Generation Rx: Young Adults and the Influence of Fear of Negative Evaluation on Perception of Health Care Services

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ABSTRACT

Most research about age discrimination in health care pertains to children or the elderly, but few scholars have considered young adults as a population that may encounter negative experiences regarding the health care industry. The study analyzes the degree to which young adults, as well as ethnic minorities, perceive health care as substandard. This research uses Stereotype Threat (defined as social implications of a negative stereotype regarding one’s ethnic group apparent) (Steele and Aronson 1995). Stereotype Threat is used in this research as a theoretical framework for determining the psychological effects of discrimination. The researcher surveyed 50 randomly selected participants that were exposed to a vignette describing either a young minority adult male or elderly Caucasian male. Then, each participant received surveys that measured client satisfaction and negative evaluation, and hypothesized that client satisfaction and fear of negative evaluation would be negatively correlated. There was not a significant relationship between client satisfaction and fear of negative evaluation.

There is ample research about the disparity in America’s health care system, specifically inequalities involving ethnic minority groups and their health care (Swami and Shobhana 2005; Jones, Vahia, Cohen, Hindi, and Nurhussein 2008; Ojeda and Bergstresser 2008). In addition to differences between minority groups (Swami and Shobhana 2005), are similar negative attitudes toward the senior citizen population (Jones et al. 2008), further contributing to the setback in adequate health care. Thus, many scholars (Swami and Shobhana 2005; Jones et al. 2008; Ojeda and Bergstresser 2008) have studied discrimination in both racial/ethnic minority groups, and ageism and health care. However, very little empirical or qualitative research exists about the disparity in health care pertaining to young, minority adults, and the age demographic they hold within the health care system. Many young people of color may feel as though they are not being taken seriously and not being treated adequately. One could argue that young adults in general do not categorize as a minority group, but in this study young adults, specifically
ethnic/racial minority young adults, will be characterized as a minority group in accordance with the concept of a “sociological minority” (Hanjorgiris, Rath, and O’Neill 2004), described by Kameny (1971) as a situation in which, “Group members share a minority characteristic, deal with discrimination and prejudice, are depersonalized and not judged on their own merits, and internalize a ‘we-they’ mentality” (27).

Members who identify within the same minority group (young adults) share negative experiences and discrimination or prejudices as other young minority adults within their sociological minority group. When an individual associates with a marginalized group where emotions of prejudice or lack of empathy are inflicted, a variety of psychological and physiological symptoms are likely to occur (Burgess, Warren, Phelan, Dovidio, and Ryne 2010). This concept, known as “Stereotype Threat” is generally used in reference to standardized testing in an educational context (Steele and Aronson 1995). The present study will use “Stereotype Threat” as a concept outside of its usual context, as a theory relevant in explaining impressions of negative attitude(s) and inadequate health care provided to young adults of color. Furthermore, cultural competency, a physicians’ understanding of culture(s) of ethnic groups she/he serves, is a theoretical framework that is known in the health care industry (Ziegahn and Ton 2011). This is an important concept that needs to be addressed in order to build a better communication between the patient and provider (Ziegahn and Ton 2011).

The United States has seen many advances in the area of health care (Carter 2007), and the country’s health care providers should be expected to have congruent behaviors and attitudes for the entire population they serves; most certainly, health care professionals should conduct their practices without a lens of prejudice that results in incompetent services. Although there have been rapid advances in contemporary health care, from advanced technologies and practices to an influx of diligent scholars in the health field, there continues to be an unacknowledged disparity in health care amongst the defined minority population (Parker, Kirchner, Bonner, Fickel, Ritchie, Simons, and Yano 2009).

