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The Influence of Culture and Self-Perception on the Mental Health Care-Seeking Intentions of College Students

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Abstract— **Mental health issues are common among young adults, especially those attending colleges and universities. There has been a growing concern related to the number of unmet mental health concerns for students and the potential ramifications associated with this unmet need. Hunt and Eisenberg (2010) found that approximately 17% of college students experience a mental health concern, yet only 20% of those with a concern obtain mental health care services. One's upbringing and background are known to influence decision making and are likely to play a role in decisions to seek mental healthcare; however, these norms can vary across cultures. In addition, depending on how one perceives the state of their own mental health, their intentions towards service utilization may be altered. The influence of culture and self-perception on intentions to seek mental health services were examined within this study. Results showed that students were more likely to recommend formal, professional, mental health treatments for their friend rather than themselves, even if symptoms were identical, χ^2 (1, n = 861) = 96.67, p < 0.001. However, there was not a significant relationship between participants' background and their likelihood to recommend formal treatment options, nor background and attitudes towards seeking professional psychological care. Neither recommendations for seeking formal treatment nor attitudes toward seeking psychological care appeared to be influenced by whether participants were from "stoic" or "emotionally-open" cultural backgrounds. Identification of specific barriers preventing individuals from obtaining formal treatment warrants future research and will aid in the development of recommendations in how to provide mental health care-services to diverse university populations.**

Keywords—Mental Health, care-seeking intentions, college students

INTRODUCTION

Self-Perception

Obtaining effective health care is often seen as highly dependent on the health care provider; however, the importance of patient receptivity is generally overlooked. Often a big challenge of evaluating health is the conflict between the patients' own exclusive viewing of their health status (the "internal" view), versus the observations and assessment of the health care provider (the "external" view; Sen, 2002; Perez-Zepeda et al., 2016). The discord between these two views could lead to some patients normalizing difficulties that a provider finds troubling or in need of treatment; and therefore, leads to the patient not seeking treatment (Sen, 2000; Villatoro, Mays, Ponce, & Aneshensel, 2018). Comparisons between the internal perception and external observations, or other objective assessments, of health have demonstrated a bias for under-reporting internal experiences (Lee & Dugan, 2015; Garbarski, 2016). However, this bias has not been well-examined when considering aspects of mental health. In addition to this under-reporting bias, cultural factors may also play a role in help seeking, which may be related to perception of need. If a patient, specifically a college student, feels that perhaps their anxiety, depression, or any other form of mental duress is "normal" due to their circumstances and environment, then they may not recognize the severity of their symptoms, further limiting their intentions to seek mental health services (Prins, Verhaak, Bensing, & van der Meer, 2008). In addition, contingent on where an individual self-identifies their origin to be, established upon country or cultural background, they may even have a different reference level of health (Jürger, 2006), which may affect their perceived need of and rate of mental health service utilization.

Culture

Ideological views and values, including openness to professional, mental health treatment, can often be influenced by a person's background (Komiya, Good, & Sherrod, 2000). Factors of emotional openness, such as strong beliefs in individualism, stoicism, low interpersonal dependence, and reluctance to disclose inner thoughts and feelings, may underlie reluctance to obtain professional help (Komiya et al., 2000).

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Stoicism is often described as a silent endurance of illness, comprised of high levels of emotional control, often through silence or acceptance that can vary based upon factors such as gender, geographic area, and cultural differences (Moore, Grime, Campbell, & Richardson, 2012). Values which promote emotional inhibition can also increase the experience of self-stigma for individuals, especially college students, who may fear becoming "weak" or "inferior" if they were to seek services such as counseling (Lannin, Vogel, Brenner, Abraham, & Heath, 2015; Nam et al., 2013). Obtaining professional mental health treatment differs in consideration of race and ethnicities. Specifically, low emotional openness has been associated with increased self-stigmatizing behavior, increasingly so from those from ethnic minority groups (Komiya et al., 2000). In a study on race and ethnic differences in treatment-seeking for post-traumatic stress disorder in the United States, it was found that a significantly lower percentage of all minority races and ethnicities receive professional treatment (e.g., via doctor, counselor, hospital) than those of Caucasian backgrounds, specifically those who identify as African American, Hispanic, or Asian (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011).

