

Perfectionism and Mental Health Help-Seeking:  
An Extension of the Social Disconnection Model

by

Noah Brierley

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**APPROVED/APPROUVÉ**

Thesis Examiners/Examineurs de thèse:

Dr. Chantal Arpin-Cribbie  
(Supervisor/Directeur(trice) de thèse)

Dr. Mélanie Perron  
(Committee member/Membre du comité)

Dr. Diana Urajnik  
(Committee member/Membre du comité)

Approved for the Faculty of Graduate Studies  
Approuvé pour la Faculté des études supérieures  
Dr. Alain Simard

Dean of Graduate Studies and International  
Doyen des Études supérieures et de la stratégie internationale  
Laurentian University / Université Laurentienne

Dr. Sean MacKinnon  
(External Examiner/Examineur externe)

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## Abstract

While access to mental health services remains an issue in Canada, many individuals who do have access to mental health services do not seek help. The current study sought to examine the impact of perfectionism on mental health help-seeking behaviour using the framework of the Perfectionism-Social Disconnection Model (PSDM). In line with the PSDM, we hypothesized that social disconnection would mediate the relationship between higher levels of perfectionism and lower help-seeking. An online sample of 346 Ontario university students completed measures of perfectionism, social connectedness, perceived social support and psychological distress, in addition to assessments of both mental health help-seeking attitudes and actual help-seeking behaviour. Results revealed that neither socially prescribed perfectionism (SPP) nor self-oriented perfectionism (SOP) showed zero-order associations with help-seeking attitudes, however SPP did predict more negative attitudes towards help-seeking via small indirect pathways through both social connectedness and perceived social support. Additionally, perfectionism was associated with higher rates of mental health help-seeking behaviour, mediated through increased psychological distress. Lastly, neither SPP nor SOP moderated the relationship between mental health help-seeking attitudes and help-seeking behaviour, though the moderation effect for SPP approached significance. Findings suggest a more complex relationship between perfectionism and help-seeking attitudes than previously documented in the literature and emphasize the importance of assessing actual mental health help-seeking behaviour in future research.

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**Perfectionism and Mental Health Help-Seeking:  
An Extension of the Social Disconnection Model**

Mental health concerns are among the leading causes of disability worldwide (WHO, 2022). Globally, around 1 in 2 individuals will experience a mental health concern at some point in their lives (McGrath et al., 2023). In Canada, it is estimated that 1 in 5 individuals will meet diagnostic criteria for a mental health concern in any given year (Statistics Canada, 2022). Additionally, in Canada, suicide is the second leading cause of death among Canadian youth and young adults aged 15-34 years (Statistics Canada, 2022). The results from the Canadian 2022 Mental Health and Access to Care survey show large increases in the prevalence of mood and anxiety disorders from 2012 to 2022, with the largest increases seen in individuals aged 15-24 years (Stephenson, 2023). This age range coincides with the typical period of onset of most mental health concerns (Kessler et al., 2007; Solmi et al., 2022). It is well established that mental health concerns are highly treatable and, in recent years, a greater emphasis has been placed on early intervention as it has been shown to produce better outcomes across most mental health concerns (Colizzi et al., 2020; McGorry & Mei, 2018; Read et al., 2018). However, concerningly, less than half of Canadians with a mood, anxiety, or substance use disorder received professional mental healthcare in 2022 (Stephenson, 2023). This presents a major challenge to patients, healthcare providers and policymakers alike.

There are many reasons why someone may not receive mental healthcare. Across Canada, there exists significant variation in the accessibility of mental healthcare. For example, data from a 2018 report from the Canadian Medical Association suggests that there are roughly eight times more psychiatrists per 100 000 residents in the Greater Toronto Area (GTA) when compared to northern Ontario. This lack of specialized mental health care creates an overreliance

on primary care providers and other allied healthcare professionals, which have also become increasingly hard to access. As of 2023, roughly 20% of Canadians did not have a primary care provider (i.e., a family doctor or nurse practitioner; Duong & Vogel, 2023). Other identified barriers to accessing mental health care in Canada include lack of knowledge on where to seek help, prohibitive costs of private services, and long wait times for publicly funded resources (Kourgiantakis et al., 2023; Moroz et al., 2020). While it is clear that access to mental healthcare in Canada is less than ideal, the fact that around 80% of Canadians do have a primary care provider demonstrates that most Canadians could have an accessible point of care. Despite this, rates of mental health help-seeking are lower than expected if it were assumed that access was the only barrier. It is clear that many individuals who do have access to mental health resources may choose not to seek help. Understanding why these individuals are not seeking help is an important step in bridging the gaps in mental health service provision.

### **Mental Health Help-Seeking**

While there is no universally agreed upon definition of help-seeking, Cornally and McCarthy (2011) have defined formal help-seeking as “a problem focused, planned behavior, involving interpersonal interaction with a selected health-care professional” (p. 286). In the literature, help-seeking has commonly been operationalized in three different ways: in terms of attitudes, intentions, and actual behaviour (Rickwood & Thomas, 2012; White et al., 2018). Attitudinal self-report measures such as the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) or the Inventory of Attitudes Towards Seeking Mental Health Services (IATSMHS; Mackenzie et al., 2004) have been used extensively to assess how favourably an individual views the help-seeking process. Intentional measures such as the General Help Seeking Questionnaire (GHSQ; Rickwood & Braithwaite,

1994) assess the likelihood of seeking help from a variety of sources if someone was experiencing a mental health concern. Assessment of actual past help-seeking behaviour has been far more inconsistent in the literature, with studies often using non-standardized measures of “service utilization” developed for the specific study.

While there is some concern around the accuracy of self-reported health service utilization data, evidence suggests that there is reasonably high concordance between self-report data and medical records up to 12 months prior (Hwang et al., 2016; Short et al., 2009). Assessment of actual help-seeking behaviour has typically featured a dichotomous “yes/no” coding of whether someone has or has not sought help from a given healthcare professional, though some researchers have included both formal (e.g. mental health professional, family doctor, etc.) and informal sources (e.g. friend, family member, etc.) of help-seeking (Rickwood & Braithwaite, 1994). Social support from family, friends or significant others is an important protective factor and can often facilitate the help-seeking process from more formal sources (Lauzier-Jobin & Houle, 2022), however, in most instances, mental health concerns require formal treatment from mental health professionals. As such, the focus of the present literature review and subsequent study will be formal forms of help-seeking.

Many models have been used to describe the help-seeking process, including the Theory of Planned Behavior (TPB; Ajzen, 1991), the Health Belief Model (Glanz & Bishop, 2010), and the Health Service Utilization Model (Andersen & Newman, 1973). While no single theory of mental health help-seeking is universally accepted, the Theory of Planned Behavior is arguably the most widely adopted and empirically well-supported model (Armitage & Conner, 2001; McEachan et al., 2011). The TPB was originally adapted from Ajzen and Fishbein’s Theory of Reasoned Action (1980) as a general theory of behavioural action. The model posits three main

predictors in explaining behavioural action: attitudes, subjective norms, and perceived behavioural control. These three factors interact to produce intentions, which are seen as the proximate antecedent to behavioural performance (Ajzen, 1991). Attitudes can be thought of as an individual's own positive or negative perceptions of the behaviour, whereas subjective norms refer to the social pressures to perform or not perform the behaviour that arise from an individual's given sociocultural context. Perceived behavioural control refers to the individual's perceived ability to perform the behaviour, and is closely related to Bandura's concept of self-efficacy (Bandura, 1977), but also incorporates perceived barriers to performing the behaviour. In general, more favourable attitudes and subjective norms, and higher perceived control all lead to greater likelihood of behavioural intentions. While the current study is not operating explicitly within the framework of the TPB, it provides an important context for how mental health help-seeking has been studied so far.

While the TPB was not developed specifically as a help-seeking model, it has been applied extensively to both mental health help-seeking as well as help-seeking in broader health contexts (McEachan et al., 2011). A recent review conducted by Adams and colleagues (Adams et al., 2022) identified 49 studies that applied the TPB to mental health help-seeking intentions and behaviour, including 39 studies that specifically tested the 3 components of the TPB (attitudes, subjective norms, and perceived behavioural control) as predictors of help-seeking intentions and behaviour. They found that, in the vast majority of these studies, all three components of the TPB were significant predictors of mental health help-seeking intentions or behaviour. The results also demonstrated that mental health help-seeking intentions were a significant predictor of actual behaviour, providing further support for the model proposed in the TPB.

One limitation of the TPB, in its application to mental health help-seeking when compared to models specifically developed for this issue, is that it does not directly include subjective needs: the recognition that one is experiencing a mental health concern that requires external help (Gross & McMullen, 1983). The experience of psychological distress is likely a prerequisite to help-seeking in almost all cases. Indeed, there is significant evidence supporting the assumption that symptom severity is predictive of mental health help-seeking (Doll et al., 2021; Nagai, 2015; Ward-Ciesielski et al., 2019), suggesting that the worse a mental health concern gets the more likely someone is to seek help.

Given the importance of mental health help-seeking in facilitating access to care, significant attention has been paid to identifying correlates of help-seeking in order to guide intervention and outreach policy. Variables of focus have included gender, mental health stigma, mental health literacy and perceived social support. Gender differences in mental health help-seeking have long been documented (Kessler et al., 1981), and there is a robust literature showing that women are more likely to seek professional help for mental health problems than men. Data from both the United States and the United Kingdom show that women are about 1.6 times more likely to receive mental health treatment, controlling for prevalence rates (McManus et al., 2016; Wang et al., 2005). The prevailing explanations for the disparate help-seeking rates between men and women often focus on the prevalence of social norms around masculinity. Traditionally masculine values of strength, stoicism and self-reliance are often incongruent with the mental health help-seeking process. Indeed, endorsement of these types of traditional masculine norms has been shown to predict more negative attitudes towards mental health help-seeking (Seidler et al., 2016; Vogel et al., 2011). Mediating this relationship between masculine norms and help-seeking attitudes is self-stigma (Vogel et al., 2011).