**LITERATURE REVIEW**

Negative stereotypes are a significant potential cause for disparities in health care regarding services to minority groups, specifically a phenomenon named by Steele and Aronson (1995) as “Stereotype Threat” (Burgess et al. 2010). According to Burgess et al. (2010), “Stereotype threat occurs when cues in the environment make negative stereotypes associated with an individual’s group status salient, triggering physiological and psychological processes that
have detrimental consequences for behavior” (169). The context of Steele and Aronson’s original study pertaining to Stereotype Threat was that of the performance of African American and Caucasian students on standardized tests. In their study, African American college students were found to score drastically worse than Caucasian college students when told that the test being conducted was an analysis of their degree of intellect. However, African American college students of the control group scored relatively similar to Caucasian students when told that the test being conducted was nonevaluative (Steele and Aronson 1995; Aronson, Lustina, Good, Keough, Steele, and Brown 1999). What these results suggest is that African American students, when put under situational pressure that implies already existing negative social stigmas regarding the intellect of the group they belong to are addressed, performance and behavior become negatively affected. Furthermore, Stereotype Threat triggers physiological and psychological reactions (including anxiety) in the individual, along with negative cognitions and emotions which result in decreased efforts and demonstration of intellect (Burgess et al. 2010). Additional symptoms shown to stem from Stereotype Threat within minority college students are depression and anxiety (Cole, Matheson, and Anisman 2007).

In sum, the consequences of Stereotype Threat decrease self-validity in the group being stereotyped. In the context of health care, a young adult of racial/ethnic minority background could experience stereotype threat when seeking and receiving care. The individual’s age and physical appearance could lead to stereotypes of being unintelligent, of exaggerating symptoms, and of deserving less quality care from the provider than perhaps that of an older patient of European origin (Hanjorgiris et al. 2004; Burgess et al. 2010).

It is not unusual to suggest that discrimination and lack of quality services exist, but perhaps our society accepts this problem and has become too comfortable with its existence. Burgess et al. (2010) extend the concept of Stereotype Threat beyond its original context into a theoretical existence in the realm of health care. Scholars argue that a distinctive characteristic of this particular social construct theory is that such cognitions and feelings can either develop through the actions of an opposing party (the superior, majority, stereotyping party), or through the individual’s own manifestation of negative stigmas of themselves (Burgess et al., 2010). Many scholars believe that race and ethnicity are already accepted as factors that influence mental health seeking behavior, such as attitudes and perception (Alvidrez 1999; Ojeda and McGuire 2006; Ojeda and Bergstressor 2008). The already negative social stigmas placed on ethnic and racial groups shape the attitudes they have of themselves and become barriers that impede their willingness to seek mental health services. Such mental health behaviors include stress...
and anxiety, which can be the result of adaptation to mainstream culture and expectations, interaction styles and language barriers, and overall experiences regarding racism, discrimination, and oppression (Stevens and Vollebergh 2008). The present study will explore this concept in an attempt to show how young adults, including those young adults of ethnic minority, are perceived as negative or being “young and dumb” and thus less likely to be taken seriously by health care providers, thereby hindering their adequate health services.

The mental health of the young minority adult population is an important issue in public health (Eisenberg, Gollust, Golberstein, and Hefner 2007). As discussed, Stereotype Threat may trigger any nonspecific psychological processes. Depressive and anxiety disturbances are two highly common psychological disorders assessed in college students (Eisenberg et al. 2007). Researchers conducted a study that led to significant findings of prevalent depressive disorders, anxiety disorders, and suicidal reports in undergraduate and graduate students, and most commonly in those students of lower socioeconomic status (Eisenberg et al. 2007). For example, body dysmorphic disorder (BDD), a psychiatric disorder, occurs when an individual has an excessive preoccupation with a defect in her/his appearance, but often the defect is imagined (Wolrich 2011). Psychological features of BDD include low self-esteem, and high levels of sensitivity to criticism or rejection from others (Wolrich 2011). Recent research has shown that there are higher levels of body dysmorphic disorder on college campuses than in the levels of the general population, especially with female college students (Wolrich 2011). Depressive, anxiety, and body dysmorphic disorders are just a few psychological disorders commonly found in the population of young adults. Thus, the consequences of experiencing stereotype threat when receiving health care services as a young or minority adult, could include an increase in negative thoughts and emotions and the resulting psychological disorders (Burgess et al. 2010). Young minority adults who do seek care and experience a negative or dissatisfied experience (e.g. poor manner, insensitive tone, judgmental looks), and who feel that the health care providers give poor quality care due to the patient’s age and/or ethnic/racial group, can lose trust of the system and ultimately be deterred from seeking health care in the future.