Alexithymia, or the difficulty expressing, managing, or experiencing emotions, has been shown to be negatively associated with attitudes towards help-seeking and is typically more common in men (Berger, Levant, McMillian, Kelleher, & Seller, 2005). Additionally, alexithymia has been associated with increased avoidance of mental health care services for fear it does not align with the male gender role social construct (Berger et. al, 2005; Brenner, Cornish, Heath, Lannin, & Losby, 2019). There are various cultural groups that value the notion of stoicism, or emotion inhibition, during duress, believing there is virtue in suffering silently (Moore et. al, 2012). There are notable differences with help-seeking behaviors and intentions of those from different ethnic/racial backgrounds. For example, there have been studies which demonstrate that people of color may, specifically, African-American may tend to seek informal methods of support for mental health concerns, and are more likely to believe that their mental health concerns will improve over time. Asian-Americans have also been found to be less likely to seek assistance for mental health concerns than those who are not of Asian descent (Villatoro et al., 2018). Understanding self-concepts, which can often be culturally predisposed, give us additional information which may help us understand the cultural factors which influence the willingness to seek help, specifically those mental health-related in nature.

Mental Health Care-Seeking

The purpose of this study was to examine factors that affect the likelihood of college students seeking mental health care services with a primary focus on the influence of culture and self-perception. While it is understood that a person's background and upbringing influence their daily lives and values, there is limited research on the extent of this influence on mental health treatment seeking. Previous research has found that those coming from families that have not fully acculturated, specifically those of Asian descent, may have more stoic attitudes related to mental health (Sen, 2002; Han & Pong, 2015). Additionally, it has been found that individuals who identify as Asian-American and African-American are significantly less likely that Caucasian individuals to perceive a need to seek mental health care, all other factors held constant (Villatoro et al., 2018). As such, this study sought to understand if there are variances in the likelihood to seek and obtain mental healthcare services between students from more traditionally, emotionally open cultures and students from more traditionally emotionally inhibited cultures. It is hypothesized that individuals from less emotionally open backgrounds would endorse less intentions to seek mental health treatment and endorse less favorable attitudes towards mental health treatment. Education levels are associated with positive attitudes with treatment; however, this may intersect with ideologies with racial/ethnic minorities where one may be able to perceive overall mental health concerns but be unable to recognize them within themselves (Villatoro, 2018). There may be better mental health literacy for college-level educated individuals, but certain groups, such as non-Latino Whites, may have a better "advantage" to recognize a need for care and seeking treatment (Villatoro, 2018). Furthermore, many people tend to downplay their mental health concerns and forego mental health services, yet it was unknown whether they would acknowledge and recommend seeking care for their friends who experience the same symptoms. Therefore, it was hypothesized that participants would be less likely to select formal, mental health treatment options for themselves but would recommend that their friends obtain these services if they were experiencing the same symptoms as the participants.

METHODOLOGY

Participants

A total of 984 surveys were completed, and 861 participants were included in analyses. Reasons for exclusion included incomplete data (n = 42), duplicate answers (n = 16), or likely invalid responses based on response time (< 10 minutes) and validity items (incorrectly answering 1/4 items; n = 65).