Self-stigma refers to the internalized negative attitudes and shame that an individual feels related to their own mental health concerns (Vogel et al., 2006). Corrigan and Watson (2002) draw a distinction between self-stigma and public stigma: the negative perceptions that individuals hold towards other people who experience mental health concerns. While both forms of stigma have been demonstrated to predict more negative attitudes towards mental health help-seeking, Vogel and colleagues (Vogel et al., 2007) found that self-stigma fully mediates the relationship between public stigma and mental health help-seeking attitudes. This finding lends support to the theory posited by Corrigan and Watson (2002) that self-stigma is a downstream internalization of the negative perceptions of mental illness that are perceived to be present in an individual's broader sociocultural environment. This is consistent with early work on mental health help-seeking that described the help-seeking process as a potential threat to self-esteem, as the recognition of a need for help may be perceived by individuals as a display of weakness or failure (Fisher et al., 1982). The perceived threat to self-esteem and concerns around display of weakness that stem from seeking mental health support are likely higher in some individuals than others. In particular, individuals higher in perfectionistic predispositions are highly concerned with avoiding displays of weakness and maintaining an image of perfection (Hewitt et al., 2008). As such, perfectionism is an important consideration in understanding help-seeking behaviours.

### **Perfectionism**

Perfectionism is a multifaceted personality construct defined as a tendency to set impossibly high standards and the negative self-evaluation that results from a failure to live up to these standards. Historically, Adler (1956) and Horney (1950) were among the early theorists to discuss characteristics now associated with perfectionism, particularly in relation to neuroticism. It wasn't until much later that efforts were made to more comprehensively define and

operationalize perfectionism (Burns, 1980; Frost et al., 1990; Hewitt & Flett, 1991). Hewitt and Flett's conceptualization of perfectionism posits a three-dimensional model consisting of self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. Self-oriented perfectionism involves the unreasonable standards one sets for oneself and the striving for flawlessness in one's day-to-day life. Other-oriented perfectionism refers to the setting of unreasonable expectations towards other individuals in one's life. Socially prescribed perfectionism relates to the perceived expectation of perfection placed on an individual by other people in their life. These three dimensions are reflected in the three subscales of the Multidimensional Perfectionism Scale (HF-MPS; 1991). While there are multiple other validated instruments for the assessment of perfectionism with different proposed structures, such as Frost's Multidimensional Perfectionism Scale (F-MPS; 1990) and the Perfectionism Inventory (Hill et al., 2004), factor analytic evidence suggests that two higher-order factors emerge across different measures consisting of perfectionistic strivings (e.g. self-oriented perfectionism, personal standards etc.) and perfectionistic concerns (e.g. socially prescribed perfectionism, concern over mistakes etc.; Dunkley et al., 2003; Frost et al., 1993; Smith & Saklofske, 2017).

The extent to which perfectionism may be both adaptive and maladaptive in different individuals and different contexts has been the subject of considerable debate. It has been argued that perfectionistic strivings represent a more adaptive form of perfectionism that may confer some benefit in terms of accomplishment whereas perfectionistic concerns represent the maladaptive form of perfectionism commonly found to be associated with mental health concerns. Early works on perfectionism reflected this view as exemplified, for example, by Hamachek (1978), who described these two forms of perfectionism as "normal perfectionism" and "neurotic perfectionism". While there is evidence that perfectionistic strivings are associated

with more positive outcomes when compared to perfectionistic concerns (Stoeber & Otto, 2006), the observed “adaptiveness” of perfectionistic strivings often only shows up when perfectionistic concerns are controlled for (Powers et al., 2011). However, the degree of shared variance across the two dimensions makes controlling for one dimension to analyze the residual effect of the other potentially problematic (Hill, 2014, 2017). Smith and Saklofke (2017) found that a single general perfectionism factor underlying both dimensions accounts for nearly 40% of the total variance, and the correlation between the two dimensions is in the range of 0.7. In practice, this means that when removing the shared variance across perfectionistic strivings and concerns, it is unclear whether the residual effect of perfectionistic strivings is still interpretable as the same construct. Additionally, large meta-analyses have found that both perfectionistic strivings and concerns are associated with increased risk of various forms of psychopathology (Callaghan et al., 2023; Limburg et al., 2017).

For decades, clinicians have noted the pernicious effects of perfectionism on mental health (Burns, 1980; Hamachek, 1978). In recent years, significant attention has been paid to perfectionism as a transdiagnostic risk factor, implicated in the etiology and maintenance of a wide range of mental health concerns (Egan et al., 2011). The volume of work on perfectionism and its association with various forms of psychopathology has resulted in several large-scale reviews and meta-analyses. Meta-analytic studies have provided robust evidence in support of the view that perfectionism is a major risk and maintaining factor in depression (Smith et al., 2021), eating disorders (Stackpole et al., 2023), including both anorexia nervosa (Dahlenburg et al., 2019) and bulimia nervosa (Kehayes et al., 2019), anxiety disorders (Smith, Vidovic, et al., 2018), OCD (Callaghan et al., 2023; Limburg et al., 2017), and suicidal ideation (Smith, Sherry, Chen, et al., 2018). The evidence is clear that perfectionism confers significant risk for the onset

of these disorders, and is also significantly predictive of symptom severity within a broad range of clinical populations. Additionally, perfectionism is associated with a higher number of comorbid mental health diagnoses in clinical samples (Bieling et al., 2004). Given the evidence for perfectionism as a transdiagnostic process implicated in both the onset and maintenance of mental health concerns, it is crucial that clinicians consider perfectionism in their assessment of patients.

Perfectionism not only puts individuals at higher risk of mental health concerns but can also interfere with the treatment process in several ways. Perfectionism has been consistently observed to interfere with the development of the therapeutic alliance. Individuals higher in perfectionism at the onset of psychotherapy have been shown to view their therapist as less warm and empathetic, and more threatening (Hawley et al., 2006; Hewitt et al., 2008; Miller et al., 2017; Zuroff et al., 2000, 2010). The need to maintain a self-presentation of perfection and the high sensitivity to self-esteem threats is antithetical to the psychotherapeutic process. The therapeutic alliance has been consistently identified as one of the most important predictors of psychotherapeutic outcomes (Cameron et al., 2018; Crits-Christoph et al., 2011; Webb et al., 2010) and so the implications of the impact of perfectionism on this process are profound. Related to this, perfectionism has been linked to poorer treatment outcomes across various mental health concerns (Blatt et al., 1998; Hewitt et al., 2020; Nilsson et al., 2008), and impaired therapeutic alliance appears to mediate the relationship between perfectionism and treatment outcomes (Zuroff et al., 2010). Perhaps most concerning, perfectionism may interfere with the treatment process by preventing it from ever beginning. Perfectionism has been shown to be highly predictive of negative attitudes towards mental health help-seeking (Dang et al., 2020; Shannon et al., 2018), with the largest associations seen with socially prescribed perfectionism.

Additionally, one study of medical and dental students found that among participants who were experiencing elevated levels of psychological distress, those who were not currently receiving mental health treatment displayed higher levels of socially prescribed perfectionism than those in treatment (Ey et al., 2000). This finding suggests that perfectionism is a significant barrier to mental health help-seeking even when individuals are experiencing clinically significant distress.

### **Perfectionism-Social Disconnection Model**

Given the robust evidence for the link between perfectionism and psychopathology of varying forms, the question of what mechanisms underlie this relationship is an important area of inquiry. One model that has been utilized to explain this relationship was the Stress Generation Hypothesis (SGH; Hammen, 1991). The SGH posits that individuals who are prone to depression, influenced by their particular individual personality dispositions, exhibit behavioural patterns that tend to create negative circumstances in their lives that ultimately lead to depression. Applying this model to the perfectionism-depression relationship, Hewitt and Flett (2002) argue that individuals higher in perfectionism generate stress in their lives as a result of their unflinching commitment to perfection and persistent negative self-evaluation. Additionally, they argue that perfectionism also creates a preoccupation with future stressors and exacerbates existing stressors as they occur, all of which place these individuals at higher risk for developing depressive symptoms.

Hewitt and Flett (2006) expanded on this model by positing, in line with their view that perfectionism involves a fundamental interpersonal component, that socially prescribed perfectionism uniquely predicts depression and suicidal ideation through the mechanism of interpersonal distress. They termed this idea the Perfectionism-Social Disconnection Model (PSDM). They argue for two main paths through which perfectionism leads to social

disconnection and, ultimately, to depression and suicidal ideation: interpersonal hostility (i.e., aversive social behaviours) which leads to objective social disconnection (i.e., actual impaired relationships), and interpersonal sensitivity (i.e., fear of negative evaluation by others) which leads to subjective social disconnection (i.e., subjective experience of aloneness). Nearly two decades after this seminal paper was published, this model has subsequently become the most widely adopted conceptualization of the perfectionism-psychopathology link.

In the first empirical study of the PSDM, Sherry and colleagues (2008) tested both paths proposed by Hewitt and Flett (2006) using measures of received social support and perceived social support to assess objective and subjective social disconnection, respectively. They found that perceived social support, but not received social support, significantly mediated the relationship between socially prescribed perfectionism and depressive symptoms. This finding provided the first empirical evidence for the PSDM, suggesting that perceived social disconnection is a crucial factor in understanding the relationship between perfectionism and negative mental health outcomes. Since this study, many other studies have been published providing empirical evidence for the PSDM in various contexts. Longitudinal designs have found that perfectionism predicts negative changes in interpersonal functioning over time that in turn lead to increases in depressive symptoms at follow-up (Rnic et al., 2021; Sherry et al., 2013; Smith, Sherry, McLarnon, et al., 2018). The PSDM has also been examined in the context of romantic relationships whereby perfectionism predicts increased conflict and dysfunction in romantic relationships that ultimately leads to depressive symptoms (Mackinnon et al., 2012, 2017). One study has been conducted with mother-daughter dyads where it was found that maternal other-oriented perfectionism predicted daughters' depressive symptoms, primarily by lowering daughters' social self-esteem (Smith et al., 2017). The PSDM has also been expanded

beyond depression and has been applied to other mental health outcomes, including anxiety and disordered eating symptoms in adolescents (Magson et al., 2019). The PSDM has generated a wide range of testable hypotheses since its inception, is well supported empirically, and provides an important conceptualization of the mechanisms through which perfectionism confers risk for psychopathology.

