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A PROPOSAL FOR THE APPLICATION OF CULTURALLY GROUNDED  
NARRATIVE THEORY AND STIGMA MANAGEMENT COMMUNICATION IN  
EXPLORING HELP SEEKING BEHAVIORS AMONG DEPRESSED COLLEGE STUDENTS

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## ABSTRACT

This Schreyer Honors College Senior Thesis examines the applicability of culturally grounded narrative theory and stigma management communication to programs related to help seeking intentions for depression. Current literature is reviewed concerning depression, stigma communication, and narrative theory to provide a clear set of guidelines for future initiatives. Guidelines are informed by the theories and literature and are meant to be adapted and revised according to future developments.

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## INTRODUCTION

Depression is the most common psychiatric disorder in the United States and is among the top causes of mortality in the world (Gladstone et al., 2011; Richards, 2011). It impairs the ability to function in school, work, interpersonal relationships, and is a risk factor for substance abuse and suicidal behavior (Gladstone et al., 2011). It is a recurrent disorder with 50% of those diagnosed experiencing a relapse within two years and 80% in five to seven years (Hankin, 2006). Depression is also one of the most treatable mental illnesses (Gladstone et al., 2011). While help seeking estimates in the general population are already alarmingly low, college students have the lowest rates of help-seeking from 3% to 12% due to fears of stigma and being judged by others (Ting, 2011). Previous research has shown that consideration of stigma decreases willingness to seek help (Schomerus et al., 2009b).

This thesis reviews the current literature pertaining to depression, stigma, and help-seeking behavior to provide a perspective on alleviating this significant public health concern by examining the stigma associated with treatment among college age adults. There is a wide variety of research that is dedicated to examining why college students do or do not seek help, but there is a limited amount that examines how students who do seek help cope with the attached stigma. Therefore this thesis also proposes program strategies and future research inquiries in order to learn more about how students cope with depression stigma. Key tools used to make these recommendations will include Stigma Management Communication (SMC) and culturally grounded narrative theory. Recommendations for future programs will be made along with related models for narrative elicitation and message organization.

## DEPRESSION

### Significance

Depression is a significant illness with serious consequences. The World Health Organization (WHO) has named depression as among the most burdensome diseases in the world and the second most common chronic illness with rates that are only increasing (Richards, 2011; Cassano & Fava, 2002). More than 16% of the population reports having a major depressive episode and one in every five adults will suffer from a mental illness (Gladstone et al., 2011; Richards, 2011).

An estimated 1.5 million life years are lost annually because of Depression and by 2020 WHO predicts it will carry the second greatest disease burden worldwide (Cassano & Fava, 2002). By 2030 it is expected to be the first highest (Grav et al., 2011). Depression exacts a high health care price, often not for the depressive symptoms, but for other symptoms (Richards, 2011). Studies consistently show that health care costs are higher for individuals with depression (Richards, 2011). Individuals with depression are more likely to engage in unhealthy behaviors such as smoking, unhealthy eating, excessive drinking, and physical inactivity (Cassano & Fava, 2002). Depression is a risk factor for suicide with half of symptomatic individuals having suicidal thoughts and 24% attempting (Richards, 2011; Gladstone et al., 2011). Among all age groups depression is the tenth top cause of death claiming 34,000+ lives annually (CDC, 2011).

Economically, depression is associated with loss in quality of life, increased absenteeism, presenteeism (decreased productivity), and impairment in interpersonal relationships (Richards, 2011). Suffering from depression will cause a person to age faster, experience more illnesses, and experience more cognitive decline (Forbes & Dahl, 2012). In 2000 the estimated cost of depression was \$83.1 billion, more than half of which was attributed to work related losses

(Richards, 2011). The estimated amount lost because of absenteeism and presenteeism was \$52 million in 2000 (Richards, 2011). Depression increases mortality rates and increases the risk of other illness caused mortality rates (Richards, 2011). In 2000 the cost of suicide related mortality was \$5.4 billion (Richards, 2011). While prevalence for depression is higher for females than males, rates for completed suicide are much higher for men than women (Richards, 2011).

## Types and Symptoms

Depression is a complex and often comorbid mental illness that has distinct sub disorders that often overlap with other mental and physical illnesses. There are three diagnosable forms of depressive disorders according to the DSM-IV-TR that include Major Depressive Disorder (MDD), Dysthymic Disorder, and double depression (APA, 2000; Richards, 2011). Additional, more debated, forms include minor depression, psychotic depression, postpartum depression, and seasonal affective disorder (SAD; NIMH, 2011). This thesis will discuss depression as a mental illness category, and will not differentiate among the different types. Nevertheless, it is important to review all of the diagnoses.

MDD is classified as having five items present for a period of two weeks or longer and interferes with a person's ability to function normally in their life (APA, 2000; NIMH, 2011; Richards, 2011). Some of the most commonly cited symptoms include a loss of interest, depressed mood, changes in sleep and eating habits, anxiety, and suicidal thoughts/behaviors (Cassano & Fava, 2002). While the symptoms of depression often vary depending on the individual and the illness, they generally include persistent "empty" feelings, hopelessness, pessimism, guilt, irritability, loss of interest in once pleasurable activities, changes in sleeping behavior, changes in eating behavior, suicidal ideation and attempts, and persistent physical pains such as headaches and digestive issues (NIMH, 2011). The two key symptoms in diagnosing MDD are depressed mood and/or loss of interest (Cassano & Fava, 2002). The second category is Dysthymic Disorder, which includes the same criteria, but is lower in severity and longer in duration, specifically at least two years (APA, 2000; Richards, 2011). Double depression is a combination of both MDD and dysthymic disorder (Richards, 2011). Minor depression involves symptoms of MDD for more than two weeks, but do not meet the full

criteria for MDD diagnosis (NIMH, 2011). Minor depression is a risk factor for MDD (NIMH, 2011). Psychotic depression is a combination of severe depressive symptoms along with psychosis (delusions and/or hallucinations) (NIMH, 2011). Postpartum depression is experienced by women after giving birth and affects from 10 to 15% of new mothers (NIMH, 2011). SAD is depression that only occurs during the winter months and is relieved during summer months (NIMH, 2011). There also gender differences in the manifestation of symptoms. Women will report emptiness and guilt more often, whereas men use drugs and alcohol and become more irritable and angry more often (NIMH, 2011). The DSM-5 will rename MDD as Chronic Depressive Disorder (CDD), but the criteria will remain the same (Richards, 2011). The International Classification for Diseases and Related Disorders (ICD-10) by the World Health Organization (WHO) is very similar to the DSM-IV diagnostic, except for the classification of MDD, which includes the same criteria but only requires four items to be present for a period of at least two weeks (Richards, 2011). The ICD-10 is less rigid than the DSM-IV in diagnosis of MDD, but the differences in diagnosis are not significant and both have high rates of concordance (Richards, 2011).

## Misconceptions about Depression

There is common conception among the general public that depression is a mental issue that lies outside the area of the scientific field, but brain imaging scans show that the brains of depressed individuals are visibly different especially in reward-related areas (NIMH, 2011; Forbes & Dahl, 2012). The amygdala, the mesolimbic dopamine system, the prefrontal cortex, and the striatum show abnormal function in symptomatic depressed individuals (Hankin, 2006). The amygdala, a subcortical area in the brain, has functions in fear and emotion that exhibits arousal to social rewards (Hankin, 2006; Forbes & Dahl, 2012). Depressed individuals exhibit less sensitivity to rewards and do not show a response bias in stimulus tests where one choice is slightly more rewarding than the other (Forbes & Dahl, 2012). The mesolimbic dopamine system is a pleasure management pathway that travels from the midbrain to the limbic system and the relationship of disrupted dopamine signaling to depression has been under debate (Hankin, 2006; Forbes & Dahl, 2012). Dopamine is thought to function as a key aspect of goal seeking and learning through the release of projections from the midbrain to the striatum and the medial prefrontal cortex (Forbes & Dahl, 2012). Symptomatic individuals show uneven activity in the frontal cortex, specifically the left-frontal region, which is involved in functions of approach and withdrawal (Hankin, 2006). The striatum, located below the corpus callosum, demonstrates reduced activity in response to monetary reward, decision making, anticipation, and positive facial expressions in symptomatic individuals (Forbes & Dahl, 2012). Alternatively, depression can also be associated with a greater sensitivity to stimulant drugs suggesting that depression is associated with altered responses to dopamine responses but the responses may vary depending on whether the reward is natural or drug related (Forbes & Dahl, 2012).

Another common misconception regarding depression is that there are only two phases:

depressed, and not depressed, or symptomatic and asymptomatic. This is a gross misunderstanding as the life cycle of depression is more complex and can involve six stages. The first is an episode, which describes the symptomatic phase of depression and, on average, lasts six months or longer for women (APA, 2000; Richards, 2011). The second, remission, is divided into partial and full (APA, 2000). Partial remission involves more than minimal symptoms and full is less than the minimum symptoms for 2 to 8 weeks (APA, 2000; Richards, 2011). A response is either partial or full remission in response to a treatment intervention (Richards, 2011). Recovery is a full remission longer than 8 weeks and refers to recovery from an episode (Richards, 2011). Relapse is a return of symptoms after a positive response to treatment during the remission period that meets the full syndrome criteria (Richards, 2011). Recurrence refers to a new episode that occurs during recovery (Richards, 2011).