**Problem and Cause**

The present study focuses on young adults, ages 17 to 34, and included ethnic minority groups as well as Caucasians. There are many health care issues to address regarding this age group; from negative accounts in the past when visiting a health care provider, and feeling ashamed or having a
negative stigma for receiving health attention regarding birth control, Sexually Transmitted Disease (STD), or the common cold. In summary, there are two issues that need to be focused on in the health care industry that include the equality of health care services regardless of age or race/ethnicity. The independent variable was the vignette the subject received; she/he was exposed to either vignette J.A. or vignette J.B. The dependent variables include the two questionnaires: Client Satisfaction Questionnaire−8 (CSQ−8) and Fear of Negative Evaluation (FNE). In addition, age and ethnicity/racial groups were assessed.

The long-term objective of the present study is a movement to eliminate the disparities and inequalities; thus, research must attempt to find several pathways to a solution. Cultural competency provides an umbrella framework for these pathways. Increased cultural competency in health care in the following areas may lead to a reduction in Stereotype Threat (Lightner 2004): interpreter services such as bilingual community health workers who can thoroughly convey the importance of cancer screenings and health monitoring (Henderson, Saras, Kendall, and Laurenne 2011), training, coordinating with traditional healers, culturally competent health promotion, inclusion of a family and/or community member, and immersion into another culture (Lightner 2004). Henderson et al. (2011) analyzed sixteen studies regarding cultural competency, all of which supported bilingual interpreter services to be effective in improved communication between the health care provider, and improved satisfaction with health care system in general.

Cultural Competency
Cultural competency provides a way to address disparities in health care. “Cultural competency” is essentially a method that refers to diverse knowledge, understanding, and empathy between one party—health care providers—and another from a different culture—patients of various ethnic/racial and cultural backgrounds, and patients in the young adult age bracket (Johnston and Herzig 2006). Sometimes, a medical professional may receive ridicule from the patient when explaining the etiology of an illness that contradicts the cultural views of the patient, or at least their medical perspective on the illness (Kittler and Sucher 2008). However, the patient may be more receptive when unconventional practitioners, such as folk healers, provide an understanding of the etiology of the illness because it is delivered in a congruent way to the patient’s worldview; delivery includes sincerity, sympathy, and hope (Kittler and Sucher 2008). According to Lightner (2004), cultural competency is more than mere cultural knowledge and sensitivity; it is an understanding and respect for different practices or healing therapies.
within a culture. Take for example cultures that credit illnesses to the supernatural world, such as being the will of God as held by some Jews, Christians, and Muslims (Kittler and Sucher 2008). Some ethnic groups such as Latinos, Africans, and Pacific Islanders believe in bad-natured spirits who may cause illness in a person; for example, death in some Cambodian beliefs occurs when an evil spirit sits on their chest at night, causing heavy pressure and fright (Kittler and Sucher 2008). The concept of an evil spirit being someone’s cause of death may be difficult to understand and accept coming from the perception of a biomedical professional. Yet, for these cultures, the use of alternative approaches such as botanical medicine, or the use of Latin American root doctors and remédemen (remedies) may be more receptive (Kittler and Sucher 2008).

HYPOTHESIS
The study will attempt to explain attitudes about health care and negative evaluation in the culture minority group of young, minority adults using the approach of Stereotype Threat, testing two hypotheses:

1) Participants who randomly receive and read the vignette J.A. are predicted to score lower on the Client Satisfaction Questionnaire−8 (CSQ−8) and higher on the Fear of Negative Evaluation (FNE) survey.

2) Participants who randomly receive and read vignette J.B. are predicted to score higher on the Client Satisfaction Questionnaire−8 (CSQ-8) and lower on the Fear of Negative Evaluation (FNE) survey.