The empirical work on the PSDM has demonstrated that high levels of perfectionism are consistently predictive of subjective social disconnection, operationalized in several ways, including perceived social support and social connectedness. Importantly, these variables have also been identified as predictors of mental health help-seeking attitudes (Koydemir-Özden, 2010; Nam et al., 2013), intentions (Kenny et al., 2016), and behaviours (Juhl et al., 2021). These findings suggest that the experience of social disconnection may have an inhibitory effect on mental health help-seeking. When considering the known link between perfectionism and social disconnection, as well as the potential link between social disconnection and help-seeking, the PSDM may provide a valuable framework from which to understand the relationship between perfectionism and mental health help-seeking.

### **The Present Study: Rationale and Hypotheses**

In the present study, we sought to expand the application of the Perfectionism-Social Disconnection Model (PSDM) to account for the relationship between perfectionism and mental health help-seeking attitudes and behaviour. To date, the PSDM has provided a mechanistic explanation for the relationship between perfectionism and psychopathology, but has not been applied to other facets of behaviour associated with perfectionism. Given the relationship between perfectionism and mental health outcomes, individuals who are higher in perfectionism are likely to require higher rates of mental health care. Despite this, these same individuals are

more likely to hold negative attitudes towards mental health help-seeking (Dang et al., 2020; Shannon et al., 2018) and preliminary evidence suggests may be less likely to receive mental health care (Ey et al., 2000). The pernicious combination of higher rates of mental health concerns and lower rates of help-seeking presents a significant challenge. Given that we know very little about the mechanisms that underpin the relationship between perfectionism and help-seeking, this issue certainly demands further study. Identifying these underlying mechanisms may help guide future intervention research aimed at increasing mental health help-seeking in certain populations.

To date, research on the relationship between perfectionism and mental health help-seeking has primarily focused on measuring help-seeking attitudes (Dang et al., 2020; Shannon et al., 2018). While these attitudes are well documented to be predictive of actual help-seeking behaviour, there is still a gap between stated attitudes towards mental health help-seeking and actual behaviour (Mojtabai et al., 2016). Given that attitudinal measures were merely a proxy for the variable of interest in these studies, mental health help-seeking behaviour, it is crucial to assess actual behaviour wherever possible. One study, to date, has attempted this in a sample of medical and dental students and found perfectionism to be associated with a lower likelihood of receiving mental health treatment (Ey et al., 2000). However, it is important for this finding to be replicated in a wider sample.

Additionally, one study has explored mediators of the relationship between perfectionism and mental health help-seeking and has found that self-concealment, the tendency of individuals to conceal personal information they perceive as negative, mediated the relationship between socially prescribed perfectionism and mental health help-seeking attitudes (Abdollahi et al., 2017). While this study provides a plausible mechanism for the relationship between

perfectionism and help-seeking, it leaves gaps for further exploration. Firstly, it was conducted with a sample of Malaysian high school students so there are questions of generalizability. Second, the authors observed a positive correlation between self-oriented perfectionism and help-seeking attitudes, which is inconsistent with the direction of associations observed in other studies (Dang et al., 2020; Shannon et al., 2018). Most importantly, it is unclear whether the observed mediation effect would hold for actual help-seeking behaviours as opposed to just attitudes. Further examination would clarify the association and provide much-needed information on overt help-seeking behaviours.

The primary aim of the current study was to examine the relationship between perfectionism and help-seeking using the framework as set forth in the PSDM. To address this aim, a large sample of university students from across Ontario was recruited. Participants were invited to complete an online survey consisting of measures of perfectionism, help-seeking attitudes and behaviour, perceived social support, social connectedness, and psychological distress.

The following three hypotheses were proposed:

- I) Self-oriented perfectionism (SOP) and socially prescribed perfectionism (SPP) will both be negatively associated with both mental health help-seeking attitudes and actual mental health help-seeking behaviours assessed over the previous 12 months.
- II) In line with the PSDM, perceived social support and social connectedness will mediate the relationship between both SOP and SPP and mental health help-seeking attitudes and behaviours. Higher levels of SOP and SPP will predict lower levels of perceived social support and social connectedness which in turn will predict more

negative attitudes towards mental health help-seeking and lower levels of actual help-seeking behaviours.

- III) SOP and SPP will moderate the relationship between mental health help-seeking attitudes and behaviours such that the relationship between attitudes and behaviour will be weakened by higher levels of perfectionism.

## **Method**

### **Participants**

Data for this study were collected in October and November of 2024. A final sample of 346 participants was recruited (after data cleaning; described below), consisting of university students enrolled in any university program across Ontario, Canada, including both undergraduate and graduate degree programs, as well as professional graduate programs such as medical/dental school. Participant demographic data is summarized in Table 1. University students were chosen as the target sample as all students enrolled at universities have access to on-campus mental health support services. This helps minimize disparities in access to care as a potential confound in assessing mental health help-seeking behaviour, although wait times for on-campus services may persist as a barrier to access. The age range for this study was chosen as it coincides with the average age of onset for most mental health concerns (Kessler et al., 2007; Solmi et al., 2022).

**Table 1***Participant Demographic Data*

	Social Media	SONA	Overall
	M (SD)	M (SD)	M (SD)
Age	20.9 (2.8)	22.7 (3.7)	21.5 (3.2)
	N (%)	N (%)	N (%)
Gender Identity			
Female	165 (67.6)	91 (89.2)	256 (74.0)
Male	17 (7.0)	8 (7.8)	25 (7.2)
Trans-gender Female	2 (0.8)	1 (1.0)	3 (0.9)
Trans-gender Male	10 (4.1)	1 (1.0)	11 (3.2)
Non-binary	50 (20.5)	1 (1.0)	51 (14.7)
Ethnic Identity			
Asian	42 (17.2)	2 (2.0)	44 (12.7)
Black	8 (3.3)	3 (2.9)	11 (3.2)
Indigenous	11 (4.5)	8 (7.8)	19 (5.4)
Middle Eastern/North African	8 (3.3)	1 (1.0)	9 (2.6)
South Asian	37 (15.2)	6 (5.9)	43 (12.4)
White/Caucasian	113 (46.3)	74 (72.5)	187 (54.0)
Other	25 (10.2)	8 (7.8)	33 (9.6)
Area of residence			
Greater Toronto	43 (17.6)	8 (7.8)	51 (14.7)
Hamilton	22 (9.0)	-	22 (6.4)
Kingston	11 (4.5)	-	11 (3.2)
Kitchener/Waterloo	14 (5.7)	2 (2.0)	16 (4.6)
London	10 (4.1)	1 (1.0)	11 (3.2)
Northern Ontario	7 (2.9)	5 (4.9)	12 (3.5)
Ottawa	35 (14.3)	1 (1.0)	36 (10.4)
Outside Ontario	1 (0.4)	14 (13.7)	15 (4.3)
St. Catherines/Niagara	7 (2.9)	3 (2.9)	10 (2.9)
Sudbury	4 (1.6)	50 (49)	54 (15.6)
Toronto	55 (22.5)	5 (4.9)	60 (17.3)
Other	35 (14.3)	13 (12.7)	48 (13.9)
Program Type			
Undergraduate	193 (79.1)	101 (99.0)	294 (85.0)
Graduate	33 (13.5)	-	33 (9.5)
Medical/Dental	2 (0.8)	-	2 (0.6)
Graduate Profess. Program	12 (4.9)	1 (1.0)	13 (3.8)
Other	4 (1.6)	-	4 (1.2)

*Note:* Participants outside Ontario were students at Ontario universities attending remotely. Graduate professional programs include MSW, law school, etc.

## Measures

### *Multidimensional Perfectionism Scale – Short Form (MPS-SH)*

The MPS-SH (Hewitt et al., 2008; see Appendix A) is a 15-item questionnaire used to assess trait perfectionism. The MPS-SH is an abbreviated version of the 45-item MPS (Hewitt & Flett, 1991). This version consists of three 5-item subscales corresponding to the original subscales of the MPS: Self-Oriented Perfectionism (SOP), Other-Oriented Perfectionism (OOP), and Socially Prescribed Perfectionism (SPP). Items are reproduced with citation for academic purposes under fair use. Items are rated on a 7-point Likert scale (Strongly Disagree to Strongly Agree) with higher scores indicating higher levels of perfectionism. While it is unclear how the items in this abbreviated version were chosen, subsequent factor analytic studies have found it conforms well to the original 3-factor structure of the MPS (Stoeber, 2018). It shows correlations with the original subscales of .93, .73, and .88 for SOP, OOP and SPP, respectively. Cronbach's alpha values for the three subscales are .86, .75, and .75, respectively, indicating good internal consistency.

### *Multidimensional Scale of Perceived Social Support (MSPSS)*

The MSPSS (Zimet et al., 1988; see Appendix B) is a 12-item measure used to assess perceived social support from Family, Friends and Significant Others. Items are rated on a 7-point Likert scale (Strongly Disagree to Strongly Agree) with higher scores indicating higher levels of perceived social support. The MSPSS is a widely used measure with a well-established three-factor structure supported in numerous studies (Pérez-Villalobos et al., 2021; D. Wang et al., 2021; Zimet et al., 1990); however, it has also been validated as a unidimensional measure (Osman et al., 2014), supporting its use as a single-factor scale. Cronbach's alpha for the total

score is 0.93, and the Cronbach's alpha for the three subscales are .91, .89, and .91, respectively. In the present study, the MSPSS will be used as a unidimensional measure with a single total score to avoid unnecessary model complexity given our lack of specific hypotheses related to the various dimensions of perceived social support.