## Co-Occurring Illnesses

It is common for depression to be diagnosed along with other illnesses. For example, half of MDD patients have comorbid anxiety disorders and 75% have some other DSM-IV diagnosable disorder (Richards, 2011). These comorbid diagnosed individuals often face an additional 12-month recovery period, more extreme depressive symptoms, and lowered responses to treatment (Richards, 2011). Other disorders commonly combined with depression can include post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), panic disorder, social phobia, generalized anxiety disorder (GAD), alcohol and other substance abuse, physical conditions such as cardiovascular issues and irritable bowel syndrome, and personality disorders (NIMH, 2011; Richards, 2011). Treating a patient's depression can improve the recovery of the co-occurring illness (NIMH, 2011). The percentage of patients who have comorbid physical illnesses range from 64.9% to 71.0% (Cassano & Fava, 2002). Common comorbid medical illnesses with depression include arthritis, hypertension, diabetes, heart conditions, and body aches (Cassano & Fava, 2002). Aggressive behavior and drug addictions are common with depressed patients (Cassano & Fava, 2002).

## Causes

The cause of depression has long been debated but researchers agree that there is not one answer and the development of depression in an individual is due to a complex combination of risk factors that is likely to be different for every person. A risk factor is determined by the interactions of genes with environmental events that make the triggering of depressive events more likely (NIMH, 2011). Risk factors for depression include being female, family history, genetics, psychology, stressful environment, low socioeconomic status, difficult childhood, interpersonal factors, psychological factors such as neuroticism, and lack of social support have been consistently shown to be causal (Cassano & Fava, 2002; Eisenberg et al., 2007).

Longitudinal research shows that stressful experiences can contribute to the development of depression, but is highly dependent on interactions with additional personality and genetic risk factors (Hankin, 2006). The percentage of those who develop depression after negative stressful life events is only 20% to 50% (Hankin, 2006). Genetic liabilities, such as the length of a functional polymorphism in the promoter region of the serotonin transporter (5-HTT) may influence how a person handles stressful life events (Hankin, 2006). Those with a short allele of the 5-HTT promoter have greater genetic risk compared to those with the long version of the allele (Hankin, 2006). This has been confirmed in tests exposing individuals to the same environmental stressors and short allele individuals are more likely to develop depressive symptoms (Hankin, 2006). Demonstrating a low reward function in the brain, whether in the amygdala, striatum, or related areas, is thought to be hereditary and is a risk factor for depressive symptoms (Forbes & Dahl, 2012).

Depression across the lifetime is often preceded by youth depression and a significant percentage of symptomatic adults report having their first episode during their youth (Hankin,

2006; Cassano & Fava, 2002). The most likely age group to experience an episode of MDD is 15-24 years-old (Michael et al., 2006). Three fourths of those with lifetime mental disorders have their first episode by the time they are 24 years-old (Eisenberg et al., 2007). In addition, adverse childhood experiencing such as physical/sexual abuse, divorce, and problematic parent-child relationships are strongly correlated with MDD later in life (Cassano & Fava, 2002). Having a family history of depression increases the risk of someone being depressed by three to four times (Cassano & Fava, 2002).

There are five main cognitive risk factors including negative causal inferential styles, dysfunctional attitudes, neuroticism, rumination, and self-criticism (Hankin, 2006). Negative causal inferential style refers to the tendency to attribute the cause of negative events to global reasons, while a dysfunctional attitude refers to perfectionism, or dependency on others (Hankin, 2006). Neuroticism, the tendency of an individual to perceive things to be distressing, or pessimism, is among the strongest predictors of developing depression (Hankin, 2006). Rumination involves increased and more than necessary attention to what their feelings mean and what that means about them as a person (Hankin, 2006). Self-criticism is a preoccupation with defining one's self and determining self-worth from that definition (Hankin, 2006).

Interpersonal risk factors have been identified, but due to the cross-sectional nature of the involved studies, direct relationships are difficult to establish (Hankin, 2006). They include reassurance seeking, dependency, lack of social support, and insecure attachment (Hankin, 2006). Reassurance seeking describes the tendency to determine self-worth on the reassurance from others dependency is a heightened need to be around others (Hankin, 2006). Social support can include emotional, financial, informational or enacted, and can involve family, friends, colleagues, or other close relationships (Hankin, 2006). Lack of these different dimensions of

support can put a person at risk for depression (Hankin, 2006).

Social support or lack thereof, is a risk factor for people of all ages to develop depression (Grav et al., 2011). It is defined as information that leads a person to believe that they are loved and have an important place in a social network (Grav et al., 2011). The most important form of social support in relation to depression is emotional, and more specifically perceived emotional support (Grav et al., 2011). Emotional support is a support system that is able to provide resources that aid in emotional realms (Grav et al., 2011). Perceived support is a specific type of emotional support that refers to an individual's perception of what social support is available to them and how much they trust it (Grav et al., 2011). Emotional support is very valuable to people who are experiencing stressful events, but the value is only effective to the extent that it is perceived to exist (Grav et al., 2011).

There are many dimensions of risk factors that contribute to suicide. Personality risk factors for suicide ideation include perfectionism, low emotional expression, pessimistic thought patterns, dependency, impulsivity, and introversion (Miller & Day, 2002). A family history of violence or suicide puts an individual at greater risk (Miller & Day, 2002). Miller and Day's (2002) self-report survey suggest that in addition to personality factors family communication pattern may explain the likelihood of ideation in females. The study found that in women with expectations of perfection from the mother and the father uses a conformity communication orientation, suicide may be influential in addition to other risk factors (Miller & Day, 2002). A conformity family communication orientation values compliance and cooperation whereas a conversation orientation values the exchange of differing ideas in conversation (Miller & Day, 2002). A possible explanation for why these factors influence suicidality in the way that they do is that an important aspect of female identity formation is the separation of her own autonomous

identity from that of her mother (Miller & Day, 2002). In a family with a perfectionistic mother and a conformist father, the daughter would not be allowed to create her own identity and expectations of perfection, which are already a risk factor for suicide, may make more of an impact in women (Miller & Day, 2002).

Half of all lifetime cases begin at age 14 and three fourths of the cases start before age 24 (Richards, 2011). The incidence of depressive symptoms is more common among women in the United States and worldwide and this contrast continues across all ages (Richards, 2011). In the US 21.3% of women have depression compared to 12.7% of men; however the reasons for this recorded difference have been contested (Cassano & Fava, 2002). Depressive symptoms manifest differently in men and women, most of which are not accounted for in diagnostic settings (Michael et al., 2006). Men are more likely to abuse drugs and alcohol, have problems at work and in relationships, and develop increased antisocial and narcissistic personality traits (Michael et al., 2006).

## Treatment

Just as there are many possible causes for depression, there are also numerous effective treatment options. Depression is highly treatable and the majority of those who receive an intervention, from 50% to 75%, will have some form of recovery 12 months after treatment (Richards, 2011). Nevertheless, there is still a significant portion that will not respond to treatment (Richards, 2011). A treatment's effectiveness increases the earlier it is administered (NIMH, 2011). Aside from those that recover, 14% to 35% will have recurring episodes, and 6% to 15% will have constant chronic depressive symptoms for years, sometimes more than 4 (Richards, 2011). Men respond better to treatment than women do and the longer and more chronic an episode is, the less a treatment will be effective (Richards, 2011).

Relapse is common and found in 25% of those in remission for MDD (Richards, 2011). This rate increases as the timeframe increases reaching as high as 42% by 5 years (Richards, 2011). Factors that contribute to relapse include a history of depressive symptoms, history of other psychiatric disorders, old age, underlying chronic depression, and psychosocial impairment (Richards, 2011).

Recurrence is common for many suffering from depression and the rate increases as time goes on, with 85% experiencing a recurring episode after 15 years (Richards, 2011). In patients who have experienced two previous episodes of depression, 70% will experience a recurrence and 90% after three episodes (Cassano & Fava, 2002). It is difficult to definitively determine likelihood of recurrence but some risk factors tend to include being female, being unmarried, a history of depressive episodes, and long duration of those episodes (Richards, 2011). Quality of recovery is an important factor with 66% of fully recovered patients experiencing a recurrence as compared to 87% with some symptoms (Richards, 2011). Risk factors for recurrence are similar

to those of relapse (Richards, 2011).

Treatment options generally include medication, psychotherapy, and brain stimulation therapies (NIMH, 2011). Brain stimulation therapies mainly involve electroconvulsive therapy (ECT) and are used when a patient does not respond to psychotherapy and medication treatments (NIMH, 2011). Other treatments such as vagus nerve stimulation (VNS) and repetitive transcranial magnetic stimulation (rTMS) are also used, although not as frequently (NIMH, 2011). The session takes a few minutes, is painless, and can be very effective at providing relief (NIMH, 2011).