METHODOLOGY
College students were recruited from the Psychology department’s research website (34 female, 16 male, Modal_{age} = 17-22, age range of respondents: 17-34) from a Northern California university. Convenience sampling of the particular population was done due to the availability of subjects, and because these subjects represented one of the main research components of the target population of study, which is age. Participants volunteered for the research study, and were compensated in research credit when applicable. Participants were scheduled to survey individually or in groups no larger than seven depending on the research room in which the session was scheduled. Participants were randomly assigned to read a vignette and fill out a survey packet including demographic information consisting of gender, age, race/ethnicity, and class. Demographics form was always placed at the end of the survey packet (see Table 1; Appendix D). Each subject participated in the research study only once.
Table 1. Descriptives for Gender, Age, and Race/Ethnicity

<table>
<thead>
<tr>
<th>Demographics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (Gender)</td>
<td>34</td>
<td>68</td>
</tr>
<tr>
<td>Male (Gender)</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>17-22 (Age)</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>23-28 (Age)</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>29-34 (Age)</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Latino (Race/Ethnicity)</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>African American (Race/Ethnicity)</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Asian (Race/Ethnicity)</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Caucasian (Race/Ethnicity)</td>
<td>19</td>
<td>38</td>
</tr>
<tr>
<td>Biracial (Race/Ethnicity)</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Other (Race/Ethnicity)</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: N = 50

Materials

The materials used in this study were two types of vignette: J.A. and J.B. and two survey scales: Client Satisfaction Questionnaire−8 (CSQ−8) and Fear of Negative Evaluation (FNE). Survey packets contained only one of the two types of vignette, the two scales of measurement, CSQ-8 and FNE, and the demographics form. The unique vignette and scales of measure were introduced to the participants in a survey packet form. Participants’ reaction and scoring to the vignettes and surveys was the dependant variable in this study.

Both vignette J.A. and vignette J.B. were researcher produced and used for priming purposes. According to Gerrig and Zimbardo (2002), when evaluating one’s implicit memory, priming is the advantage provided by the subject’s prior exposure to a situation. The vignettes describe a patient who is ill and in need of medical attention. The two vignettes differ only in the brief description of the patient discussed in the very beginning of the vignette. Vignette J.A. is a 22-year old biracial African and Latino American male who attends college; vignette J.B. is an older European American male who works full-time (see Appendix A). The types of patients, J.A. and J.B. describe a young biracial student and an older nonbiracial worker. Therefore, age and race of the character in the vignette is considered the independent variable for the study.

The common protocol when using vignettes in a study is for the purpose of priming. After a participant reads a vignette, they are commonly evaluated or asked questions directed toward the vignette. However, in this study, instead of analyzing participants’ direct response or reaction to the vignette, they were asked to read the vignette and answer questionnaires regarding
themselves. Therefore, the vignettes were still used as a means of priming, but the objective was to determine whether the different types of vignette could influence the way in which a participant responded to questions relating to their experiences and perspectives.

The first scale of measure was the Client Satisfaction Questionnaire−8 (CSQ-8), originally produced by Clifford C. Attkisson (Corcoran and Fischer 1987). The CSQ-8 is a survey of self-client satisfaction of recent healthcare received. The CSQ-8 is a four-point Likert scale (higher scores indicate positive client satisfaction; lower scores indicate negative client satisfaction) and consists of eight items. Some of the items on the scale were: “Did you get the kind of service you wanted? (item 2); How satisfied are you with the amount of help you have received? (item 5); In an overall, general sense, how satisfied are you with the service you have receive? (item 7)”. The CSQ-8 has high reliability, with an alpha range from .86 to .94 in various studies (Corcoran and Fischer 1987) and α = .931 in this study. The following items were analyzed more closely: 1, 2, 5, and 7. Although the researcher administered the entire questionnaire, focus was on these particular questions when analyzing this particular variable. The Client Satisfaction Questionnaire−8 (CSQ-8) was a dependent variable for this study (see Appendix B).