### ***Social Connectedness Scale – Revised (SCS-R)***

The SCS-R (Lee et al., 2001, see Appendix C) is a 20-item measure used to assess the subjective sense of connectedness and belonging that an individual feels in their interpersonal life. Items are rated on a 6-point Likert scale (Strongly Disagree to Strongly Agree) with higher scores indicating higher levels of social connectedness. The SCS-R is an updated version of the SCS (Lee & Robbins, 1995) developed to address the psychometric limitations of the original tool. Factor analysis of the SCS-R has indicated a unidimensional structure provides the best fit (Lee et al., 2001) and, as such, it is intended to be used as a single factor measure using a total score. Good internal consistency was observed in that study in two different samples, with Cronbach's alphas of .94 and .92.

### ***Attitudes Toward Seeking Professional Psychological Help Scale – Short (ATSPPH)***

The ATSPPH-SF (Fischer & Farina, 1995; see Appendix D) is a 10-item measure used to assess attitudes towards mental health help-seeking. The ATSPPH-SF is an abbreviated version of the original 29-item instrument (Fischer & Turner, 1970). Items are rated on a 4-point Likert scale (Disagree to Agree) with higher scores indicating more favourable attitudes towards mental health help-seeking. The original development study of the ATSPPH-SF reported a unidimensional structure, Cronbach's alpha of .84 and a correlation of 0.87 with the original 29-item scale (Fischer & Farina, 1995). Although some subsequent studies have found different

factor structures (Elhai et al., 2008), the one-factor model has consistently produced high internal consistency ( $>.80$ ) across studies (Constantine, 2002; Komiya et al., 2000; Vogel et al., 2005).

### ***Modified Mental Health and Access to Care Survey (MHACS)***

The MHACS (Statistics Canada, 2022; see Appendix E) is an epidemiological tool developed and distributed by the Canadian Government to assess the prevalence of mental health concerns in the population and access to mental healthcare. In this study, we have used an abbreviated version of the *Mental Health Services* section of the survey (32 items) to assess mental health help-seeking behaviour. Participants are asked to identify healthcare professionals that they have interacted with over the past 12 months about a mental health concern. Professionals listed include a psychiatrist, family doctor or general practitioner, psychologist, social worker, nurse or nurse practitioner, and therapist or counsellor. Data from Item 1 of this instrument were used to compute a binary outcome variable where an individual either had or had not sought help from a healthcare professional over the past 12 months. This acted as our measure of help-seeking behaviour. Additional follow-up questions are included for descriptive purposes only, assessing modality of contact with the professional, whether contact has been discontinued and why, and how helpful the contact was. Additionally, there are questions related to the use of emergency departments, mental health helplines, and self-help groups.

### ***Distress Questionnaire 5 (DQ5)***

The DQ-5 (Batterham et al., 2016) is a 5-item measure used to assess psychological distress. Items are rated on a 5-point Likert scale (Never to Always) with higher scores indicating higher levels of psychological distress. The DQ-5 yields a unidimensional total score, and has shown high internal consistency in two large population based studies, with Cronbach's alpha

values of 0.86 and 0.91 (Batterham et al., 2016, 2018). The DQ-5 compares favourably to other brief psychological distress screening tools in its psychometric properties, including higher sensitivity and specificity for DSM-5 disorders (Batterham et al., 2018)

### *Demographic Questionnaire*

Demographic data were collected for assessment of eligibility as well as for descriptive purposes. Data collected included gender identity, ethnicity, age, university attended, program of study, and city of residence (see Appendix G).

### **Procedure**

This study was approved by the Laurentian University Research Ethics Board (REB). Prospective participants were recruited via Laurentian's SONA system, and through social media ads on Instagram and Facebook (Appendix H) where Ontario university students were invited to participate in a study on personality and student mental health. Upon accessing the link in the ad, prospective participants were brought to the study page on REDCap and presented with the consent form (Appendix I) which included a more detailed description of the study. Upon completing the consent form they were then directed to the demographic questionnaire which was also used to confirm their eligibility. To be eligible, participants had to be between 17 and 29 years old, and enrolled in any university program in Ontario (undergraduate, graduate, professional etc.) Participants who were deemed ineligible did not complete any further questionnaires and were automatically directed to the study debriefing form.

Those who met the eligibility criteria continued to the rest of the study measures, presented in the following order: MHACS, MSPSS, SCS-R, ATSPPHS, DQ5 and MPS-SH. The order of the administration of measures was chosen based on both conceptual similarity and the

desire to minimize potential order effects. Following the completion of all measures, participants were brought to the debriefing form which contained further detail about the purpose and aims of the study and links to mental health support resources for access if desired. For their participation, participants from SONA were offered partial course credit, and participants recruited from social media were entered into a draw for 1 of 4 \$50 Canadian Amazon gift cards.

## **Results**

### **Data Cleaning**

A total of 447 participants completed the consent form, including 133 recruited from SONA and 306 via social media. Through the process of data cleaning, data from 56 participants were removed due to incomplete responses (i.e., failure to complete all study measures). An additional 21 participants were excluded for ineligibility (e.g., age, location etc.), and data from 24 participants were removed due to incorrect responses to one or both of the two indiscriminate response items. Missing data were minimal, with only seven participants missing any items, and no participant missing more than one item per measure. Missing values were addressed using mean item scores rather than total scores. Therefore, the final sample included 346 participants, consisting of 244 participants recruited from social media and 102 from SONA.

### **Scale Descriptives and Interrelatedness of Measures**

A summary of scale means, standard deviations, and Cronbach's alpha reliability coefficients for all continuous measures is presented in Table 2. Reliability coefficients ranged from .78 to .91, indicating good internal consistency across all measures. For our main outcome, assessing actual mental health help-seeking behavior, a binary variable was computed from the Mental Health and Access to Care Survey (MHACS) indicating that participants either had or

had not sought help for a mental health concern over the past 12 months. In our sample, 61.8% (n = 214) of participants had sought help over the past 12 months. Further descriptive data from the MHACS can be found summarized in Table 3.

**Table 2***Descriptive Data and Reliability Estimates for Continuous Measures*

Measure	M	SD	Range	$\alpha$
SOP	5.17	1.18	1.4 – 7.0	.88
SPP	4.81	1.22	1.2 – 7.0	.78
SCS-R	3.64	0.89	1.3 – 5.7	.91
MSPSS	5.17	1.10	1.75 – 7.0	.90
ATSPPHS	2.00	0.54	0 – 2.9	.79
DQ5	3.38	0.76	1.0 – 5.0	.80

*Note:* SOP: Self-Oriented perfectionism, SPP: Socially Prescribed perfectionism, SCS-R: Social Connectedness Scale - Revised, MSPSS: Multidimension Scale of Perceived Social Support, ATSPPHS: Attitudes Towards Seeking Professional Psychological Help Scale, DQ5: Distress Questionnaire 5.

**Table 3***Descriptive Data on Healthcare Provider Contact from MHACS*

	N (%)
Provider Type	
Family doctor	103 (29.8)
Nurse practitioner	29 (8.4)
Registered nurse	7 (2.0)
Psychiatrist	48 (13.9)
Psychologist	48 (13.9)
Social Worker/Psychotherapist	101 (29.2)
On-campus MH service	60 (17.3)
Other	1 (0.4)
None	141 (40.8)
Other Settings	
Emergency Department	17 (4.9)
Self-help group	18 (5.2)
Tele-mental health line	42 (12.1)

*Note:* Percentages exceed 100% as participants could select multiple providers.

Bivariate correlations among all continuous measures are presented in Table 4. SPP, but not SOP, was significantly negatively correlated with both social connectedness and perceived social support. Both SPP and SOP were significantly positively associated with psychological distress. Neither SPP nor SOP was associated with attitudes towards mental health help-seeking. However, both social connectedness and perceived social support showed significant negative associations with attitudes towards mental health help-seeking.

**Table 4**

*Bivariate correlations among continuous variables*

Measure	SOP	SPP	SCS-R	MSPSS	ATSPPHS	DQ5
SOP	-					
SPP	.500*	-				
SCS-R	-.074	-.311*	-			
MSPSS	.000	-.224*	.670*	-		
ATSPPHS	.056	-0.021	.174*	.163*	-	
DQ5	.189*	.373*	-.590*	-.344*	-.065	-

*Note:* \* indicates statistical significance at  $p < .01$

### Hypothesis 1

Bivariate Pearson's  $r$  correlations were conducted to test the hypothesis that both SOP and SPP would be associated with more negative attitudes towards mental health help-seeking. Neither SOP ( $r = .056, p = .300$ ) nor SPP ( $r = -.021, p = .691$ ) was significantly correlated with help-seeking attitudes. For help-seeking behaviour, a dummy coding approach was used (sought help = 1; did not seek help = 0) to allow for bivariate correlations with SOP and SPP. Contrary to expectations, both SOP ( $r = .125, p = .020$ ) and SPP ( $r = .156, p = .004$ ) were significantly positively correlated with help-seeking behaviour. One possible explanation for this unexpected finding is that perfectionism is related to higher levels of psychological distress, which may in turn lead to more help-seeking behaviour. As such, psychological distress was introduced as a

mediator in our analyses for Hypothesis 2 as part of an additional, non-hypothesized exploratory analysis.