Selective serotonin reuptake inhibitors (SSRIs) and Serotonin and norepinephrine reuptake inhibitors (SNRIs) are the most common forms of antidepressants that work by altering neurotransmitter functioning, which are brain chemicals involved in mood regulation (NIMH, 2011). Monoamine oxidase inhibitors (MAOIs) are effective for atypical cases but are prescribed more cautiously with more restrictions (NIMH, 2011). Tricyclics are older antidepressants that are rarely used today because of their extreme side effects (NIMH, 2011). Only 25% of depressed patients are prescribed antidepressants (Cassano & Fava, 2002). Antidepressants are non-habit forming but require at least a 4 to 6 week period for results (NIMH, 2011). Of those who are prescribed medication, 63% report improvement in symptoms (Cassano & Fava, 2002). Additionally, research has shown that 50% of those who begin medication therapy do not continue their treatment past the first month (Cassano & Fava, 2002). Medication switches have been shown to be beneficial if symptoms do not improve, and abrupt termination of antidepressant intake is dangerous because of the risk for withdrawal symptoms, which could result in a depression relapse and even suicide (NIMH, 2011). This risk is especially high for children and adolescents and in 2007 the black box warning, or the most serious, was revised by

the FDA to extend the age to 24 year-olds (NIMH, 2011).

Psychotherapy, also called talk therapy, includes cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) (NIMH, 2011). CBT focuses on restructuring a person's thought patterns so they can better interpret their environment and interactions to be more realistic and in a less negative way (NIMH, 2011). ITP focuses on coping with and/or identify relationships that may be contributing to the depression (NIMH, 2011). Treatment is usually most effective when both psychotherapy and medication are combined (NIMH, 2011). This is especially true for patients with cases of recurrent depression (Cassano & Fava, 2002).

Self-help is less discussed in the literature but has the potential to be an effective, practical, and preventative alternative to traditional treatment (Morgan et al., 2011). One example of an initiative in progress is Morgan and colleagues (2011) Mood Memos study. They are currently gathering data to study the effectiveness of a self-help behavior based e-mail prevention program aimed towards individuals with minor depression . They argue that self-help is ideal for minor depression because health systems are preoccupied with severe cases, and even many of those do not receive treatment (Morgan et al., 2011). There are both beneficial and harmful self-help behaviors. Harmful and ineffective behavior can include drug and alcohol use or abuse (Morgan et al., 2011). Beneficial strategies include regular exercise, regulating and getting more sleep, and doing fulfilling activities (Morgan et al., 2011). Individuals who score in the range of major depression are not able to participate in the program and are directed to a web site that assists in locating the nearest professional health care facility due to the increased risk of complications (Morgan et al., 2011). The program sends participants two e-mails per week for six weeks with behavior modification messages informed by health researchers, theories of health communication, online communication, behavior change, and persuasion (Morgan et al.,

2011). The control group receives passive information based messages about depression and both groups are assessed three times for various measurements of depressive symptoms and others (Morgan et al., 2011).

Symptomatic individuals rarely seek professional help (Han et al., 2006; Cassano & Fava, 2002; Zivin et al., 2009) and when they do, the average time between onset and seeking help for a mental illness is 8 to 10 years (Eisenberg et al., 2007). Among those manifesting symptoms, young adults are a demographic with a high need for help, but are among those least likely to pursue it (Rickwood, 2007). General practitioners often lack adequate training to recognize, diagnose, and communicate about mental illnesses, resulting in under diagnosis (roughly 50%; Barney et al., 2006; Kravitz et al., 2011; Cassano & Fava, 2002). In a rural university survey, only 12% of students reported receiving treatment for depression (Michael et al., 2006). In that study, of those who were being treated it was almost exclusively with medication alone (Michael et al., 2006). Thus, it is clear; depression is rarely treated and often mistreated.

These statistics cannot be explained by lack of information of mental illness, as people are able to correctly identify the symptoms of depression most of the time (Elwy et al., 2011).

## Depression among College Students

While depression is a problem in the general population, it is particularly serious among college students. It accounts for half of the total disease burden in young adults in the United States (Eisenberg et al., 2007). On college campuses, depression is the most prevalent mental illness, the rates of symptoms are increasing across the country, and college students are the demographic least likely to seek help (Zivin et al., 2009; Eisenberg et al., 2007). Generally 30% to 44% of college students report depressive symptoms that hinder functioning, including having their grades affected (NIMH, n.d.; Eisenberg et al., 2007). In a longitudinal survey 27% reported that the symptoms persisted throughout a two-year period (Zivin et al., 2009). A 2005 survey found that 10% of students have considered attempting suicide (Eisenberg et al., 2007). Studies examining the rate of suicidal thoughts on college campuses have retrieved varying results depending on the demographic and methodology, but are between 2.5% and 9%, all alarmingly high rates (Eisenberg et al., 2007; Klein et al., 2011).

Among all age groups women are more likely to be diagnosed with depression and seek help for it, but these gender differences disappear and even reverse in college samples with men in this age group more frequently reporting depressive symptoms (Eisenberg et al., 2007; Klein et al., 2011). Several studies have found that across ethnic groups men and women are equally likely to have depression in college, with the exception of one type of depression, MDD, which is still more common for women (Eisenberg et al., 2007; Klein et al., 2011).

Suicide is the third leading cause of death for 15 to 24-year-olds comprising 12.2% of all deaths, totaling more than death caused by cancer, heart disease, congenital anomalies, strokes, diabetes, influenza, pregnancy complications, and HIV combined (CDC, 2011). Depression in college students is associated with risks behaviors including sexual behavior and substance

abuse, difficulties in schoolwork, social impairment including decrease of social support and problems in relationships, and morbidity (Michael et al., 2006).

Risk factors for depression in college students include being older than age 25, being male, substance abuse, history of sexual abuse, relationship problems, growing up in poor socioeconomic environment, students living with parents, stressful life events, and financial stress, and issues in gender identity (Eisenberg et al., 2007). College is a unique environment that can mean increased stress and therefore an increase in risk for depression (NIMH, n.d.). For many it is the first time that students will live away from their family and main support system, which may lead them to feel alone and isolated (NIMH, n.d.). It may also be the first time that students have to worry about finances and college schoolwork, adding to the stress burden (NIMH, n.d.). An increased level of stress compounded with a decrease in primary social support is a reciprocal increase in risk factors that is at a high level unique to college students. The most common reasons reported by depressed college students include problems with school work, financial issues, relationship problems, and loneliness (Michael et al., 2006). Possible protective factors for depression in college students could include living in a dorm, or away from home, and being married or in a domestic partnership (Eisenberg et al., 2007). Help-seeking behavior, whether in relation to treatment or prevention, is a protective factor (Rickwood et al., 2007). The study found that the only significant predictor of depressive symptoms was degree status with undergraduates being at significantly higher risk (Klein et al., 2011).

Less than one third of college students with depressive symptoms seek help from counseling and, in fact, self-medication with alcohol is more likely to be used than therapy (Michael et al., 2006; Klein et al., 2011). Of those that do seek help, it is estimated that only 1 in 10 will receive the proper dosage of treatment whether it be therapy, medication, or both

(Michael et al., 2006).

With the abundance of proven treatments available for little to no cost for students on college campuses, one might think that depression would not be such severe and pervasive problem. The reality is that a very low percentage of students actually utilize the tools available to them. Because there is no financial or accessibility burden associated with seeking help in this demographic, there must be something else stopping students from seeking help. Stigma is a component of particular importance, and understanding the dynamics between students and mental-illness stigma is essential to improving help-seeking rates. Having a thorough understanding of stigma and the possible responses to it by those who are affected by it can be beneficial to health professionals in their treatment recommendations and their utilization of the patient's resources (Boardman et al., 2011).

## STIGMA

To say that depression and/or depression treatment are stigmatized means that there is a socially constructed, simplified, and standardized negative image about it that is held by the general population (Smith, 2007a; Goffman, 1963). The emotional and cognitive processes of stigmatization are not limited to humans and historically stigma been used to identify discriminating variations of who is normal and who is not (Goffman, 1963; Smith, 2007a; Schomerus et al., 2009b).

The social construction and perpetuation of stigmas are based on both the perceptions of those affected by the stigma and those that are not because “discourse does not reflect an objective world as much as it subjectively creates one” (Meisenbach, 2010). The concept was invented by the Greeks as a system of exposing who was of bad moral character, whether they be criminals, slaves, or traitors (Goffman, 1963). The Greeks marked these individuals in order to distinguish them from everyone else by cutting or burning marks into the body (Goffman, 1963). Today, the marks of stigma can still be physical, such as making sex offenders register or marking prisoners, but just as often they are abstract concepts created and maintained only in language and on a person’s character (Goffman, 1963). Also different from Ancient Greece is the purpose: in addition to marking criminals or the like through prison garb and making sex offenders register, stigmas are used in social encounters as a tool to reduce uncertainty about the other person (Goffman, 1963).