Most participants self-identified as female (68.9%), and the average age of participants was 18.52 (range = 18-60) years old. Participants were college students attending a large southeastern university, enrolled in an introductory psychology course or on the university's Honors College's listserv. The sample included first-year students (84.7%), second-year students (10%), third-year students (3.4%), fourth-year students (1.4%), and other (0.5%). Participants were primarily White (77.2%), followed by African-American (17.9%), Asian (4.5%), Native American (1.9%), and other (4.9%). The majority of participants (93.6%) self-reported an emotionally open background based upon their own and parents' citizenship from world regions including North American (e.g., Canada, the United States) and South American (e.g., Brazil, Mexico, Peru), European (e.g., United Kingdom, Netherlands, Italy), Eastern Mediterranean (e.g., Afghanistan, Iraq, United Arab Emirates), and Western Pacific (e.g. Australia, New Zealand). The remaining participants endorsed a more traditionally stoic background based on their or their parent's citizenship in regions including Africa and Southeast Asia (Fisher, 2012).

Materials

Demographic questionnaire. Participants were asked to provide general demographic information including gender, cultural background, year in school, age, self-origin, and primary caregivers' origin.

Vignettes and questions. Four vignettes were developed using the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5; American Psychiatric Association, 2013) to provide a brief description of a person experiencing mental health concerns. The vignettes had two types of mental health concerns of different severities: 1) depressive symptoms and 2) depressive symptoms with psychotic features. Each vignette type had two versions. One version per vignette type was composed as if the participant was in a situation in which they are experiencing symptoms that clearly outline mental health concerns. The second version of each vignette type was composed as if a close friend of the participant was experiencing symptoms of the same mental health concerns. There were four vignettes total, two types, each with two perspectives (self vs. other; See Appendix A). Participants were randomized to receive one of the four vignettes and asked to provide recommendations for the friend or indicate what actions they would take given the symptoms. Four hundred, twenty-two participants received a self-vignette type, composed as if the participant was in the situation in which they are experiencing the described symptoms. The remaining 439 participants received a friend, vignette type in which the outlined symptoms were being experienced by a close friend. Answers were categorized into formal (e.g. seeking services from primary care doctor, psychologist, psychiatrist) and informal (e.g. talking to friends, family, religious figure) treatment options. Informal and formal treatment recommendation data were then each dichotomized based upon the recommendation of whether any recommendations were made or not.

Attitudes Toward Seeking Professional Psychological Help Scale – Short Form. The Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS- SF) is a 10-item, self-report measure of attitudes toward seeking mental health services (Fisher & Farina, 1995). Items are rated on a 4-point Likert-type scale from 0 (*disagree*) to 3 (*agree*). Items 2, 4, 8, 9, and 10 were reverse scored, then summed for a total rating. The higher the score, the more positive attitudes indicated towards seeking professional help. Evidence for the reliability and validity of this measure is reported by Elhai et al. (2008) and Picco et al. (2016). In the original psychometric study of the ATSPPH-SF scale, Cronbach's α was equal to 0.77 (Elhai et al., 2008), a high internal consistency reliability. A similarly high internal consistency was also achieved in our present study, $\alpha = 0.75$. Criterion and construct validity of the ATSPPH-SF scale were also found in these previous studies, where higher scores were correlated with greater intentions to seek mental healthcare services in the following month (Elhai et al., 2008; Picco et al., 2016).

Procedure

Prior to the start of data collection, approval was obtained by the university institutional review board. Participants volunteered to participate in the study on the SONA research database website or in response to an email, where they were redirected to Qualtrics, a survey software, and provided informed consent. Participants then completed the demographic questionnaire, read a vignette, completed questions related to the vignette, and completed the ATSPPHS-SF. Questions related to the vignette included commonality of the symptoms described, the frequency of which the participant has seen or experienced the described symptoms, the likelihood they would seek or recommend various treatment options, and their perceived level of support from friends and family for seeking treatment for the described symptoms within the vignette. Participants received a short explanation of the study purpose at the completion of the study as well as course credit if it was completed through the SONA system as compensation for their time. The median time to complete the survey was 10'6". Several participants left their browsers open for long periods of time before submitting the survey. Therefore, the interquartile range (IQR) is likely a better representation of the typical time to complete the survey (IQR = 16'38").