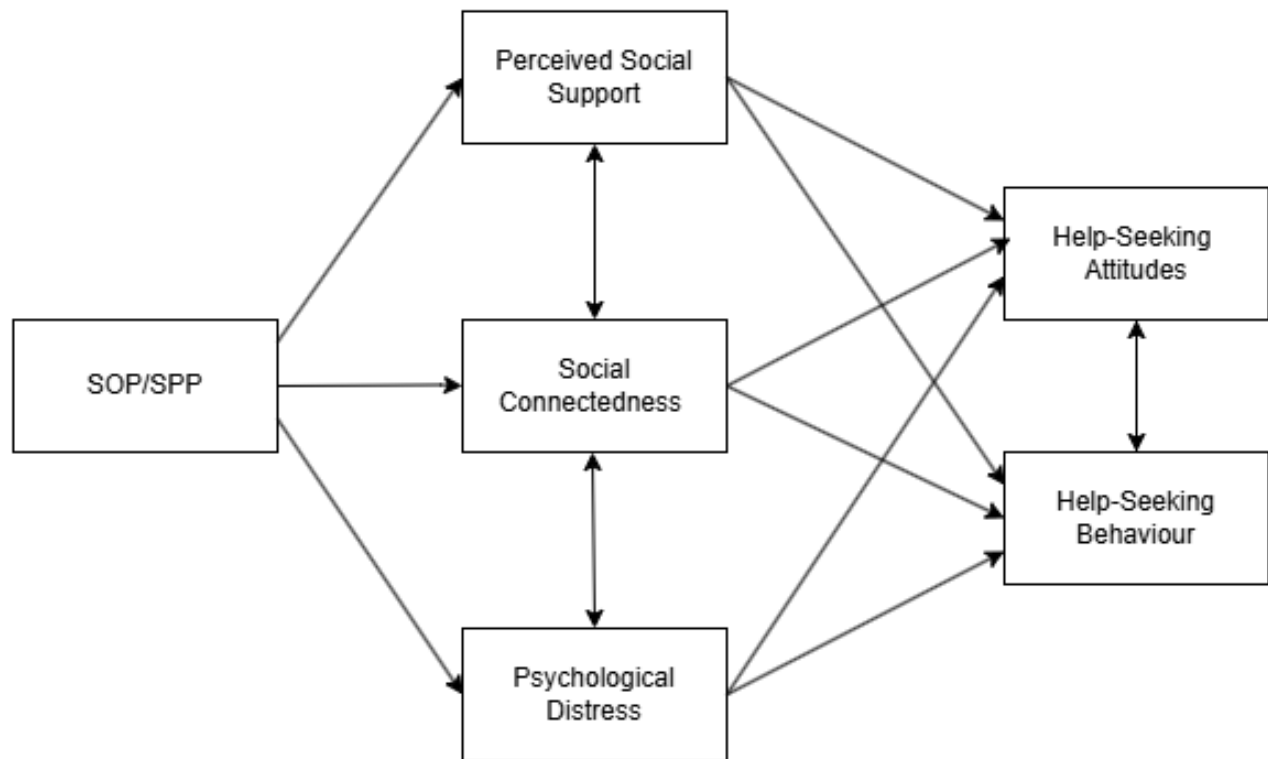
## **Hypothesis 2**

Structural equation modelling was used to test the hypotheses that social connectedness, perceived social support, and psychological distress would mediate the relationship between perfectionism and help-seeking attitudes and behaviour. SEM provides the advantage of testing multiple interrelated hypotheses in a single analysis including both direct and indirect pathways, and is among the most common approaches for conducting mediation analyses in modern studies (Preacher, 2015). The proposed conceptual model is presented in Figure 1. Separate structural models were constructed for SOP and SPP, due to the high degree of shared variance across these two facets of perfectionism. Direct effects of both forms of perfectionism on help-seeking attitudes and behaviour were examined, along with indirect effects through the three mediators: social connectedness, perceived social support, and psychological distress. Bootstrapped confidence intervals, with 5000 bootstraps performed, were used to determine the statistical significance of indirect effects. A summary of the results can be found in Table 5.

Findings indicate that SOP and SPP were not significantly directly associated with help-seeking behaviour or help-seeking attitudes. However, the models revealed a significant mediation pathway from both SOP ( $B = 0.040$ ,  $SE = 0.017$ , Bootstrapped C.I. = 0.011-0.077) and SPP ( $B = 0.075$ ,  $SE = 0.027$ , Bootstrapped C.I. = 0.021-0.131) to higher levels of help-seeking behaviour, mediated by psychological distress. No significant indirect pathways were observed through distress for help-seeking attitudes. No other significant indirect pathways were observed in this structural model, though some effects were approaching significance, particularly the

indirect pathway from SPP to more negative attitudes towards help-seeking via social connectedness.

**Figure 1**



*Note:* SOP: self-oriented perfectionism, SPP: socially prescribed perfectionism

**Table 5***Results from Full Structural Models*

Self-Oriented Perfectionism Model				
Effect	B (SE)	$\beta$	<i>p</i>	Bootstrapped CI
SOP → HS	0.096 (0.060)	0.112	.114	-0.022 - 0.216
SOP → ATSPPHS	0.027 (0.029)	0.060	.345	-0.027 - 0.085
SOP → SCS → HS	-0.001 (0.008)	-0.001	.949	-0.017 - 0.017
SOP → MSPSS → HS	0.000 (0.005)	0.00	.997	-0.010 - 0.011
<b>SOP → DQ → HS</b>	<b>0.040 (0.017)</b>	<b>0.047</b>	<b>.019</b>	<b>0.011 - 0.077</b>
SOP → SCS → ATSPPHS	-0.005 (0.005)	-0.011	.286	-0.016 - 0.003
SOP → MSPSS → ATSPPHS	0.000 (0.002)	0.00	.995	-0.005 - 0.005
SOP → DQ → ATSPPHS	0.003 (0.007)	0.007	.611	-0.010 - 0.018
Socially Prescribed Perfectionism Model				
Effect	B (SE)	$\beta$	<i>p</i>	Bootstrapped CI
SPP → HS	0.088 (0.060)	0.105	.143	-0.030 0.204
SPP → ATSPPHS	0.013 (0.026)	0.029	.632	-0.039 0.065
SPP → SCS → HS	-0.005 (0.028)	-0.006	.851	-0.060 0.049
SPP → MSPSS → HS	0.007 (0.017)	0.009	.671	-0.025 0.044
<b>SPP → DQ → HS</b>	<b>0.075 (0.027)</b>	<b>0.090</b>	<b>.006</b>	<b>0.021 0.131</b>
SPP → SCS → ATSPPHS	-0.022 (0.012)	-0.049	.079	-0.048 0.001
SPP → MSPSS → ATSPPHS	-0.008 (0.007)	-0.018	.274	-0.024 0.005
SPP → DQ → ATSPPHS	0.007 (0.012)	0.016	.559	-0.016 0.033

*Note: Bolded effects indicate statistical significance*

Given the likelihood of attenuated effects due to the model accounting for shared variance among mediators, individual mediation pathways were also analyzed. A summary of these individual mediations is presented in Table 6. In addition to the significant mediation pathways discuss above, results revealed significant indirect effects of SPP on help-seeking attitudes through both social connectedness ( $B = -0.026$ ,  $SE = 0.009$ , Bootstrapped C.I. = -0.046 - -0.010) and perceived social support ( $B = -0.017$ ,  $SE = 0.007$ , Bootstrapped C.I. = -0.031 - -0.005). These results indicate that social connectedness and perceived social support do mediate the relationship between SPP and more negative help-seeking attitudes, but not actual help-

seeking behaviour. Additionally, these results reinforce that the positive relationship between both SOP and SPP and actual help-seeking behaviour is mediated by increased psychological distress.

**Table 6**

*Results from Individual Mediation Analyses*

Self-Oriented Perfectionism				
Effect	B (SE)	$\beta$	<i>p</i>	Bootstrapped CI
SOP → SCS → HS	0.004 (0.004)	0.010	.253	-0.002 - 0.012
SOP → MSPSS → HS	0.000 (0.002)	0.00	.994	-0.005 - 0.005
<b>SOP → DQ → HS</b>	<b>0.016 (0.006)</b>	<b>0.040</b>	<b>.006</b>	<b>0.006 - 0.029</b>
SOP → SCS → ATSPPHS	-0.006 (0.005)	-0.011	.200	-0.016 - 0.002
SOP → MSPSS → ATSPPHS	0.000 (0.004)	0.00	.994	-0.008 - 0.008
SOP → DQ → ATSPPHS	-0.007 (0.006)	-0.015	.258	-0.020 - 0.003
Socially Prescribed Perfectionism				
Effect	B (SE)	$\beta$	<i>p</i>	Bootstrapped CI
SPP → SCS → HS	0.013 (0.007)	0.032	.075	0.000 - 0.028
SPP → MSPSS → HS	0.006 (0.005)	0.016	.238	-0.003 - 0.019
<b>SPP → DQ → HS</b>	<b>0.029 (0.009)</b>	<b>0.073</b>	<b>.001</b>	<b>0.013 - 0.046</b>
<b>SPP → SCS → ATSPPHS</b>	<b>-0.026 (0.009)</b>	<b>-0.058</b>	<b>.005</b>	<b>-0.046 - -0.010</b>
<b>SPP → MSPSS → ATSPPHS</b>	<b>-0.017 (0.007)</b>	<b>-0.037</b>	<b>.012</b>	<b>-0.031 - -0.005</b>
SPP → DQ → ATSPPHS	-0.011 (0.011)	-0.024	.319	-0.032 0.009

*Note:* Bolded effects indicate statistical significance

### Hypothesis 3

Binary logistic regression was used to test the hypothesis that perfectionism would moderate the relationship between help-seeking attitudes and actual help-seeking behaviour. All predictor variables were mean centered for these analyses. Models were tested in a stepwise fashion. First, a simple model was tested using help-seeking attitudes to predict help-seeking behaviour. This model was significant,  $X^2(1) = 33.25, p < .001$ , explaining between 9.2% (Cox & Snell  $R^2$ ) and 12.5% (Nagelkerke  $R^2$ ) of the variance in help-seeking behaviour. The Hosmer-Lemeshow test indicated good model fit,  $X^2(7) = 7.87, p = .345$ . As expected, help-seeking

attitudes positively predicted help-seeking behaviour ( $B = 1.25, p < .001, \text{Exp}(B) = 3.48$ ).