Stigmas can develop from stereotypes because both are similar: a stereotype is a rigid generalization about a group of people that may be negative, positive, or neutral, whereas a stigma always exists to distinguish ‘others’ in a negative way through seen or unseen marks. Stigma also has been used as a way to understand how people create and maintain social order

through power, control, inequality, and exclusion (Smith, 2007a). Laws, either legal or social, distinguish marks for stigma, isolate those with the marks, and remove their rights (Smith, 2007a). Examples of isolation can include access to health care needed by the stigmatized group or access to employment (Smith, 2007a).

The first step to understanding stigma as it pertains to communication is to review Smith's (2007a) theory of stigma communication. The theory posits that stigma communication is a process whereby communities inform each other how to recognize stigmatized, or disgraced, individuals through messages. By definition, stigmas depend on communication in order to exist let alone become common knowledge (Smith, 2007a). Stigma messages provide cues that serve to:

- Distinguish people
- Categorize distinguished people as a separate social entity
- Imply a responsibility for receiving placement within the distinguished group and the associated peril.
- Link the distinguished group to physical and social peril

Stigma messages are so contagious because they have certain elements that make them effective as communicative messages. They are appealing mainly because they are accessible, and because they elicit compelling emotions. The accessibility of a stigma message allows for it to be shared easily and repeatedly across communities and this is done through group labels and marks, peril, and responsibility (Smith, 2007a). Group labels serve the purpose homogenizing a stigmatized group, stripping members of individuality or contextualizing behavior (Smith, 2007a). All members are seen as having the same fate and all need to be kept separated from 'normal' people (Smith, 2007a). Stigmatization facilitates and encourages negative stereotyping

of neutral behavior, further emphasizing that the stigmatized group is defined by a concrete set of attributes (Smith, 2007a). Marks are the tools used to identify members of a stigmatized group (Smith, 2007a). They can evoke biological, automatic, and social responses which serve the purpose of arousing the viewer, thus bringing the mark to their attention (Smith, 2007a). Marks can have the potential to be concealed, which allow a member to appear normal, and may evoke a disgust response, which serves the purpose of arousing those who perceive the mark (Smith, 2007a).

The other reason stigma messages are so effective is because they arouse strong emotions in people, most notably fear, anger, and disgust (Smith, 2007a). These emotions are the ones most often shared and thus are prime tools to use for socializing (Smith, 2007a). They are also very beneficial to share because they are likely to result in increased bonding and popularity because it allows for easy consensus of contempt towards something (Smith, 2007a). The two stigma tools used to accomplish negative emotion is peril and responsibility. Peril is the information pertaining to the danger that the stigmatized group poses to the rest of society (Smith, 2007a). Signal words (Danger!), hazard statements (This medication can lead to death), hazard avoidance statements (Do not stop medication suddenly), and consequence statements (failure to do so may result in death) all serve the peril purpose of stigma along with nonverbal codes (Smith, 2007a). Peril is communicating that the illness is threatening and dangerous to the general population (Smith, 2007a).

Responsibility, a stereotypic belief blaming members for their stigmatized ailment, functions as an amplifier for the elicited emotion and can enhance them (Smith, 2007a). This is because if the person is responsible for their ailment in their story, then there is less need for empathy, thus it is extremely easy to strengthen notions of disgust (Smith, 2007a). Stigmatized

groups that are blamed for their illness are punished more severely than those that are not, regardless of the reality of the situation (Smith, 2007a).

Understanding the anatomy of stigma messages is the first step to understanding how they function, and how they can be coped with. Understanding how these messages operate and are applied to everyday experiences is equally important to aid understanding of identification of stigmatized communicative situations. One way to do this is to analyze popular forms of media such as advertisements in magazines and pamphlets in health centers. Smith (2007b) did this and her analysis follows.

## Stigma Messages

Stigma operate in health messages often, but what is known about these messages? Smith (2007b) examines the existence of stigma in media messages using an exploratory study and categorizing the messages according to their content. Messages were coded into one of two categories, challenge and stigma, then sub-categorized for specificity. Stigma messages communicate by utilizing and promoting stigmatized concepts while challenge cues operate by opposing the stigma and contesting stigmatized conceptions (Smith 2007b). An important finding of the study is that stigma and challenge cues are never used together, and the messages always employ types of cues from one group or the other (Smith, 2007b). These categories serve as excellent guidelines for message design in future health promotion programs.

Stigma codes operate through cues such as marks, them-language, reliability, avoidance, peril, health labels, and shame/disgust (Smith, 2007b). A mark is anything that is assigned the role of referring to an illness, almost like a logo, and could include behavior, environment, etc. (Smith, 2007b). Them-language is the opposite of us-language and uses pronouns such as ‘them’ and ‘they’ in order to create a distinction between non-stigmatized and stigmatized individuals (Smith, 2007b). Responsibility cues frame the ill person as accountable for their illness, while avoid cues suggest that stigmatized individuals should be isolated, and peril cues highlight how stigmatized individuals are harmful to the population (Smith, 2007b). Health label cues label the group of people with the ailment and shame/disgust cues suggest that stigmatized should be shameful (Smith, 2007b).

A common trend of stigma messages is to exclude any discussions of remediation and is always directed exclusively at non-stigmatized individuals without sentiments of supporting them (Smith, 2007b). This observation points to how stigmatizing messages perpetuate isolation

of stigmatized individuals simply by choosing an audience (Smith, 2007b).

“Resources for depressed people are often mentioned on related websites and in the blurbs put out by pharm companies. However reality tells a different story. A decent psychologist (psychotherapy) costs a fortune. A psychiatrist costs \$150-\$200 an hour. Lifeline is staffed by psychology students, some in first year and is not suitable for intelligent, educated, middle aged men. What are we left with is a gp who does not specialize in depression and often has no more knowledge about it than a lay person” (Barney et al., 2011).

Challenge codes use cues such as optimism, hope, us-language, personification, and fight cues (Smith, 2007b). An optimism cue communicates positivity in the message while a hope cue involves success (Smith, 2007b). Us-language cues promote inclusion and use words such as ‘we’, ‘us’, or ‘our’ in order to create a sense of unity (Smith, 2007b). Personification describes giving an illness human qualities and fight cues refer to sentiments related to fighting an illness (Smith, 2007b).

The most common challenge cues include optimism, hope, personification, and fight cues (Smith, 2007b). The least common challenge cue is social inclusion (Smith, 2007b). Most common stigma cues are marks, them-language, responsibility, avoid, peril and shame/disgust (Smith, 2007b). Labeling is less common (Smith, 2007b). Challenge and stigma messages both have cue trends which are illustrated in Table 1.

In addition to the examination of stigma cues in health messages, it is important to identify how the public marks depressed individuals in order to communicate with stigma cues about them. One way to do this is through the media, as it has often been considered among the top contributors to mental illness stigma marks (Klin & Lemish, 2008). It has the potential to preserve harmful stereotypes by framing certain stigmatized groups as a way to isolate them from the rest of the population (Pirkis et al., 2006). People who are exposed to media, including

electronic sources, have been shown to have opinions poor about mental illness that are influenced by what they consume, regardless of their depression status or mental health literacy (Klin & Lemish, 2008; Pirkis et al., 2006). Mental illness in the media is usually portrayed as distorted, exaggerated, inaccurate, or a combination and are negatively stereotyped more often than physical disabilities (Klin & Lemish, 2008). The problem with this tendency is that media impacts the perceptions that people use to manage important topics and fostering these incorrect ideas could shape people's expectations of mental illness and treatment, thus influencing their decision to ever seek help (Pirkis et al., 2006).

The percentage of violent people with mental illnesses is no greater than the percentage of violent people without mental illnesses (Klin & Lemish, 2008). This reality is not evident from the media where news reports sensationalize stories that involve both violence and mental illnesses (Klin & Lemish, 2008). Depression in particular usually includes emphasis on protecting people from self-harm (Klin & Lemish, 2008). Pirkis and colleagues (2006) discuss a number of mental illness stereotypes, but relevant to this analysis are the 'rebellious free spirit' and the 'narcissistic parasite.' The rebellious free spirit is the eccentric character who is usually put into a mental hospital but later released because their sanity has been restored in some way (Pirkis et al., 2006). This portrayal is problematic because it communicates that "good" people cannot be mentally ill and mentally ill individuals cannot be "good" (Pirkis et al., 2006). The 'narcissistic parasite' portrays people with depression as spoiled and preoccupied with their own world of trivial issues (Pirkis et al., 2006). The problem with this stereotype is self-evident as it plays into the common perception many symptomatic individuals report regarding their responsibility in their illness. Even mental health professionals and mental health treatments are not immune to stigmatization in the media. Psychologists and psychiatrists are always presented

negatively and the treatments are manipulated and selectively shown when it is convenient for plot lines (Pirkis et al., 2006). Medication is rarely, if ever, portrayed (Pirkis et al., 2006). Given the media's impact on public perception, people suffering from depression are not getting adequate representation.

Research examining stigma cues in health messages is very valuable for any future health promotion programs because it allows for clear identification of what types of cues are being used in a message and allows for greater tailoring of messages for specific purposes. In addition, identification of what marks are used to identify depressed individuals are of equal importance in classifying what group is being communicated about. Therefore, an effective challenge message should not include any cues used in stigma messages, and should include as many challenge cues as possible. Stigma communication research, however, is still in its infancy and much is unknown about what combination of cues is most or least effective.