The second scale of measure was the Fear of Negative Evaluation (FNE) survey, produced by David Watson and Ronald Friend (Corcoran and Fischer 1987). The purpose of the 0-item scale is to measure social anxiety, specifically the social anxiety one experiences when receiving negative evaluations from others, or the lack of social approval. The FNE is a “true” or “false” survey. Some of the items of the scale were: “I become tense and jittery if I know someone is sizing me up (item 3); I am afraid that others will not approve of me (item 13); I brood about the opinions my friends have about me (item 29).” The internal consistency (reliability) of the FNE was .94 in a study of 29 subjects, and the Brief version of the Fear of Negative Evaluation survey has a Cronbach’s alpha of .90 (Corcoran and Fischer 1987). For this study (n = 50), a Cronbach’s alpha was run on 10 items from the 30-item survey and had a α = .601; a commonly accepted value is α = .60. The Fear of Negative Evaluation survey (see Appendix C) was a dependent variable for this study. All data were analyzed using the Statistical Package for Social Sciences (SPSS).

Procedure
Each research session initiated with participants entering the research room and signing a consent form; forms were placed in a large envelope to ensure confidentiality. Survey packets were then randomly distributed to
participants. Participants were instructed to read the vignette, either vignette J.A. or vignette J.B., depending on which was randomly attached to the survey packet containing the Client Satisfaction Questionnaire–8 (CSQ-8), Fear of Negative Evaluation (FNE), and demographics form. Participants were then asked to answer each item or question on all scales of measure to their discretion. Once the participants completed the packet, the packets were collected and placed in a separate envelope from the consent forms to further ensure confidentiality. The researcher then distributed debriefing forms, verbally debriefed the participants, and answered any questions. Subjects were thanked for their participation in the study and then dismissed.

RESULTS

A MANOVA was used to determine the affects of vignettes on subjects’ responses to two surveys including the Client Satisfaction Questionnaire–8 (CSQ-8) and Fear of Negative Evaluation (FNE). Factors including age and race/ethnicity of participants were included to determine their overall influence on the vignette the participant was asked to read. It was found that the overall mean for CSQ-8 for vignette J.A. was (M = 2.30, SD = 0.51) and for the FNE was (M = 1.62, SD = 0.05); for vignette J.B. the CSQ-8 (M =3.20, SD = 1.15) and FNE (M = 1.68, SD = 0.07) (see Table 2).

Table 2. Descriptive Statistics of Vignette J.A. and Vignette J.B. for Client Satisfaction Questionnaire-8 (CSQ-8) and Fear of Negative Evaluation (FNE)

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>J.A. - CSQ-8</td>
<td>2.3</td>
<td>0.51</td>
<td>26</td>
</tr>
<tr>
<td>J.A. - FNE</td>
<td>1.62</td>
<td>0.05</td>
<td>26</td>
</tr>
<tr>
<td>J.B. - CSQ-8</td>
<td>3.2</td>
<td>1.15</td>
<td>24</td>
</tr>
<tr>
<td>J.B. - FNE</td>
<td>1.68</td>
<td>0.07</td>
<td>24</td>
</tr>
</tbody>
</table>

Note: N = 50

Although the mean was higher for Client Satisfaction Questionnaire–8 for vignette J.B. (older gentlemen), there was not a significant difference p >0.05. Further analysis of participants’ race to vignette read based on Hotelling’s t-test was significant p = .019. Age of subjects did not affect the overall outcome of CSQ–8 or FNE. A nonparametric test was used as well due to the small sample size which indicated no significance between race and age on questionnaires p = 0.076.

DISCUSSION

The goal of this study was to examine how young adults perceived themselves in regards to negative stigmas and social anxiety, but also their perception of received health care. Participants who read vignette J.A. were
predicted to score lower on the Client Satisfaction Questionnaire–8 (CSQ-8) and higher on the Fear of Negative Evaluation (FNE) questionnaire. Participants who read vignette J.B. were predicted to score higher on the Client Satisfaction Questionnaire–8 (CSQ-8) and lower on the Fear of Negative Evaluation (FNE) questionnaire.

Depending what vignette the subject received, it was hypothesized the vignette of the biracial male would elicit a more negative evaluation on the questionnaires administered including CSQ–8 and FNE. Because aspects of Stereotype Threat were used as a conceptual framework in explaining potential substandard health care, factors such as age, and race/ethnicity to vignette were analyzed. The results indicate there was no affect of age or race on subjects rating using Client Satisfaction Questionnaire–8 (CSQ-8) and Fear of Negative Evaluation (FNE) questionnaires between groups of subjects receiving vignettes J.A. and J.B.