Subsequently, a second block was added that included SPP and an interaction term (SPP x help-seeking attitudes). This model was also significant ( $X^2(2) = 33.25, p < .001$ ) explaining between 12.7% (Cox & Snell  $R^2$ ) and 17.3% (Nagelkerke  $R^2$ ) of the variance in help-seeking behaviour. The Hosmer-Lemeshow test again indicated good fit ( $X^2(8) = 13.06, p = .11$ ). In this model, both help-seeking attitudes ( $B = 1.35, p < .001, \text{Exp}(B) = 3.86$ ) and SPP ( $B = 0.30, p = .003, \text{Exp}(B) = 1.35$ ) significantly positively predicted help-seeking behaviour. However, the interaction between SPP and help-seeking attitudes was not significant ( $B = -0.37, p = .074, \text{Exp}(B) = 0.69$ ).

A separate binary logistic regression was conducted again in stepwise fashion but with SOP and an interaction term (SOP x help-seeking attitudes) added in the second block. Results from the first block of this model are identical to those described above. Block 2 of this model was significant ( $X^2(2) = 6.635, p = .036$ ) explaining between 10.9% (Cox & Snell  $R^2$ ) and 14.8% (Nagelkerke  $R^2$ ) of variance in help-seeking behaviour. The Hosmer-Lemeshow test suggested good fit to the data ( $X^2(8) = 4.79, p = .780$ ). In this model, help-seeking attitudes positively predicted help-seeking ( $B = 2.65, p < .001, \text{Exp}(B) = 14.11$ ) but SOP did not ( $B = 0.20, p = .052, \text{Exp}(B) = 1.221$ ), although the effect was approaching significance. The interaction effect between SOP and help-seeking attitudes was not significant ( $B = -0.27, p = .154, \text{Exp}(B) = 0.76$ ). These results suggest that neither SPP nor SOP significantly moderate the relationship between help-seeking attitudes and help-seeking behavior, although the moderation effect of SPP was approaching significance.

## Discussion

Despite the fact that roughly 80% of Canadians have a primary care provider, less than 50% of Canadians experiencing a mental health concern received care in 2022 (Duong & Vogel, 2023; Stephenson, 2023). This discrepancy may point to a significant gap in mental health help-seeking behaviour. Understanding the underlying causes of low rates of mental health help-seeking is an important step in addressing this gap. Perfectionism is one such variable that has been posited to be implicated in mental health help-seeking. The current study examined the relationship between perfectionism and mental health help-seeking using the framework of the Perfectionism Social Disconnection Model (PSDM). While the previous literature examining this relationship has primarily been focused on help-seeking attitudes, this study sought to investigate this relationship by also assessing actual help-seeking behaviour.

Overall, the findings from the study provide evidence that perfectionism may not be as predictive of either mental health help-seeking attitudes or actual help-seeking behaviours as previously suggested in the literature. We found no evidence of zero-order correlations between either self-oriented (SOP) or socially prescribed perfectionism (SPP) and help-seeking attitudes; a finding that runs contrary to previous studies (Dang et al., 2020; Shannon et al., 2018). We also found that, contrary to our primary hypothesis, both facets of perfectionism predicted higher rates of mental health help-seeking over the prior 12 months, a relationship that was mediated by increased psychological distress. While there is very little previous research examining the relationship between perfectionism and actual help-seeking behaviour, one existing study found that perfectionism was associated with a lower likelihood of receiving mental health treatment among a sample of medical and dental students currently experiencing elevated psychological

distress (Ey et al., 2000). Our findings do not align with this previous study by Ey and colleagues.

The lack of significant negative relationships between either facet of perfectionism and help-seeking attitudes or behaviour is a surprising finding. Several prior studies, as noted above, have reported moderate zero-order negative associations between perfectionism, particularly SPP, and help-seeking attitudes. Given the limited number of studies examining this relationship, it is possible that the association is simply not as robust as previously suggested. As more research is conducted, including the current study, a less consistent pattern of results may emerge.

It is also possible that some demographic features of our sample contributed to this unexpected finding. Notably, the mean scores on our measure of help-seeking attitudes were higher, and less varied, than those reported in normative samples. Additionally, among participants in our sample who reported elevated psychological distress (i.e., above the median), 71.6% had sought help for a mental health concern in the past 12 months, suggesting relatively high rates of help-seeking among participants experiencing distress. This may suggest that our recruitment method, specifically the voluntary and self-selecting nature of a social media recruitment, resulted in a sample of individuals with generally overall more favourable attitudes towards mental health help-seeking. Although the study was intentionally not advertised as being related to mental health help-seeking, it is still possible that a non-representative sample was recruited. Further, we failed to recruit a significant proportion of men in our study. Gender is a well-documented predictor of mental health help-seeking, with women being roughly 1.6 times more likely than men to seek help for a mental health concern, even when controlling for incidence rates (McManus et al., 2016; P. S. Wang et al., 2005). Although samples with a

majority of women are common in psychology research, the degree of gender imbalance in the current study may have resulted in a sample with generally more favourable attitudes and less variance.

We also posited that the relationships between perfectionism and both help-seeking attitudes and actual behaviour would be mediated by social disconnection, operationalized as social connectedness and perceived social support. In line with the PSDM, we hypothesized that both SOP and SPP would predict lower levels of social connectedness and perceived social support. In turn, these lower levels of social connection were expected to predict more negative attitudes towards mental health help-seeking and lower rates of help-seeking behaviour. Overall, our results suggest that the PSDM does not provide a robust account of the relationship between perfectionism and mental health help-seeking. Findings from the mediation analyses suggest a mixed pattern of results. Despite the absence of zero-order associations, small but significant indirect effects emerged for SPP through both social connectedness and perceived social support, predicting more negative attitudes towards mental health help-seeking. The presence of significant indirect effects in the absence of zero-order direct effects is a pattern that can emerge when there are potentially multiple mediation processes operating in opposite directions (O'Rourke & MacKinnon, 2018). This may suggest that while perfectionism predicts more negative attitudes towards help-seeking via social disconnection, there may also be an unidentified parallel mediation pathway through which perfectionism is associated with more positive attitudes towards help-seeking (e.g. a tendency towards self-improvement).

We also predicted that there would be a mediation pathway in which perfectionism would predict lower rates of actual help-seeking behaviour through increased social disconnection. However, we failed to find evidence of significant indirect effects on help-seeking behaviour

when either social connectedness or perceived social support was examined as a mediator. As previously discussed, the most pronounced mediation result was the indirect effect of both SOP and SPP on actual help-seeking behaviour, whereby higher perfectionism predicted increased help-seeking through the mediator of higher psychological distress. This finding is consistent with the extensive literature linking perfectionism to various forms of psychopathology (Callaghan et al., 2023; Limburg et al., 2017)) While we expected to find that the negative relationship between perfectionism and help-seeking would override the effect of psychological distress, our results suggest the opposite. Specifically, the relationship between perfectionism and increased psychological distress, which, in turn, prompts help-seeking, appears to outweigh the potential inhibitory effect of perfectionism on help-seeking behaviour.

Lastly, we hypothesized that perfectionism would moderate the relationship between help-seeking attitudes and actual help-seeking behaviour, such that higher levels of perfectionism would weaken the relationship between participants' stated attitudes towards help-seeking and their actual behaviour. Our findings indicated no significant moderation effects of perfectionism on the attitude-behaviour relationship. However, the moderation effect of SPP was approaching significance in the hypothesized direction. This hypothesis was primarily exploratory as this particular research question had not been directly examined in previous literature. Although the results fall short of statistical significance, they trended in the hypothesized direction, suggesting a potential moderation effect whereby perfectionism may weaken the relationship between individuals' stated attitudes towards mental health help-seeking and their actual help-seeking behaviour. These preliminary findings indicate that further exploration into the potential moderating effect of perfectionism in the attitude-behaviour relationship in mental health help-seeking is warranted.

## **Limitations**

Results of the current study should be contextualized in light of several limitations. Most importantly, this study utilized a cross-sectional design, and as such, limits the ability to draw causal inferences. Given that perfectionism is a stable individual difference with a developmental trajectory that aligns with the typical developmental trajectory of personality more broadly (i.e., typically emerges and stabilizes in late childhood or early adolescence (Damian et al., 2022; Herman et al., 2013), reverse causation is unlikely. That is, it is unlikely that more state-like constructs such as social connectedness or perceived social support are driving the development of perfectionism. Similarly, it is unlikely that help-seeking attitudes or recent help-seeking behaviour are causal factors in the development of perfectionism. However, despite the theoretical rationale suggesting reverse causation is unlikely, it cannot be ruled out entirely. Longitudinal designs are better suited for establishing temporal order and making stronger causal inferences. Unfortunately, a longitudinal design with outcomes assessed across multiple time points was not feasible for this study given time constraints.

Another limitation of the current study is the underrepresentation of men. As discussed, men tend to hold more negative attitudes towards mental health help-seeking and are less likely to seek help for a mental health concern, even when experiencing distress. This may have influenced our results as we generally observed more favourable attitudes towards help-seeking and higher rates of help-seeking than expected. Given the disproportionate representation of participants who identified as women, the findings may not be generalizable across all gender identities.

Lastly, it must be acknowledged that the effect sizes of the significant mediation effects observed in our analyses are small and should be interpreted with caution. The mediation

pathways from perfectionism through social disconnection accounted for only a small proportion of the total variance in help-seeking attitudes. While these findings do provide some insights into an understudied issue, the small effect sizes suggest that they may fall short of having direct practical applications in addressing the help-seeking gap.