## Stigma Management Communication

Understanding stigma messages is only half of the equation. People are exposed to stigmas that affect them every day and must cope with them. How do they do this, especially since stigma are often resilient to change even when substantial contradictory evidence exists (Smith, 2007a)? Researchers have explored this question. Stereotype threat is a concept used to aid in understanding how members of a stereotyped group behave in situations where there is a threat of being stereotyped. It is a situational threat that can affect anyone who belongs to a group that is vulnerable to some form of stereotype (Steele, 1997). Outperforming the stereotype is often not possible, and even when it is possible it is typically is seen as limited to a specific situation and thus often is not generalizable to outside situations (Steele, 1997). The extent that the threat is felt also is tied to how strongly relevant it is to the self (Steele, 1997). While this research is valuable, it does not extend to how stigma is coped with.

Meisenbach's (2010) Theory of Stigma Management Communication (SMC) describes a stigmatized individual's attitude about a stigmatizing message and the subsequent reaction to that attitude. It posits that stigma is complex and can be moral, physical, social, and the stigma message may not explicitly mark a person who has stigmatized qualities, and that individual has options to perceive themselves as discredited or not (Meisenbach, 2010). The theory relies on three assumptions:

1. Stigmas are created and maintained by all people, a part of the stigmatized group or not.
2. Stigmas change according to the discourse used and the conditions they are used in.
3. Stigmas vary by degree in breadth (how much is 'dirty') and depth (How 'dirty' it is).

According to SMC, the member of the stigmatized group has the ability to accept or

reject a stigma on two planes, as it applies to the self, and how the public perception exists (in the mind of the member; Meisenbach, 2010). Both of these concepts exist in the mind of the member of the stigmatized group, and because of this they can either reflect common perceptions, or not.

Following these assumptions, there are six resulting types of responses: accepting, avoiding, evading responsibility, denying, reducing offensiveness, and ignoring (Meisenbach, 2010). Each response is then divided into four subcategories depending on the degree that the response agrees with the public perception of the stigma, and how the response accepts the stigmas applicability to the self (Meisenbach, 2010). These are discussed next, and the model is illustrated in Table 2.

(I) Accept Public Perception, Accept Applicability to Self

(a) Acceptance: An incorporation of the stigma to an individual's sense of identity. The behaviors that people use in acceptance are defensive in nature and involve passive acceptance, display/disclosure, apologizing, use of humor, blaming stigma, isolation, and bonding with other stigmatized people.

(1) *Passive Acceptance*: failure to challenge a stigma and in doing so, whether they agree or not, are communicating acceptance through passivity. An example of this happening could be someone in a group setting joking that they think therapy is for 'crazy' people, and another person who uses therapy does not say anything.

(2) *Display/disclosure*: occurs when a person purposefully displays the stigmatizing marks as a way to communicate that they are comfortable with the stigma. This strategy may aid others in seeing the attribute in a non-stigmatized view, possibly as a tool of desensitization. In the film *Take Shelter* (2011) Curtis, who develops paranoid

schizophrenia, is isolated by the community at a country club dinner because of his behavior. Initially he pretends not to notice it but after being provoked stands up and screams, “You think I’m crazy? Well, listen up, there’s a storm coming like nothing you’ve ever seen, and not a one of you is prepared for it!” In this scene he copes with his stigma by using the display strategy, and judging from the fearful stares of the other people as he and his family leave, he only matched their expectations of a crazy person. Research examining this strategy has found that it is not effective in generating acceptance of the stigmatized among others.

- (3) *Apologizing*: admitting wrongdoing as defined by the stigma, and requesting forgiveness for it. This might be commonly done when someone who has depressive symptoms divulges information about what they are going through to another person, and follows it up with ‘I’m sorry for telling you this.’ Another example could involve a friend mentioning that the depressed individual hasn’t seemed like themselves lately and they respond with, ‘I know, I’ve been down, I’m sorry.’
- (4) *Humor*: Usually self-deprecating and serves the purpose of alleviating tension between the stigmatized and non-stigmatized by acknowledging that others are right in stigmatizing them. Agreement about the stigma prompts that the conversation should move on. Someone who has a history of depressive symptoms might comment, ‘I know, I’m always a Debbie-Downer with things.’
- (5) *Blaming the stigma for negative outcomes*: Scapegoating the stigma as a way to protect self-esteem. By blaming the stigma, which is out of the person’s control, the person becomes a victim and is thus comforted.

(6) *Isolation*: decreased to elimination of communication with others because they internalize and blame themselves for the stigma. This is very common in depression: A symptomatic person may blame themselves, not want to share their burden with others, and end up staying in their bed for most of the time.

(7) *Bonding*: stigmatized individuals only interact with each other to provide peer support and mentoring. Group therapy, which exists for many mental illnesses including depression, is a facilitator of bonding and encourages this type of strategy.

## (II) Accept Public Perception, Challenge Applicability to Self

(a) Avoidance: involves five sub-strategies including hiding the marked attribute(s), avoiding stigmatizing situations, stopping stigmatized behaviors, distancing the self from the stigma, and making favorable social comparisons.

(1) *Hiding the marked attribute(s)*: commonly referred to as secrecy and attempts to hide the downsides of a stigma. It can be as extreme as denying being a member of a stigmatized group, but it can also be behavioral. Someone who is experiencing a severe depressive episode with suicidal thoughts may tell friends, 'I'm not feeling good lately,' instead of explicitly stating that they are depressed and feeling suicidal. Another example could be when someone uses counseling services, they might lie to their friends about where they are going because they do not want it known that they use psychological services.

(2) *Avoiding stigmatizing situations*: distancing one's self from a stigmatized group by avoiding situations that make the stigma visible. Someone with depressive symptoms may avoid therapy and assemblies involving mental health because those situations directly acknowledge the stigma.

- (3) *Stopping stigmatized behaviors*: a form of corrective behavior that allows a person to identify themselves as no longer members of the stigmatized group because they stop the behaviors associated with the stigma. Depressed individuals often hear advice from others such as, ‘Just snap out of it,’ and this mentality is used frequently when a person is dealing with depression and the associated stigma. Symptomatic individuals may try to convince themselves to stop having depressive symptoms as a way to ‘fix’ themselves and thus no longer be associated with that group.
- (4) *Depersonalization*: a cognitive strategy of distancing the self from the stigma. It allows a person to tune out while doing a stigmatized behavior as a way to dissociate it from their conceptualized identity. There are many ways to do this. It could involve a symptomatic individual rationalizing that ‘this isn’t who they really are’ after attending a counseling session. It could also involve a symptomatic individual avoiding someone who openly displays and discusses their depression diagnosis.
- (5) *Making favorable comparisons*: Done between a stigmatized individual and others who are similar enough to make a comparison but somehow “lesser” in order to make the individual feel less stigmatized. These lesser persons may not even exist, but serve the purpose of allowing the individual to avoid the stigma. Someone who is depressed may look at a news story of a young adult who committed suicide, and rationalize that they aren’t as bad as that person, and are much more normal.

(III) Challenge Public Perception, Accept Applicability to self.

- (a) Evading responsibility: a tool to shift agency away from the self and present themselves as victims to outside circumstances who have no control over their stigmatization.

Includes:

(1) *Defeasibility*: A symptomatic individual may say they asked for help when first experiencing depressive symptoms, but did not receive adequate help and thus is not responsible for their symptoms increased severity.

(2) *Provocation*: A symptomatic depressed individual may reason that they had a difficult childhood that involved abuse, therefore they became depressed.

(3) *Unintentional*: A symptomatic individual may reason that they talked with a trusted confidant regularly, so they did everything that they could in their power to not become depressed.

(b) Reducing offensiveness: focuses on changing the public perception of a stigma and can be done through:

(1) *Bolstering/reinforcing*: shifting the gaze to a non-stigmatized aspect of the stigmatized group as a way to compensate and develop an identity outside of the stigma. A symptomatic individual may develop very good masking skills in order to hide their depressed feelings when in the presence of others.

(2) *Minimizing*: Pointing out that the stigmatized quality does not do any harm to others. Someone who is depressed may add onto any discussion of his or her depression, 'I'm not suicidal though, so don't worry.'

(3) *Transcending*: Used to show how stigmatized attributes can be used to accomplish valuable ends through a higher purpose. A symptomatic depressed person may rationalize that because they have depression, it only makes them stronger and they can overcome this obstacle just as everyone overcomes challenges.

(IV) Challenge Public Perception, Deny Applicability to Self.

(a) Denying: Proactive strategies to show the public perception of the stigma is incorrect, thus it naturally does not apply to the self. This can be explained by the extended parallel process model (EPPM) which suggests that if the fear a person feels towards an issue is greater than their perception of their self-efficacy, then they control the fear by denying the issue (Smith, 2007a). It has been found that only a small percentage of individuals who use mental health services actually actively oppose the related stigmas (Klin & Lemish, 2008).