Since there was not signifcance found between age and race on the questionnaires, $p = 0.076$, the results conflict with those of previous research (Burgess et al. 2010), specifically the qualitative work of Burgess et al. (2010) that presents priming as a source for Stereotype Threat in the context of health care disparity. However, it is still important to acknowledge that participants’ internal mechanisms, such as negative cognitions, emotions, and anxiety—conditions detected through the Fear of Negative Evaluation scale—can manifest in a clinical setting from Stereotype Threat situations, and essentially result in disengagement (Burgess et al. 2010, 169). In this case, “disengagement” means a disconnect from the domain (health care system) perceived as uncomfortable and daunting.

LIMITATIONS

A limitation for this study was the sample size. Although the sample ($n=50$) was over the generally accepted sample size in statistical research ($n=30$) it is very likely that a Type II error occurred. Furthermore, there was limited diversity in the subject pool (see Table 1). In the current study, this researcher used vignettes and the entire CSQ-8 and FNE questionnaires were not utilized. In addition, methodological issues that may have compromised internal validity of this study will be addressed in future studies.

FUTURE RESEARCH

Future research will be more defined in structure, and contain detailed questions regarding participants’ health care services (e.g. private insurance, community clinic, etc); specific health care conditions and participants’
average level of exercise. Future research will also focus on health findings and health promotion for specific race/ethnic groups (e.g. Mexican, Nicaraguan, Puerto Rican, Hmong, Laotian, etc.) and gender groups (lesbian, gay, bisexual, transgender, queer, etc.). In summary, doctors should take continual courses in ethical treatment of patients when working with any patient population, even those of the young adult population. Both physical and psychological well being of a patient is important in global health promotion.

CONCLUSION

Although the results of this research do not indicate a significant relationship between client satisfaction and fear of negative evaluation, it does help solidify the need for health care providers to understand diversity issues in the population they are treating. Along with an increase of diversity in the country is an increase in advocacy for such groups of this diverse population (e.g., Latinos, African Americans, and Asian Americans) in a health care context. Issues from stereotypical assumptions and discrimination, such as those reported by African Americans and health insurance assumptions, language discrimination in Latinos, and age discrimination in Caucasians (Ziegahn and Ton 2011), support the need in contributing to a more culturally aware health care field. Additionally, further research of incorporating the population of young minority adults into a cultural competent framework in health care has yet to be developed.
APPENDIX A

Instructions: Please read the following vignette.

J.A. is a 22 year old biracial African and Latino American male who attends college. Lately, J.A. has begun to experience physical pains in his stomach and has experienced symptoms such as body aches, fever, and nausea. He finally went to see his primary healthcare provider. At the office, J.A. was given a brief and standard evaluation (temperature and blood pressure measurements). However, J.A. told his doctors that he had the flu before but this was much more severe. He was told by his doctor he simply had the common stomach flu and needed to rest. He listened to the doctor and rested. Several weeks later as the symptoms became worse, J.A. returned to the healthcare provider and asked for a blood test. He was later diagnosed with pancreatic cancer, and was immediately started on chemotherapy treatment.

Instructions: Please read the following vignette.

J.B. is an older European American male who works full-time. Lately, J.B. has begun to experience physical pains in his stomach and has experienced symptoms such as body aches, fever, and nausea. He finally went to see his primary healthcare provider. At the office, J.B. was given a brief and standard evaluation (temperature and blood pressure measurements). However, J.B. told his doctors that he had the flu before but this was much more severe. He was told by his doctor he simply had the common stomach flu, and needed to rest. He listened to the doctor and rested. Several weeks later as the symptoms became worse, J.B. returned to the healthcare provider and asked for a blood test. He was later diagnosed with pancreatic cancer, and was immediately started on chemotherapy treatment.
APPENDIX B

Instructions: Please think back to your most recent experience with a healthcare provider, and rate the following questions that best apply based on that experience. Please answer all of the questions.