### **Future Directions**

Building on the current study's findings and limitations, several avenues for future research are warranted. First, to address the limitation of the cross-sectional design, future studies examining the relationship between perfectionism and mental health help-seeking should employ longitudinal designs. These designs would allow for stronger inferences about causal relationships between perfectionism, social disconnection, and help-seeking behavior. Understanding causal relationships among these variables is important for the development of targeted interventions that aim to increase mental health help-seeking. For example, if perfectionism was an important causal variable in predicting help-seeking, it may be an important target of interventions to promote mental health help-seeking.

Future research should also prioritize more representative sampling with regard to gender diversity and broader community representation. The current study's predominantly woman-identifying sample limits the generalizability of the findings and may obscure gender-specific help-seeking patterns due to the inability to conduct gender-based comparisons, given the low number of participants identifying as men or other genders. Future studies should also prioritize broader community sampling to enhance external validity. As is often the case in psychological research, there is a tradeoff between internal and external validity. In this study, a student-based sample was chosen to minimize the potential confounding effect of lack of access to mental

health care. However, this limits the representativeness of the sample and, consequently, the generalizability of the findings to the general population.

Finally, future studies examining the relationship between perfectionism and help-seeking should continue to assess actual help-seeking behaviour as opposed to relying solely on help-seeking attitudes. The results of this study suggest that, while related, patterns that emerge in the prediction of help-seeking attitudes do not necessarily hold for actual mental health help-seeking behaviors. Despite the logistical complexity of assessing actual help-seeking behaviour, it is critical that studies measure the construct of true interest, help-seeking behaviour, rather than using help-seeking attitudes as a proxy.

## **Conclusions**

The current study contributes to the growing body of literature examining the complex relationship between perfectionism and mental health help-seeking by uniquely focusing on actual help-seeking behaviour. Additionally, it offers the first exploration of the mechanisms underlying this relationship using the framework in the Perfectionism Social Disconnection Model. Our findings indicate that perfectionism was not directly associated with more negative help-seeking attitudes or a lower likelihood of seeking help. Instead, perfectionism predicted higher rates of help-seeking behaviour indirectly through increased psychological distress. This suggests that the adverse effect of perfectionism on mental health may ultimately outweigh any perfectionism-related attitudinal barriers to mental health help-seeking. These results highlight the importance of considering psychological distress as a key mediator when evaluating perfectionism's influence on mental health help-seeking behaviour.

While overall our findings suggest that the PDSM does not provide a robust account of the relationship between perfectionism and mental health help-seeking, we did find evidence that a mediation pathway from perfectionism through social disconnection may account for a small portion of the variance in help-seeking attitudes. Moving forward, longitudinal research with more representative samples, as discussed above, is essential to clarify the causal pathways and contextual influences underlying these associations. Despite its limitations, the present study provides a valuable foundation for future research and underscores the importance of assessing actual help-seeking behaviour to more accurately understand the factors that influence mental health help-seeking.

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## Appendix A

### Multidimensional Perfectionism Scale (MPS-SH)

**Directions:** Listed below are a number of statements concerning personal characteristics and traits. Read each item and decide whether you agree or disagree and to what extent.

If you *strongly agree*, circle 7; if you *strongly disagree*, circle 1; if you feel somewhere in between, circle any one of the numbers between 1 and 7. If you feel neutral or undecided, the midpoint is 4. Please do not leave any blanks.

1. One of my goals is to be perfect in everything I do.
2. Everything that others do must be of top-notch quality.
3. The better I do, the better I am expected to do.
4. I strive to be as perfect as I can be.
5. It is very important that I am perfect in everything I attempt.
6. I have high expectations for the people who are important to me.
7. I demand nothing less than perfection of myself.
8. I can't be bothered with people who won't strive to better themselves.
9. Success means that I must work even harder to please others.
10. If I ask someone to do something, I expect it to be done flawlessly.
11. I cannot stand to see people close to me make mistakes.
12. I must work to my full potential at all times.
13. My family expects me to be perfect.
14. People expect nothing less than perfection from me.
15. People expect more from me than I am capable of giving.

Items 1, 4, 5, 7, and 12: self-oriented perfectionism

Items 2, 6, 8, 10, and 11: other-oriented perfectionism

Items 3, 9, 13, 14, and 15: socially prescribed perfectionism

## Appendix B

### Multidimensional Scale of Perceived Social Support (MSPSS)

**Instructions:** We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

**Rating Scale:**

- 1 Very Strongly Disagree
- 2 Strongly Disagree
- 3 Mildly Disagree
- 4 Neutral
- 5 Mildly Agree
- 6 Strongly Agree
- 7 Very Strongly Agree:

- 1. There is a special person who is around when I am in need.
- 2. There is a special person with whom I can share my joys and sorrows.
- 3. My family really tries to help me.
- 4. I get the emotional help and support I need from my family.
- 5. I have a special person who is a real source of comfort to me.
- 6. My friends really try to help me.
- 7. I can count on my friends when things go wrong
- 8. I can talk about my problems with my family
- 9. I have friends with whom I can share my joys and sorrows.
- 10. There is a special person in my life who cares about my feelings.
- 11. My family is willing to help me make decisions.
- 12. I can talk about my problems with my friends.

## Appendix C

### Social Connectedness Scale – Revised (SCS-R)

**Directions:** Following are a number of statements that reflect various ways in which we view ourselves. Rate the degree to which you agree or disagree with each statement using the following scale (1 = Strongly Disagree and 6 = Strongly Agree). There is no right or wrong answer. Do not spend too much time with any one statement and do not leave any unanswered.

**Rating Scale:** (\*Items 3, 6, 7, 9, 11, 13, 15, 17, 18 and 20 are reverse coded)

1 Strongly Disagree

2 Disagree

3 Mildly Disagree

4 Mildly Agree

5 Agree

6 Strongly Agree

1. I feel comfortable in the presence of strangers
2. I am in tune with the world
3. Even among my friends, there is no sense of brother/sisterhood
4. I fit in well in new situations
5. I feel close to people
6. I feel disconnected from the world around me
7. Even around people I know, I don't feel that I really belong
8. I see people as friendly and approachable
9. I feel like an outsider
10. I feel understood by the people I know
11. I feel distant from people
12. I am able to relate to my peers
13. I have little sense of togetherness with my peers
14. I find myself actively involved in people's lives
15. I catch myself losing a sense of connectedness with society
16. I am able to connect with other people
17. I see myself as a loner
18. I don't feel related to most people
19. My friends feel like family
20. I don't feel I participate with anyone or any group

## Appendix D

### Attitudes Towards Seeking Professional Psychological Help Scale – Short Form (ATSPPH)

**Directions:** Please read each statement carefully and indicate your agreement or disagreement using the scale below.

**Rating Scale:**

0 Disagree

1 Partly Disagree

2 Partly Agree

3 Agree

\* Items 2, 8, 9, 10 are reverse coded.

1. If I thought I was having a mental breakdown, my first thought would be to get professional attention.
2. Talking about problems with a psychologist seems to me as a poor way to get rid of emotional problems.
3. If I were experiencing a serious emotional crisis, I would be sure that psychotherapy would be useful.
4. I admire people who are willing to cope with their problems and fears without seeking professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counselling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is more likely to solve it with professional help.
8. Given the amount of time and money involved in psychotherapy, I am not sure that it would benefit someone like me.
9. People should solve their own problems, therefore, getting psychological counselling would be their last resort.
10. Personal and emotional troubles, like most things in life, tend to work out by themselves.

## Appendix E

### Modified Mental Health and Access to Care Survey (MHACS)

*Now I would like to ask you some questions about your contacts with health professionals as well as other people about problems with your emotions, mental health or use of alcohol or drugs.*

1. During the past 12 months, have you seen or talked on the telephone or over the Internet to any of the following people about problems with your emotions, mental health or use of alcohol or drugs? (Select all that apply)

1. Family doctor or general practitioner
2. Nurse or Nurse Practitioner
3. Psychiatrist
4. Psychologist
5. Social worker, counsellor, case worker or psychotherapist
6. On-campus Counselling/Mental Health Service
7. Other – Specify
8. None

2. How did you talk with a family doctor? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer
4. Text message or written chat

3. In general, how much would you say this family doctor or general practitioner helped you (for your problems with your emotions, mental health or use of alcohol or drugs)?

1. A lot
2. Some
3. A little
4. Not at all

4. Have you stopped talking to this family doctor or general practitioner about your problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No

5. Why did you stop talking to your family doctor?

1. I felt better
2. I completed the recommended treatment
3. I thought it was not helping
4. I thought the problem would get better without more professional help
5. I couldn't afford to pay
6. I were too embarrassed to see the professional
7. I wanted to solve the problem without professional help

8. I had problems with things like transportation, childcare or your schedule
9. The service or program was no longer available
10. I was not comfortable with the professional's approach
11. Because of discrimination or unfair treatment
12. Other – Specify

6. How did you talk with a nurse or nurse practitioner? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer
4. Text message or written chat

7. In general, how much would you say this nurse or nurse practitioner helped you (for your problems with your emotions, mental health or use of alcohol or drugs)?

1. A lot
2. Some
3. A little
4. Not at all

8. Have you stopped talking to this nurse or nurse practitioner about your problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No

9. Why did you stop talking to this nurse or nurse practitioner?

1. I felt better
2. I completed the recommended treatment
3. I thought it was not helping
4. I thought the problem would get better without more professional help
5. I couldn't afford to pay
6. I were too embarrassed to see the professional
7. I wanted to solve the problem without professional help
8. I had problems with things like transportation, childcare or your schedule
9. The service or program was no longer available
10. I was not comfortable with the professional's approach
11. Because of discrimination or unfair treatment
12. Other – Specify

10. How did you talk with a psychiatrist? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer
4. Text message or written chat

11. In general, how much would you say the psychiatrist helped you (for your problems with your emotions, mental health, or use of alcohol or drugs)?

