 76% of respondents and group descriptive statistics were unavailable, the result requires replication; sex-responsive outreach is warranted, but a universal program with targeted components is more defensible than assuming one sex will not seek help.

The small correlation also guards against a common policy error: attributing low utilization entirely to student stigma. If a student holds favorable attitudes but encounters an unclear booking system, limited clinic hours, long waiting times, cost, or fear that records will not remain confidential, willingness may still fail to become action. Conversely, accessible services alone may not be used when students normalize serious symptoms or prefer self-management. Institutional strategy must address both demand-side factors—literacy, stigma, perceived need, and trust—and supply-side factors—workforce, accessibility, privacy, referral capacity, and continuity of care.

Large studies likewise show that high need and increasing service use can coexist with a treatment gap [13,14,17], while meta-analyses confirm that stigma is meaningful but not exclusive [15,16]. The weak correlation therefore supports a multicomponent response addressing community stigma, institutional access, and students' educational experiences.

## RECOMMENDATIONS

*University administrators and governing boards.* Adopt and fund a university-wide mental-health and suicide-response policy aligned with Republic Act No. 11036, with clear accountability, confidential access, stepped care, crisis referral, and adequate personnel and resources [7].

*Counseling, health, and student-affairs personnel.* Provide accessible, confidential, and culturally responsive counseling through simple booking, flexible delivery, proactive outreach, and regular monitoring of access, referrals, satisfaction, and crisis outcomes [18–21].

*Faculty members, advisers, and peer leaders.* Train faculty, advisers, peer leaders, and frontline staff to recognize warning signs, protect privacy, and make timely referrals without acting beyond their competence [20].

*Students and families.* Strengthen mental-health literacy, encourage peer and family support with student consent, address reflected shame, and involve students in program design and evaluation [21].

*Institutional and national policymakers.* CHED, DOH, university boards, and health partners should set and fund

measurable standards for service capacity, waiting times, confidentiality, crisis response, referral networks, training, student consultation, and annual outcome reporting.

**Researchers.** Use multi-institutional samples, validate the instruments in Filipino populations, report effect sizes and confidence intervals, and examine how intentions translate into actual service use.

Findings are limited by the single-university, cross-sectional design, unequal sex distribution, self-report and online-response biases, and measurement of intention rather than actual behavior.

## CONCLUSION

College students reported low personal shame but substantial perceived community stigma and mixed reflected shame. They most often identified mental health professionals, partners, and friends as potential sources of help, although willingness declined for suicidal thoughts and some avoidance remained. More negative attitudes were associated with lower help-seeking intentions, but the small relationship shows that stigma is only one component of access. A comprehensive university response should combine stigma reduction with confidential services, peer-to-professional referral pathways, family-sensitive communication, crisis protocols, and routine evaluation. These measures translate the study's findings into actionable institutional policy while meeting the preventive and supportive intent of the Philippine Mental Health Act.