Circle your answer:

1. How would you rate the quality of service you received?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
</tr>
</tbody>
</table>

2. Did you get the kind of service you wanted?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, definitely</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>

3. To what extent did the healthcare program meet your needs?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost all of my needs have been met</td>
<td>Most of my needs have been met</td>
<td>Only a few of my needs have been met</td>
<td>None of my needs have been met</td>
</tr>
</tbody>
</table>

4. If a friend were in need of similar help, would you recommend your healthcare program/provider to him or her?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, definitely not</td>
<td>No, I don’t think so</td>
<td>Yes, I think so</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>

5. How satisfied are you with the amount of help you received?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
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<tbody>
<tr>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

6. Did the services you receive help you to deal more effectively with your problem?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, they helped a great deal</td>
<td>Yes, they helped somewhat</td>
<td>No, they really didn’t help</td>
<td>No, they seemed to make things worse</td>
</tr>
</tbody>
</table>
7. In an overall, general sense, how satisfied were you with the service(s) you received?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
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<tbody>
<tr>
<td>Very satisfied</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mostly satisfied</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indifferent or mildly dissatisfied</td>
<td></td>
<td></td>
<td></td>
<td>Quite dissatisfied</td>
</tr>
</tbody>
</table>

8. If you were to seek help again, would you return to that healthcare center?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, definitely not</td>
<td></td>
<td></td>
<td></td>
<td>Yes, definitely</td>
</tr>
<tr>
<td>No, I don’t think so</td>
<td></td>
<td></td>
<td>Yes, I think so</td>
<td></td>
</tr>
</tbody>
</table>

*Note: D. Larsen, Clifford Attkisson, W. Hargreaves, and T. Nguyen*
APPENDIX C

Instructions: For the following statements, please answer each in terms of whether it is true or false for you. Circle T for true or F for false.

1. I rarely worry about seeming foolish to others.  T F
2. I worry about what people will think of me even when I know it doesn’t make any difference.  T F
3. I become tense and jittery if I know someone is sizing me up.  T F
4. I am unconcerned even if I know people are forming an unfavorable impression of me.  T F
5. I feel very upset when I commit some social error.  T F
6. The opinions that important people have of me cause me little concern.  T F
7. I am often afraid that I may look ridiculous or make a fool of myself.  T F
8. I react very little when other people disapprove of me.  T F
9. I am frequently afraid of other people noticing my shortcomings.  T F
10. The disapproval of others would have little effect on me.  T F
11. If someone is evaluating me I tend to expect the worst.  T F
12. I rarely worry about what kind of impression I am making on someone.  T F
13. I am afraid that others will not approve of me.  T F
14. I am afraid that people will find fault with me.  T F
15. Other people’s opinions of me do not bother me.  T F
16. I am not necessarily upset if I do not please someone.  T F
17. When I am talking to someone, I worry about what they may be thinking about me.  T F
18. I feel that you can’t help making social errors sometimes, so why worry about it.  T F
19. I am usually worried about what kind of impression I make.  T F
20. I worry a lot about what my superiors think of me.  T F
21. If I know someone is judging me, it has little effect on me.  T F
22. I worry that others will think I am not worthwhile.  T F
23. I worry very little about what others may think of me.  T F
24. Sometimes I think I am too concerned with what other people think of me.  T F
25. I often worry that I will say or do the wrong things.
T
26. I am often indifferent to the opinions others have of me.
T
27. I am usually confident that others will have a favorable impression of me.
T
28. I often worry that people who are important to me won't think very much of me.
T
29. I brood about the opinions my friends have about me.
T
30. I become tense and jittery if I know I am being judged by my superiors.
T

*Note: David Watson and Ronald Friend

APPENDIX D

Gender (gender you currently identify with): F M Other

Age: (17-22) (23-28) (29-34) (35-40) (41-46) (47-52) (53+)

Race/Ethnicity: _______________________

Class: Freshman Sophomore Junior Senior
REFERENCES


Eisenberg, Daniel, Sarah E. Gollust, Ezra Golberstein, and Jennifer L. Hefner. 2007. “Prevalence and Correlates of Depression, Anxiety, and