1. A lot
2. Some
3. A little
4. Not at all

12. Have you stopped talking to the psychiatrist?

- Yes
- No

13. Why did you stop talking to the psychiatrist?

1. I felt better
2. I completed the recommended treatment
3. I thought it was not helping
4. I thought the problem would get better without more professional help
5. I couldn't afford to pay
6. I were too embarrassed to see the professional
7. I wanted to solve the problem without professional help
8. I had problems with things like transportation, childcare or your schedule
9. The service or program was no longer available
10. I was not comfortable with the professional's approach
11. Because of discrimination or unfair treatment
12. Other – Specify

14. How did you talk with a psychologist? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer
4. Text message or written chat

15. In general, how much would you say this psychologist helped you (for your problems with your emotions, mental health, or use of alcohol or drugs)?

1. Not at all
2. A little
3. Some
4. A lot
5. Extremely

16. Have you stopped talking to this psychologist?

- Yes
- No

17. Why did you stop talking to this psychologist?

1. I felt better
2. I completed the recommended treatment
3. I thought it was not helping

4. I thought the problem would get better without more professional help
5. I couldn't afford to pay
6. I were too embarrassed to see the professional
7. I wanted to solve the problem without professional help
8. I had problems with things like transportation, childcare or your schedule
9. The service or program was no longer available
10. I was not comfortable with the professional's approach
11. Because of discrimination or unfair treatment
12. Other – Specify

18. How did you talk with a social worker, counsellor, case worker, or psychotherapist? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer
4. Text message or written chat

19. In general, how much would you say this professional helped you (for your problems with your emotions, mental health or use of alcohol or drugs)?

1. A lot
2. Some
3. A little
4. Not at all

20. Have you stopped talking to this professional about your problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No

21. Why did you stop talking to this professional?

1. I felt better
2. I completed the recommended treatment
3. I thought it was not helping
4. I thought the problem would get better without more professional help
5. I couldn't afford to pay
6. I were too embarrassed to see the professional
7. I wanted to solve the problem without professional help
8. I had problems with things like transportation, childcare or your schedule
9. The service or program was no longer available
10. I was not comfortable with the professional's approach
11. Because of discrimination or unfair treatment
12. Other – Specify

22. How did you talk with the On-campus Counselling/Mental Health Service? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer

4. Text message or written chat

23. In general, how much would you say this On-campus Counselling/Mental Health Service helped you for your problems with your emotions, mental health or use of alcohol or drugs?

1. A lot
2. Some
3. A little
4. Not at all

24. How did you talk with this On-campus Counselling/Mental Health Service? Was it... ?

1. In person
2. Over the telephone (voice only)
3. Using video on a phone, tablet or computer
4. Text message or written chat

25. In general, how much would you say this On-campus Counselling/Mental Health Service helped you (for your problems with your emotions, mental health or use of alcohol or drugs)?

1. A lot
2. Some
3. A little
4. Not at all

26. Have you stopped talking to this On-campus Counselling/Mental Health Service about your problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No
- Don't know, refusal

27. Why did you stop talking to this On-campus Counselling/Mental Health Service?

1. I felt better
2. I completed the recommended treatment
3. I thought it was not helping
4. I thought the problem would get better without more professional help
5. I couldn't afford to pay
6. I were too embarrassed to see the professional
7. I wanted to solve the problem without professional help
8. I had problems with things like transportation, childcare or your schedule
9. The service or program was no longer available
10. I was not comfortable with the professional's approach
11. Because of discrimination or unfair treatment
12. Other – Specify

28. During the past 12 months did you present at a hospital emergency department for help with problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No

29. During the past 12 months, did you go to a self-help group for help with problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No

30. What type of self-help group did you go to?

1. Emotional or mental health (e.g. groups for eating disorders, bipolar disorder, bereavement, etc.)
2. Alcohol or drug use (e.g. Alcoholics Anonymous, Narcotics Anonymous, etc.)
3. Other – Specify

31. During the past 12 months, did you use a telephone or texting helpline for problems with your emotions, mental health or use of alcohol or drugs?

- Yes
- No

32. Please specify what telephone or texting helpline you used:

## **Appendix F**

### **Distress Questionnaire 5**

**In the past 30 days....**

1. My worries overwhelmed me
2. I felt hopeless
3. I found social settings upsetting
4. I had trouble staying focused on tasks
5. Anxiety or fear interfered with my ability to do the things I needed to do at work or at home

#### **Rating Scale**

1 Never

2 Rarely

3 Sometimes

4 Often

5 Always

## Appendix G

### Demographic Questionnaire

1. Do you currently live in Ontario??
  - a. Yes
  - b. No
  
2. Are you currently enrolled as a student at a university in Ontario?
  - a. Yes
  - b. No
  
3. Please indicate your current age (in years):
  - a. \_\_\_\_\_
  
4. What city do you live in?
  - a. \_\_\_\_\_
  
5. Please type the full name of the university you attend:
  - a. \_\_\_\_\_
  
6. What type of program are you enrolled in?
  - a. Undergraduate degree program (BA, BSc etc)
  - b. Graduate degree program (MA, MSc, PhD. etc.)
  - c. Medical/dental school
  - d. Graduate professional program (Law, Social work, Physiotherapy, Nursing etc.)
  - e. Other (please specify)
  
7. What is your gender identity?
  - a. Male
  - b. Female
  - c. Transgender male
  - d. Transgender female
  - e. Non-binary
  - f. I prefer to specify my own gender identity:
  
8. What is your ethnicity?
  - a. Asian
  - b. Black or African American
  - c. First Nations
  - d. Hispanic/Latino
  - e. Metis
  - f. Inuit
  - g. Middle Eastern or North African

- h. Native Hawaiian or Other Pacific Islander
- i. South Asian
- j. White/Caucasian
- k. Other (Please specify): \_\_\_\_\_
- l. Prefer not to say

## Appendix H

## Study Recruitment Advertisement

**UNIVERSITY STUDENTS NEEDED  
FOR AN ONLINE STUDY ON  
PERSONALITY AND MENTAL  
HEALTH**

**TIME REQUIRED:  
10-15 MIN**

**YOU WILL BE ENTERED INTO 1  
OF 4 DRAWS FOR A \$50  
AMAZON GIFT CARD**

**REQUIREMENTS :**

- Enrolled at an Ontario university
- Between the ages of 17-29
- Fluent in English



**INTERESTED IN PARTICIPATING?  
LINK:**

*This study has been reviewed and approved by the  
Laurentian University Research Ethics Board (File#)*

## Appendix I

### Consent Form



**Study Title:** The role of personality in university student mental health

**Researchers:** Noah Brierley & Dr. Chantal Arpin-Cribbie

The goal of this study is to investigate the role that personality plays in personal relationships and mental health in university students. For this study, we are recruiting Ontario university students, between the ages of 17-29, who are currently enrolled in any undergraduate, graduate, or professional program.

If you choose to participate in this study, you will be asked to answer questions about your personality, personal relationships and some questions related to your mental health. The online study will take about 10-15 minutes to complete. For your participation, you may choose to be entered in a draw for 1 of 4 \$50 Amazon Gift Cards. At the end of the study, we will provide more detail about the purpose of the study. In case you have any additional questions, we have provided the researchers' contact information below.

We don't expect this study to cause any harm, though it is possible that answering some of the questions may result in a slight increase in psychological distress. If you feel like you need help, or you want to talk with someone, you can reach out to the following free contact(s):

**Good2Talk (support services for post-secondary students in Ontario)**

(T): 1-866-925-5454

(Text): GOOD2TALKON to 686868

**Canadian Mental Health Association (in your regional area):**

(W): <https://cmha.ca/find-your-cmha>

**Connex Ontario**

(W): <https://www.connexontario.ca/en-ca/>

**Talk Suicide Canada**

(T): 1-833-456-4566

(Text): 45645 (4:00PM to Midnight ET)

**Suicide Crisis Helpline**

(T): 9-8-8

(Text): 9-8-8

You can decide whether or not you want to do this study. If you start, you can stop at any time. There is no consequence if you choose to stop. We won't ask you for your name, so any answers you give us cannot be linked to you in any way. Once you have submitted your responses they are not linked to your email or personal information in any way. Your responses cannot be removed after submission as there is no way to differentiate them from other participants. The identifying information (i.e. email address) we collect in this study will be kept safely and confidentially on password protected drives for a period of 5 years, after which it will be destroyed. The compiled results from this research study may be shared in the form of presentations or publication

If you have any questions about this study, you can contact either researcher:

Noah Brierley at [nbrierley@laurentian.ca](mailto:nbrierley@laurentian.ca)

Dr. Chantal Arpin-Cribbie at [carpincribbie@laurentian.ca](mailto:carpincribbie@laurentian.ca) or at 1-855-675-1151 ext. 6702.

For questions about the ethics of your participation in the study, you may contact a Research Ethics Officer from the Laurentian University Research Office at [ethics@laurentian.ca](mailto:ethics@laurentian.ca) or 1-800-461-4030 ext. 2429.

I have read the information and agree to participate in this study. I know that even though I did not sign a consent form, information related to my participation is sent to the researchers and answering questions can be understood as consent.

I agree to participate in this study:  Yes  No

- Email: \_\_\_\_\_
  - Please note, the email will NOT be linked to any of your data. Your email address will be used only for the purposes that you agree to below.
- I wish to be entered into the draw for 1 of 4 Amazon Gift Cards.
  - Yes (the email from above will be used)
  - No.
- I wish to have the provided list of mental health support resources emailed to me.
  - Yes (the email from above will be used)
  - No.
- I wish to have the findings of this study shared with me.
  - Yes (the email from above will be used)
  - No.