## REFERENCES

- [1] World Health Organization, "Mental health of adolescents," WHO, Geneva (2025).
- [2] R. Zhao, Y. Amanvermez, J. Pei, et al., "Help-seeking intentions, behaviors, and barriers in college students: A systematic review and meta-analysis," *Journal of Child Psychology and Psychiatry*, 66(10): 1593-1605 (2025). doi:10.1111/jcpp.14145.
- [3] J. C. Lui, I. Sagar-Ouriaghli and J. S. L. Brown, "Barriers and facilitators to help-seeking for common mental disorders among university students: A systematic review," *Journal of American College Health*, 72(8): 2605-2613 (2024). doi:10.1080/07448481.2022.2119859.
- [4] M. McCabe, K. Meadows and M. Goldstone, "The relationship between university student help-seeking intentions and wellbeing," *Frontiers in Psychiatry*, 15: 1407689 (2024). doi:10.3389/fpsy.2024.1407689.
- [5] A. B. Martinez, S. H. Co, J. Lau and J. M. Brown, "Filipino help-seeking for mental health problems and associated barriers and facilitators: A systematic review," *Social Psychiatry and Psychiatric Epidemiology*, 55: 1397-1413 (2020). doi:10.1007/s00127-020-01937-2.
- [6] R. Pe-Pua and E. A. Protacio-Marcelino, "Sikolohiyang Pilipino (Filipino psychology): A legacy of Virgilio G. Enriquez," *Asian Journal of Social Psychology*, 3(1): 49-71 (2000). doi:10.1111/1467-839X.00054.
- [7] Republic of the Philippines, Republic Act No. 11036: Philippine Mental Health Act, Official Gazette, Manila (2018).
- [8] P. Gilbert, R. Bhundia, R. Mitra, K. McEwan, C. Irons and J. Sanghera, "Cultural differences in shame-focused attitudes towards mental health problems in Asian and non-Asian student women," *Mental Health, Religion & Culture*, 10(2): 127-141 (2007). doi:10.1080/13694670500415124.
- [9] C. J. Wilson, F. P. Deane, J. V. Ciarrochi and D. Rickwood, "Measuring help-seeking intentions: Properties of the General Help-Seeking Questionnaire," *Canadian Journal of Counselling*, 39(1): 15-28 (2005).
- [10] World Health Organization and United Nations Children's Fund, *Mental Health of Children and Young People: Service Guidance*, WHO, Geneva (2024).
- [11] A. P. Tuliao, "Mental health help seeking among Filipinos: A review of the literature," *Asia Pacific Journal of Counselling and Psychotherapy*, 5(2): 124-136 (2014). doi:10.1080/21507686.2014.913641.
- [12] J. Hunt and D. Eisenberg, "Mental health problems and help-seeking behavior among college students," *Journal of Adolescent Health*, 46(1): 3-10 (2010). doi:10.1016/j.jadohealth.2009.08.008.
- [13] R. P. Auerbach, P. Mortier, R. Bruffaerts, et al., "WHO World Mental Health Surveys International College Student Project: Prevalence and distribution of mental disorders," *Journal of Abnormal Psychology*, 127(7): 623-638 (2018). doi:10.1037/abn0000362.
- [14] S. K. Lipson, S. Zhou, B. Abelson, et al., "Trends in college student mental health and help-seeking by race/ethnicity: Findings from the national Healthy Minds Study, 2013-2021," *Journal of Affective Disorders*, 306: 138-147 (2022). doi:10.1016/j.jad.2022.03.038.
- [15] S. Clement, O. Schauman, T. Graham, et al., "What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies," *Psychological Medicine*, 45(1): 11-27 (2015). doi:10.1017/S0033291714000129.
- [16] N. Schnyder, R. Panczak, N. Groth and F. Schultze-Lutter, "Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis," *Epidemiology and Psychiatric Sciences*, 26(5): 462-482 (2017). doi:10.1017/S2045796016000101.
- [17] D. D. Ebert, P. Mortier, F. Kahlke, et al., "Barriers of mental health treatment utilization among first-year college students: First cross-national results from the WHO World Mental Health International College Student Initiative," *International Journal of Methods in Psychiatric Research*, 28(2): e1782 (2019). doi:10.1002/mpr.1782.
- [18] J. D. Abrazado, S. O. Namoco and S. Dalonos, "A transcendental phenomenological study on special education teachers' use of distance learning modalities in Misamis Oriental, Philippines during COVID-19 pandemic," *Science International (Lahore)*, 33(4): 271-278 (2021).
- [19] M. A. I. Cap-atan and S. O. Namoco, "Untold stories of TLE students on modular distance learning during the pandemic: A narrative inquiry study," *Science International (Lahore)*, 36(2): 225-230 (2024).
- [20] S. O. Namoco and J. T. Lesaca, "Persistence against the odds: Narratives of senior high school technical-vocational strand SARDOs and their parents," *Science International (Lahore)*, 38(1): 33-40 (2026).
- [21] S. O. Namoco, L. M. Thien and S. H. Kho, "Satisfaction with school life: Capturing Malaysian pupils' voice from a multiethnic perspective," *Kajian Malaysia*, 41(2): 55-79 (2023). doi:10.21315/km2023.41.2.4.