(1) *Simple denial*: Refuting the public understanding of the stigma and any applicability of that stigma to the self. A symptomatic person may state something along the lines of, ‘depressed people aren’t faking it,’ or ‘depressed people cannot just snap out of it.’

(2) *Logical denials*: Complex version of simple denials that utilize argumentation and can be done using three different techniques:

- **Discrediting the discreditor**: Delegitimizing the source of the stigma to make the stigma therefore invalid. A depressed person may say, ‘you don’t know what it’s like, so you can’t judge me for the way I feel.’
- **Providing evidence**: Educating others about how the stigma is wrong and therefore invalid through examples and facts that refute it. A symptomatic individual may mention that depression is in part caused by a chemical imbalance that has been observed in brain imaging scans, therefore they are not making it up.
- **Highlighting logical fallacies**: Arguing that the logic being used to uphold the stigma is faulty. A depressed individual may argue that if they could really choose the way they feel, they would surely choose happiness over depression.

(b) Ignoring: Refusing to acknowledge a stigma as a way to discredit it. This is similar to passive acceptance in behavior, but acknowledges agency. A depressed individual may ignore someone making a comment about how only crazy people go to therapy, as they are on their way to counseling themselves.

Meisenbach's (2010) theory of Stigma Management Communication coupled with Smith's research in stigma communication provides an extremely valuable tool for health communication and this thesis because it allows researchers to map the messages being used by health promotion initiatives and figure out what works and what does not in the process of stigmatization and stigma coping. Additionally, researchers are able to identify certain behaviors and communicative strategies that may or may not be effective for stigma management. Message designers for promotion programs are able to distinguish exactly what cues they are using to construct messages to a certain aim. A promising way to integrate these strategies is through the elicitation and coding of narrative messages from depressed college students who acknowledge their stigma and how they seek help. How to do this will be discussed later, in the recommendations section.

## Depression and Help-Seeking Behaviors

There are two categories of factors, structural and individual that interact to determine the help seeking decisions of an individual (Rickwood, 2007). Structural factors involve available support systems, whether family or community, health care systems, and referral pathways (Rickwood, 2007). Having trusted relationships with health professionals has been observed to increase help seeking intention rates (Rickwood, 2007). Individual factors that determine help seeking intentions can be conceptualized using the Self-Regulation Model of Illness Behavior (Elwy et al., 2011). It describes how a person perceives an illness, how they emotionally respond to their perceptions, and how those factors affect coping strategies (Elwy et al., 2011). The first stage of the model is three pronged: First an individual is presented with symptoms of depression that require attention (Elwy et al., 2011). Second, those symptoms are given meaning based on their views of depression, which are complex and involve the persons perceptions of identity (the illness and the symptoms), the expected time frame of the illness, cause of the symptoms, the expected consequences of the illness, beliefs about the curability and control over symptoms of depression, and the coherence (how well a person understands) of the illness (Elwy et al., 2011). Steps one and two of the Self-Regulation Model of Illness Behavior are illustrated in Appendix A. Mental health literacy and emotional communication competence both increase the likelihood of help seeking intention (Rickwood, 2007). Third the person's emotional response will be altered according to their perceptions and interpretations of depression (Elwy et al., 2011). Possible emotional responses include anger, fear, and anxiety, all of which may be influenced by stigma (Elwy et al., 2011). A person's belief of curability and control of depression is divided into personal and treatment control, referring to the effectiveness of the self and professional sources respectively (Elwy et al., 2011). Those who feel personal responsibility for their

emotions are less likely to seek help (Rickwood, 2007). In addition, individuals who have negative views or experiences regarding health providers have decreased likelihood of seeking help (Rickwood, 2007). All of these factors then influence the second stage of the model, or coping strategies used by the person, which include help seeking behavior, or avoidance of the issue thus resulting in reluctance to seek help (Elwy et al., 2011). The third stage involves evaluation of the effectiveness of the chosen coping strategy and will include continuing their method of coping or opt for one that they perceive may work better (Elwy et al., 2011).

There are various dimensions of stigma that have varying effects on help seeking behaviors. When people perceive consequences of depression, these perceptions are often informed by stigma in that the illness is in the control of the individual affected (Elwy et al., 2011). These views are consistent across populations, from ethnicity, to depression status, to academic area including students in differing areas such as psychology, social work, nursing, or medicine (Ting, 2011). In addition, willingness to seek help tends to be more influenced by anticipated benefits than consequences (Schomerus et al., 2009a).

Stigma plays a significant role in determining a willingness to seek treatment. For example, a qualitative analysis of an online depression support forum found that stigma was a common obstacle to treatment that participants dealt with on a daily basis (Barney et al., 2011). People will withhold information about their depression in general practice settings because of their fears of negative, stigmatized responses, whether based on past experiences or anticipated responses (Barney et al., 2011). Stigma is a strong contributor to withholding information, whether with friends, employers, or even health professionals (Barney et al., 2011).

## Stigma Impacts on Help-Seeking

The impacts of stigma on help-seeking behaviors and intentions are multidimensional and complex. Different types of stigma influence different intentions and interpretations depending on individual factors listed from the Self-Regulation Model of Illness Behavior. This thesis will examine different types of stigma and how perceptions of identity, such as race and gender, impact depression conceptions.

Two forms of stigma, perceived and self-stigma are particularly influential in help-seeking intentions (Barney et al., 2006). Perceived or public stigma describes how a person will believe that others hold stigmatizing views, particularly against them (Barney et al., 2006; Yap et al., 2011). Self-stigma is a self-deprecating response that describes when people feel and think badly of themselves because of internalized stigma from society (Barney, et al. 2006; Yap et al., 2011). It is important to note that both forms originate in the person affected by stigmatization.

Additional types of stigma include personal discrimination and social distance. Personal discrimination is the views an individual holds of others with mental illnesses, whereas social distance refers to an individual's desire to not associate with stigmatized individuals, and dangerousness is an individual's belief that stigmatized individuals are dangerous (Yap et al., 2011).

Fear of disclosing in a work environment was of particular concern for fear of discrimination and even the possibility of losing their job, which appeared to be the case for one participant who stated, "I believe I was fired from my last job because of it" (Barney et al., 2011, p. 6). Health professionals were also described as sending negative messages, which indicated a subsequent lack of trust in sources of treatment (Barney et al., 2011, p. 7). In a qualitative study, one participant told researchers,

"The problem is now they won't offer me any help at all. If I turn up to the hospital they are

abusive and threatening and refuse to assess me. If I go anywhere else they say they can't see me because I don't live in their area... all I want is some help. ...I'm worried, I'm scared. And I don't know where to go for help. My family and psychiatrist are as stumped as I am" (Barney et al., 2011, p. 5).

Self-stigmatizing was also very common. One participant stated, "I wish I could stop being so hard on myself, but I blame myself for being this way and no matter what I do or say, that feeling won't stop" (Barney et al., 2011, p. 7). Studies have shown that in college student populations, attributing symptom causes to biological factors has led to increased help seeking intentions while attributing symptoms to personal weakness and responsibility is related to a decreased willingness to seek help (Han et al., 2006).

Research inquiring as to which type of stigma, perceived/public stigma or self-stigma, has more impact on help seeking behaviors for depression have shown consistent results that the answer is both, but in different ways (Barney et al., 2006). Self-stigma has consistently been cited as especially important for help seeking intentions because of the related reluctance to admit that there is a problem, or the utilization of a secrecy coping strategy (Barney et al., 2006; Schomerus et al., 2009b). Perceiving a mental illness as a weakness as opposed to a sickness, a form of personal stigma and possibly related to self-stigma, was correlated with less intention to seek help from professional sources (Yap et al., 2011). This relationship was especially prevalent for any type of service outside the immediate family and friends (Yap et al., 2011).

Perceived stigma is more widely debated. Some studies have found a correlation with a reluctance to divulge the problem especially to medical professionals, regardless of specialty, because of a fear of being judged as unstable (Barney et al., 2006). Other studies have not found a relationship between the two when measuring for perceived stigma among the population, arguably because perceived stigma is easily coped with through secrecy (Schomerus et al.,

2009b; Schomerus et al., 2009a). However, other studies have found a relationship for both health practitioners and those in the general population (Barney et al., 2006). Perceived parent stigma has no effect on help-seeking intentions (Yap et al., 2011).

Desire for social distance from individuals who seek mental health and a general negative attitude towards mental health care services is a risk factor for poor outcomes if a mental disorder develops (Schomerus et al., 2009b; Yap et al., 2011). Social distance reduced intentions to seek any form of help and also did not believe informal sources of help such as a web site or friend (Yap et al., 2011). These findings are consistent with previous studies that found college students with higher self-stigma attitudes were less likely to seek help compared to those concerned with anticipated discrimination from others (Schomerus et al., 2009b). A European stigma survey found that those who are comfortable interacting with someone who has a mental illness have lower levels of self-stigma, lower levels of perceived discrimination, and greater self-efficacy (Evans-Lacko et al., 2011). This was consistent across 14 countries and. People who are familiar with the symptoms of depression and have contact with people who are depressed are less likely to feel the need to distance themselves socially (Chang, 2008).