Data analytic plan. In order to address the first hypothesis that participants will undermine their own need for mental health services but refer peers and friends to seek professional mental health services for the same symptoms, we conducted two separate chi-square tests. In the first chi-square test, we compared type of vignette received, either self or other, on informal mental health care treatment recommendations made. In the second chi-square test, we compared type of vignette received on formal mental health care recommendations provided. Although no specific hypotheses were made regarding type of formal and informal help seeking recommended, exploratory chi-square analyses were performed to examine differences between participants given each type of vignette and specific recommendations provided.

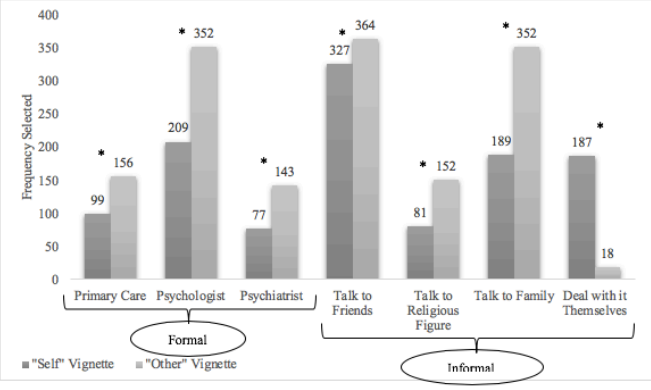
To test the second hypothesis that participants from less emotionally-open, or stoic, backgrounds will be less likely to seek mental health service and have less favorable attitudes towards seeking services, a chi-square test and t-test were performed respectively. Categorization of emotionally-open (e.g., U.S., Canada, Philippines) versus stoic regions (e.g., Singapore, Madagascar, Nepal) was based upon Fisher's (2012) classification of 150 countries and the self-identified participant and primary caregiver citizenships. In the chi-square test, we compared individuals from stoic or emotionally-open backgrounds on likelihood to recommend formal treatment options. In the t-test, we compared individuals from stoic or emotionally-open backgrounds in regard to their mean scores on the ATSPPHS-SF. All analyses were run in the Statistical Package for the Social Sciences (SPSS) v24 statistical analysis software (IBM Corp, 2016).

RESULTS

Participants were equally likely to recommend informal mental health (MH) services regardless of the subject (self vs friend) of the vignette they received, χ^2 (1, n = 861) = 2.20, p = .138. However, when the informal recommendations were examined separately, participants who received "other" vignettes were significantly more likely to recommend speaking with a religious figure, friends, or family member and significantly less likely to recommend dealing with it by themselves than participants who received a "self" vignette (all p's < .05). Participants were significantly more likely to

recommend formal MH services when the subject of the vignette was a friend rather than themselves, χ^2 (1, n = 861) = 96.67, p < 0.001. When each formal recommendation was examined separately participants who received "other" vignettes were significantly more likely make all three formal recommendations than participants who received "self" vignettes. See Figure 1.

Figure 1. Recommendations by Vignette Type

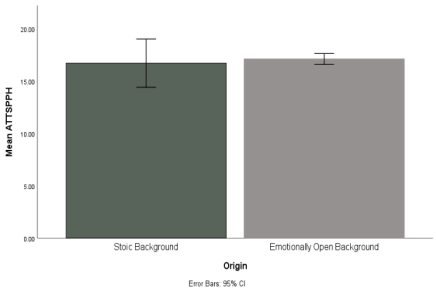


*p < .05

To test whether participants from less emotionally open or stoic cultures were less likely to seek MH services, a chi-squared test of independence was performed for participants who received the self-vignette. Participants of stoic and emotionally-open backgrounds were equally likely to recommend formal MH services χ^2 (1, n = 422) = .549, p = .459. Those from stoic backgrounds were as likely to self-refer to formal mental services as those from emotional open backgrounds.

To test whether attitudes towards seeking professional psychological care were related to the emotional-openness of an individual's background, an independent samples t-test was conducted. The results showed no significant differences in attitudes between those from emotionally open backgrounds (M = 16.89, SD = 5.18) compared to those of stoic backgrounds (M = 16.45, SD = 4.42), t(832) = -0.592, p = 0.554, d = 0.091. See Figure 2.

Figure 2. ATSPPHS Score Difference by Cultural Background



DISCUSSION

Conclusions

The results of the study did not find a similar significance in the relationship between informal mental health treatment recommendations being provided for others versus self. Participants were equally likely to endorse informal mental health care options for themselves as they would recommend them for others. Thus, unlike previous studies which suggested that perceived need may differ based upon certain races and ethnicities, the present study did not find significant differences in perception of mental health care needs (Villatoro, 2018). In contrast, talking to your friends, family, or a religious leader may be perceived as less threatening than seeking formal mental healthcare. Informal mental health treatment options offer little-to-no backlash, whereas obtaining formal treatment can be intertwined with public stigma, or even self-stigma one perceives themselves (Vogel, Wade, & Hackler, 2007).

The results of this study supported the notion that there is a difference in the likelihood of providing formal mental health treatment recommendations for others compared to one's self. Based on this study's results, it appears that participants were significantly less likely to indicate behavioral intent to seek formal treatment for themselves than they were to refer a friend. This pattern of results implicates some other underlying factor besides a bias towards normalization of symptoms which may be driving these differences with formal care utilization such as attitudes towards treatment seeking and stigma. An individual can also view obtaining formal care as an extreme option when referring to their own mental health concerns but not when considering the similar concerns of others. In fact, a meta-analysis conducted by Leong and Lau (2001) concluded that perceived stigma hinders help-seeking behaviors to the intensity that individuals may confine their mental health concerns until behaviors become unmanageable. Other than shared group perceptions of high stigma related with mental illness, other explanations for less frequent professional care treatment in race/ethnic minorities can be rooted in perceptions of racial or ethnic bias from care providers, mistrust of physicians, and inaccessibility to general or mental-health facilities due to socioeconomic factors (Roberts et al., 2011). From this point, we can conclude that while individuals were less likely to select formal treatment measures for themselves, they did make formal treatment recommendations for others, indicating it is not a lack of knowledge nor awareness of need that prevents formal service utilization. The present research adds to the literature on self-perception and self-recommendation, as students in our sample did recommend professional treatment, if the subject of the vignette was a friend rather than themselves. Thus, future research should examine what specific barriers, such as possible stigma, hesitations, or uncertainty on whether they need formal care, students may experience when considering formal treatment measures for themselves.

The results of the present study were not consistent with previous research as there was not a significant relationship between coming from a less emotionally-open, or stoic background and a decreased likelihood to seek mental health services. Participants from stoic backgrounds were equally as likely as those from emotionally-open backgrounds to recommend formal mental health services. Similarly, results

of this study did not find a significant association between cultural openness of one's background and attitudes toward seeking professional psychological help. Participants of less emotionally-open backgrounds did not have any less favorable attitudes than those of emotionally-open backgrounds. This is in contrast to previous research such as Komiya and colleagues (2000), who found that young people from ethic minority groups, such as Asian cultures, are more reluctant to seek mental health services. This reluctance may be rooted from a background valuing inhibition of emotion, strong individualism, and stoicism and therefore, are associated with decreased levels of mental health service utilization (Komiya et al., 2000). Inconsistencies between this study and previous studies could be due to the small group of individuals in the present study who self-reported being first- or second-generation individuals of a geographic region known to be more stoic in nature, such as the Asian and African regions as compiled by Fisher (2012). Additionally, another possible explanation could be that participants of the sample from self-reported stoic backgrounds may be more accultured. Leong and Lau (2001) conducted a meta-analysis and concluded that individuals from stoic cultures who are more highly accultured tend to possess more positive attitudes toward help-seeking behaviors. A study conducted similar to the present study also found that degree of need, or one's level of psychological distress, was not associated with help-seeking attitudes among Asian-American college students (Ying & Hwang, 2009). They speculated that it may be other variables (i.e., culture-related or predisposing characteristics) that may be more influential in help-seeking attitudes. However, in order to make any conclusions and determine if there was a confounding factor of acculturation in variability, future studies need a large enough sample size of individuals self-identifying as being from or having a primary caregiver from a traditionally, stoic region.