Personal stigma can hinder a person's mental health literacy. Past research has shown that it is common for people to not know the symptoms of depression and are more likely to think that the symptoms point to having a life crisis as opposed to a mental illness (Chang, 2008). Depression is also regarded as more manageable than any physical illnesses, especially in terms of self-responsibility (Chang, 2008). A common perception of depression is that it will go away eventually and the individual experiencing the symptoms can take care of them (Chang, 2008). The less a person believes a depressed person is responsible for their symptoms, the more sympathy they are likely to feel towards that person (Chang, 2008).

While these forms of stigma appear across groups, research shows that gender plays a role in how and when they are experienced. There are noteworthy gender differences in how men and women perceive depression, treatment, and help seeking behavior (Elwy et al., 2011). Men are consistently less likely to seek help by a wide margin and are more likely to have self-stigmatizing views and blame themselves for their symptoms (Barney et al., 2011; Schomerus et al., 2009b; Rickwood, 2007). In general, men use counseling services at lower rates than women (Klein et al., 2011). Possible explanations for this disparity include emotional competence, lack of adaption for men's depressive symptoms, and media portrayals.

Rates of recognizing the symptoms of depression vary by gender with women being more likely to recognize depression (Lawlor et al., 2008). This variance disappears, however, when the symptoms are that of psychosis, which involve symptoms indicating a loss of touch with reality such as delusions or hallucinations, instead of depression (Lawlor et al., 2008). Recognizing the symptoms of depression and communicating about them require emotional competence (EC), which is something that is less developed in young men (Rickwood, 2007; Michael et al., 2006). From childhood boys are taught to not show emotion, with the exception of anger, and this may predispose them to be less able or willing to disclose any feelings if they are experiencing them (Michael et al., 2006). EC is defined as "the ability to perceive emotions, and the ability to manage self-relevant emotions and to manage others' emotions in a socially acceptable way (Ciarrochi & Deane, 2001). Evidence also exists that EC is related to self-efficacy measures of hopelessness in that people with low self-efficacy will tend to also have poor EC (Ciarrochi & Deane, 2001). An Australian survey examining the relationship between EC and help-seeking willingness found that individuals with high EC were more willing to seek help from both professional and nonprofessional sources (Ciarrochi & Deane, 2001). This relationship most

likely exists because those with high EC tend to have more social support, will have had good health care experiences in the past, and thus have more positive expectations of treatment and more likely to return (Ciarrochi & Deane, 2001; Rickwood, 2007; Warren et al., 2010).

Emotional communication competence is of increased importance because of findings that show individuals who ineffectively manage their emotions and lack communication skills to express them without defensiveness are conversely associated with a decreased likelihood of seeking help (Rickwood, 2007).

Male college students have been shown to have concerns about their alcohol and substance use, but would not seek help because of judgment from their peers (Michael et al., 2006). Therefore, when men go to general practitioners, they may discuss alcohol use or physical problems but will not describe emotional issues. Doctors may be trained to only look for traditional symptoms such as loss of motivation or depressed mood and thus may overlook the possibility that their patient has depressive symptoms (Michael et al., 2006). Peers, especially intimate partners, have been found to be an important aspect of their help seeking process for this reason (Rickwood, 2007). They will push to discuss the symptoms which aids in identifying depressive symptoms.

These differences can be traced back to media portrayal, as there are differences in the way mental illness is portrayed according to gender. In the media, it is common for men's depression symptoms to be sudden and dramatic, whereas for women they were subtle and escalating (Johansson et al., 2009). The causes for men were also usually outside forces in the environment, while causes for women were psychological and internal (Johansson et al., 2009). Medical research concerning depression in women usually focuses on the biological, i.e. hormonal, aspect of the illness (Johansson et al., 2009). There is also evidence that women will

use the biological approach to manage their stigma (Johansson et al., 2009). Most medical research studying depression in women will use a biological framework to explain the gender differences, especially in instances of postpartum depression (Johansson et al., 2009). Most notably, advertising of antidepressants frame depression as a female illness, presenting women as biologically depressive (Klin & Lemish, 2008). These biases have even been found in medical journals (Klin & Lemish, 2008).

It becomes clear that help seeking intentions vary greatly on both the first and second stage of the Self-Regulation Model of Illness Behavior, depending on whether the individual is male or female. Symptom recognition is complicated because depressive symptoms manifest themselves differently in men and women, and the meanings given to those symptoms vary significantly because men and women are affected differently by depression stigma. Gender is therefore a necessary component to consider when discussing depression. This brings up an additional issue: If gender impacts help seeking behaviors so strongly, then can race?

Despite the low amount of literature on the mental health help seeking behaviors among minorities, the research that does exist indicates that race is a significant factor in help-seeking rates (Rickwood, 2007). Asian Americans hold perceptions of mental illness that are more stigmatized than European Americans (Chang, 2008). Only 3.5% Chinese Americans seek help and Japanese American students are more likely to equate their symptoms with “weak-mindedness” (Han et al., 2006). African Americans and European Americans have the same rate of mental illness, yet African Americans are far less likely to seek help for their illness (Kranke et al., 2012). African American adolescents in particular are less likely than white youth to acknowledge that they need mental health help, and if they do acknowledge it are less likely to trust the health system (Lindsey et al., 2006). They are more likely to seek help from religious

services, family, or from themselves because they do not feel represented or adequately helped and feel that medical professionals are not competent (Kranke et al., 2012). This is problematic because these sources of help tend to be uniformed or misinformed about mental illness (Kranke et al., 2012).

Factors that impact stigma negatively among African American youth include peers, family, culture, autonomy, media, and perceived stigma (Kranke et al., 2012; Lindsey et al., 2006). A very common attitude is that medication is for “crazy people” and not beneficial (Kranke et al., 2012). Culturally grounded psychoeducation models for African Americans are very rare (Kranke et al., 2012).

Explaining the huge difference in help-seeking behaviors and attitudes can begin using the identity-based motivation model. According to the model, behavior is determined by identity and behaviors impact inclusion or exclusion of identity groups that one identifies with (Oyserman et al., 2007). Health behaviors, then, are not just personal choices made for the benefit of one’s well-being, but are socially purposeful habits (Oyserman et al., 2007). The socially constructed characteristics that define membership to social groups create a sense of belonging, particularly who belongs and who does not (Oyserman et al., 2007). Looking through an identity-based motivation perspective, American citizens who are not white are simultaneously expected to assimilate to white norms while at the same time are forever ‘othered’ as a minority (Oyserman et al., 2007). These factors influence health promotion efforts in various ways. Consistently research has shown that health promotion behaviors are perceived as “white” behaviors, while unhealthy behaviors are more relevant to the in-group identity of non-whites (Oyserman et al., 2007). Research has shown that when group stereotypes are activated even those who are not members of the stereotype will act in stereotype-consistent

manners (Oyserman et al., 2007). For American minorities, if behaviors are more consistent with acting white than with their in-group norms, then they are more likely to not participate in those behaviors (Oyserman et al., 2007).

## Structural Barriers for African Americans

Numerous structural problems reinforce the concept of seeking mental health help as a ‘white’ behavior. The DSM-IV-TR does not cover subtle symptoms of depression that are unique to African Americans and the diagnosis is commonly missed among health professionals (Lindsey et al., 2006). Primary health providers have shown tendencies to under diagnose, not provide enough information, racially bias symptoms and health decisions, and be less likely to listen to patient input when the patient is an American minority (Klein et al., 2011; Warren et al., 2010).

Understandably, then, African Americans with depression perceive less available opportunities to obtain help (Lindsey et al., 2006). African American women feel discriminated against in their health care and thus participate less in services (Warren et al., 2010). Qualitative data show that there is common perception among African American women that they are given “secondhand” healthcare, and are not given all of the needed information (Warren et al., 2010).

Even when help is available, barriers exist for minorities. Trust in traditional health care settings increases when the doctor is also African American (Warren et al., 2010). Cuing inclusion of in-group definitions with health messages is therefore necessary in order to promote health behaviors among all Americans (Oyserman et al., 2007). Warren et al.’s (2010) model of health information seeking in disadvantaged groups involves barriers to health care, group-based identities, and perception of control. Stigma impacts all three of those areas. Despite ethnicity not being a predictor of depressive symptoms, it was found to increase the risk of no detection in primary care, where African Americans have lower levels of detection (Klein et al., 2011).

Both race and gender significantly impact help seeking behavior on both individual and structural levels, from detection in primary care, to EC, to perceived discrimination. These

factors are under discussed if they are discussed at all in mental health conversations. The harmful effects are evident in the stark contrast of lower help seeking rates for men and African Americans compared to women and White non-Hispanic individuals (Barney et al., 2011; Schomerus et al., 2009b; Rickwood, 2007; Klein et al., 2011; Kranke et al., 2012; Lindsey et al., 2006).

One of the next steps to SCM is to isolate and test each strategy to determine the effectiveness of each specifically for depression stigma. Several studies have tested related and similar concepts mentioned in the theory, but none have modeled studies off of Meisenbach's communication strategies. This needs to be done in the future, but the related research that does exist will be discussed.