Limitations

The strengths of this study such as large sample size should be considered in the context of several limitations. The data were derived from self-report measurement tools. Thus, it is possible that data were biased by the effects of social desirability or low motivation resulting in random responding. However, we attempted to minimize this bias through confidential participation and screening responses for patterns consistent with random responding (e.g., minimal time completing the survey, incorrect responses to validity items). Fewer than 8% of the survey population indicated that they or their parents came from a stoic cultural background, which may have resulted in limited power to find significant results. Future studies with a larger sample size of stoic-background reporting participants may increase confidence in this null finding. External generalizability may be limited as this sample was fairly homogenous in regard to racial/ethnic diversity.

The present study primarily surveyed those who were White and in their first year of college. Expanding the study to include a more diverse sample may provide a more representative sample and thus increase generalizability of the results. Further, it would be important to expand the study to other universities or settings to explore the prevalence and influence of other barriers such as lack of diversity in counselors, lack of accessibility, or simply lack of knowledge on how and where to obtain services. In accordance with results that found participants were more likely to recommend formal services for their friends compared to themselves, future efforts to decrease psychological barriers to seek services may be more successful by pinpointing and researching particular hesitations and misgivings the participants may have when managing their personal mental health concerns in a formal manner. Research shows that those of ethnic and racial minorities are less likely to perceive a need or seek assistance; in order to increase likelihood of self-identification and treatment seeking, counseling centers could possibly reach out to ethnic-based clubs and campus organizations and provide information on what classifies into mental health concerns. Doing such seminars or presentations may assist students in merely recognizing the possibility of a need. Furthermore, since previous research provides us information on the preference of informal methods of obtaining care for mental health concerns, colleges and universities can promote more informal, inclusive, and intimate support group opportunities. This could be a vital resource for those who shy away from obtaining care or speaking about their mental health concerns due to their trepidation for formal service settings. Additionally, this study used only quantitative measures and adding qualitative measures asking students about barriers they believe prevent them from pursuing mental health care services on campus may help uncover obstacles overlooked by the present study, as well as previous studies. This will reduce assumptions of previous data and identify specific barriers or hesitations that students possess on utilizing on-campus services, directly from the population target.

In conclusion, contrary to what was predicted, those from less emotionally-open backgrounds were not any less likely to recommend formal mental health care options, nor were they more likely to have less favorable attitudes towards seeking professional psychological care. However, the results of this study did illuminate that there is some barrier or hesitation present that prevents students from seeking formal mental health care services for themselves, even when they are willing to recommend such measures for their friends. Mental health issues are increasingly becoming a concern for all individuals; however, young adults, especially those attending colleges and universities, are especially susceptible. The relevance of the topic, especially in academic settings, is a topic of great importance. While many college and university settings are partaking in mental health awareness initiatives, in order to help students of all diverse backgrounds, it is vital to continue to build this awareness and opportunities to obtain health in variety of manners. It is not enough to provide a formal counseling center but various settings, mediums, and environments for students to seek care. It is even more vital to understand that self-labeling concerns and mental health concerns differ greatly in individuals, and academic settings need to evaluate their students to find the best methods for competence and inclusion of their care-seeking initiatives. By further researching the influence of culture and self-perception in regard to care-seeking intentions, we can pinpoint factors that may influence service utilizations and develop future directions for how to best provide mental health care services to a diverse academic population. As mental health concerns, specifically in the lives of college students, continue to increase rapidly, it is vital to identify any physical, psychological, and social barriers that may exist and prevent students from seeking

care. Addressing and reducing these barriers may decrease untreated mental health concerns, and in turn, increase the mental well-being of college and university students to allow students to lead a more holistic, positive life.

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APPENDIX

Vignettes

Vignette 1 (Friend as Subject, MDD): Your friend works outside of school as a laboratory technician. Their supervisor has become concerned after they became tearful while being mildly criticized during an otherwise positive annual performance review. They realize that they have been "feeling low for years" and that hearing criticism at work feels like it is "just too much." They've been feeling low for the past three years though sometimes they feel worse than others.

Your friend feels frustrated with their job, which they see as a "dead end," yet fear that they lack the talent to find more satisfying work. As a result, they struggle with guilty feelings that they "haven't done much" with their life. Despite troubles at work, your friend can concentrate without difficulty. They are not having any suicidal thoughts, yet sometimes wonder, "What is the point of life?" They occasionally have trouble falling asleep. However, have not had any changes in their weight or appetite. Although they occasionally go out

with friends, your friend feels shy and awkward in social situations unless they know the people well. They acknowledge that they have few friends. They are still able to enjoy activities, such as jogging and being outdoors. In the past, their romantic relationships tended "not last long," but they feel like their sex drive is normal.

Vignette 2 (Self as Subject, MDD with Psychotic Features): You have begun to "lose interest in life" about 4 months ago. During this time, you have felt excessively sad. You have lost 9 pounds without dieting because you do not feel like eating. You have trouble falling asleep almost every night and wake at 3:00 a.m. several mornings per week (you normally wake at 6:30 a.m.). You have diminished energy, concentration, and ability to do your job at a dog food processing plant. You are convinced that you made a mistake that could lead to the deaths of thousands of dogs. You describe the mistakes you have believed to have made at work and insist that you would soon be apprehended for your mistake. Your boss tells you that you have not made any mistakes and that you are worrying over nothing. You begin to hear a voice that tells you that you are "no good" and "not worth anything." This voice is not your own internal monologue. Others do not hear the voice and it makes you feel frightened. You go to see your doctor. Despite these troubles, your doctor tells you that you are healthy.

Vignette 3 (Self as Subject, MDD): You work outside of school as a laboratory technician. Your supervisor has become concerned after you became tearful while being mildly criticized during an otherwise positive annual performance review. You realize that you have been feeling low for years and that hearing criticism at work feels like it is just too much. You've been feeling low for the past three years though sometimes you feel worse than others. You feel frustrated with your job, which you see as a dead end, yet fear that you lack the talent to find more satisfying work. As a result, you struggle with guilty feelings that you haven't done much with your life. Despite troubles at work, you can concentrate without difficulty. You are not having any suicidal thoughts, yet sometimes wonder, "What is the point of life?" You occasionally have trouble falling asleep. However, have not had any change in your weight or appetite. Although you occasionally go out with coworkers, you feel shy and awkward in social situations unless you know the people well. You have few friends. You are still able to enjoy activities, such as jogging and being outdoors. In the past, your romantic relationships tended to not last long, but you feel like your sex drive is normal.

Vignette 4 (Friend as Subject, MDD with Psychotic Features): A friend tells you that they had begun to "lose interest in life" about 4 months earlier. During this time, they have conveyed feeling excessively sad. They have lost 9 pounds without dieting because they do not feel like eating. They have trouble falling asleep almost every night and wake at 3:00 a.m. several mornings per week (they normally wake at 6:30 a.m.). They have diminished energy, concentration, and ability to do their job at a dog food processing plant. They are convinced they made a mistake that could lead to the deaths of thousands of dogs. They described the mistake they believed they made at work and insisted that they would soon be apprehended for their mistake even though their boss told them that they did not make any mistake. Your friend asks you if you hear anything and you do not. They acknowledge that they are hearing a voice telling them that they are "no good" and "not worth anything." Your friend appears frightened by what they have been hearing. Despite these troubles, your friend tells you that her recent physical examination was normal and their doctor told them they were healthy.