The third sector of SCM involves acceptance of the stigma applicability to the self, but challenges the public perception of the stigma. One way to do this is through reducing the offensiveness of the stigma, which can be accomplished through transcending the stigma. Boardman and colleagues (2011) explored the use of resilience as a tool to combat mental illness stigma through transcendence. The study hypothesized that using a stigma coping strategy of accepting the stigmas applicability to the self and rejecting the perceived public stigma, that symptomatic individuals would feel empowered and transcend self-stigma (Boardman et al., 2011). The study found that symptomatic individuals often held conflicting views about the responsibility of the illness, where they would evade responsibility for the onset of symptoms (The other SCM strategy in the third sector) but would take full responsibility for the recovery and maintenance of symptoms. Instead of evading responsibility for recovering, they took ownership of it and used it as a tool to show that they are just as strong as other asymptomatic individuals. Boardman and colleagues termed this strategy as 'resilience' but it is the same

strategy of 'transcendence' in SMC.

Forty-five percent of the participants in the study answered that they felt it was important to take responsibility, specifically in motivation and willingness, for their recovery, but research suggests that this attitude does more harm than good (Boardman et al., 2011). The study found that those who used transcendence and took responsibility for their recovery felt stronger levels of stigmatization from others and thus demonstrated lower rates of help-seeking intentions. Those who did not use transcendence with recovery were more likely to seek help and perceived lower levels of stigma. While self-empowerment has the potential to be a helpful tool to recovering from depression, it may only get in the way of improvement and in some cases even hinder it (Boardman et al., 2011). For some participants of the study, the impact of personal responsibility hindered the individual's ability to admit their symptoms and open up to judgment and help (Boardman et al., 2011). Those who give up their responsibility for recovery are less likely to perceive stigma (Boardman et al., 2011). The problem, Boardman and colleagues (2011) state, is that "notions of resilience and 'being strong' ... are static concepts ... with inner strength conceptualized as a pre-existing resource there to be drawn on in times of need with no sense of change or evolution" (p. 274). Sufferers of depression who believe that only they are responsible for their recovery use up a large amount of energy and effort that is really only playing into and perpetuating the stigma that depression is the individuals own fault (Boardman et al., 2011). Boardman and colleagues (2011) therefore suggest different levels or steps to stigma responses, where at one end strategies of resilience are enacted whereas at the other with a breaking point, giving up of responsibility. Transcendence and the notion of being strong and making it on your own is especially relevant to young people who are at a point, especially in college, where they are pursuing autonomy and independence (Rickwood, 2007).

The second sector of SCM involves accepting the public perception of stigma but challenging that stigma's applicability to the self. Avoiding is the key strategy used and one way to do so is to make favorable comparisons. Romer and Bock (2008) studied the use of favorable comparisons through the use of counterstereotypes (CS) and the effectiveness on mental illness stigma. The study used hypothetical narratives that embodied one of two characters: the stereotypical depressed person, and a recovered formerly depressed person (Romer & Bock, 2008). The hypothesis was that if the symptomatic character was contrasted with the asymptomatic recovered character, then stereotypes would become challenged and thus less relevant (Romer & Bock, 2008). The study confirmed that depressed individuals are viewed as more suicidal and violent, and less capable than asymptomatic individuals (Romer & Bock, 2008). In addition, showing treatment information along with a character profile of a treated individual was viewed as less violent, suicidal and more capable, but not to the extent that a person who never experienced depression would be (Romer & Bock, 2008).

While these results are notable, the premise of the study is problematic and unpractical. It utilizes a 'making favorable comparisons' strategy that may not only reinforce negative stereotypes of depressed individuals, but also may legitimate and perpetuate them. This type of strategy communicates that stigmas of mentally ill people are correct. In fact Romer and Bock (2008) state themselves that some stereotypes are born out of statistical truths. It is the goal of this study, they state, "to educate people about the conditions under which stereotypes are invalid" (Romer & Bock, 2008). This strategy is problematic because it creates a reality where there are only two types of depressed individuals: 100% symptomatic (depressed) and 100% now asymptomatic (recovered). The reality of mental illness is that it is not comparable to a viral infection such as the flu, where you either have it or you don't. Mental illness exists on a

continuum and this strategy erases everyone who does not fit into the dichotomy. They argue that the benefits of decreased stigma for the image of a treated individual will outweigh the risks associated with reinforcing negative stereotypes in that more people will want to get treatment (Romer & Bock, 2008). This is not realistic nor is it reflective of the existing literature on why people seek help. Nevertheless, the results show that a communicative approach does yield results.

From this review it can be concluded that stigma strongly impacts help seeking perceptions in complex and circumstantial ways. Countermeasures to combat stigma are vital to improving help seeking rates among college students, especially males and non-whites. Guided by the Stigma Management Communication theory, initiatives now have a groundwork to map and track how stigma is challenged. The remaining question is, how can programs and research effectively use this information to help students cope with stigma? The following section addresses this issue through recommendations for both research and program initiatives.

## RECOMMENDATIONS

A review of recent literature allows for a number of guidelines for future health programs and research regarding depression in college students, stigma, and help-seeking behaviors. The following recommendations can be made for future college-based depression programs. They are discussed in detail below.

1. Programs should be primarily Internet based.
2. Programs should target all students regardless of whether they have depressive symptoms or not.
3. Programs aims should include:
  - a. Emphasis on increasing contact between non-depressed and depressed individuals.
  - b. Promotion of self-efficacy through de-legitimation of personal responsibility in both cause and recovery of depressive symptoms.
  - c. Optional: The remaining coping strategies from SMC that have not been tested for effects.
4. Programs should accomplish these aims through the use of narratives.
  - a. Narratives should be culturally grounded and tailored to at least two dimensions of identity: gender and race.
  - b. Narrative structure should all have the common theme of stigma coping strategies as classified by the SCM model and include a resolution.
5. Programs should use messages that utilize cues that challenge stigma, and exclude cues that support stigma.

### *1. Programs should be primarily Internet based.*

An Internet platform, accessible by smart phones, is beneficial because it is relevant to the college student demographic, allows for personalization and interaction, is low in cost, allows for anonymity, and is efficient for information dissemination (Morgan et al., 2011; Oh et al., 2009). The most prevalent users of the Internet are people 25 years old and younger (Oh et al., 2009; Rickwood, 2007). Despite the low number of Internet interventions currently available for depression in English, those that do exist have been found by evidence-based reviews to be effective in reducing depressive symptoms (Griffiths, 2010). Online health messages additionally have been shown to be effective in improving health behaviors in general (Morgan et al., 2011).

The Internet also is an increasingly prominent source for the dissemination of health information, particularly for the targeted age group (Lawlor et al., 2008). An Australian telephone survey of 2,113 youth aged 18-25 found that 72% rate websites as helpful for mental health interventions, similar to rated helpfulness of self-help books (68%), mental health services (72%), and counseling (93%; Oh et al., 2009). There were no gender differences found in preferences for websites or self-help books, but there was significant difference for in-person services with men less likely to find helpful (Oh et al., 2009). It has been suggested that websites are likely first steps taken by young people who encounter struggles with a mental illness (Oh et al., 2009). It has also been found that depression literacy can be as effective as cognitive behavioral therapy (CBT) in symptom reduction (Christensen et al., 2004). These findings are consistent with results pertaining to symptom improvement in general practice (Christensen et al., 2004). The Internet is useful for self-help information (Rickwood, 2007).

The use of an Internet platform is also beneficial to non-white students. Information campaigns alone are not effective among minorities (Klin & Lemish, 2008). Online services

have been found to be advantageous for information dissemination, confidentiality, counseling, and other treatment services (Klin & Lemish, 2008). The Internet is also a promising medium for reaching populations that are disadvantaged (Warren et al., 2010). Almost a decade ago the number of average Americans that went online for health advice was 6 million—more than those who visit health professionals in person (Warren et al., 2010). When the content was considered to be culturally relevant, African American college students have been found to use the Internet for health information more than whites (Warren et al., 2010). Using Internet for health information has been shown to positively influence the perception of control regarding health (Warren et al., 2010). There is concern that while accessing technology is fairly available, the feeling regarding control of information is not mutual, as there is concern that the dominant culture controls the information (Warren et al., 2010). It is therefore essential to create a sense of control and ownership in the content available online related to health information (Warren et al., 2010). This can be done through narratives.

In an evidence-based review of online mental health programs, six out of the eight specific to depression were effective at reducing symptoms (Griffiths, 2010). One of these programs is the *beyondblue* campaign, an Australian funded non-profit organization dedicated to the improvement of public perceptions of depression through awareness, support, and destigmatization (Jorm et al., 2006). The program has been found to result in higher mental health literacy, more help-seeking intentions, and higher awareness of discrimination (Oh et al., 2009; Jorm et al., 2006). Increased exposure has resulted in twice the effectiveness as baseline exposure levels (Jorm et al., 2006). Due to the recent nature of online-based mental health interventions, conclusions regarding what factors make a program effective or ineffective are not available (Griffiths, 2010).

*2. Programs should target all students regardless of depressive status.*

Targeting both symptomatic and asymptomatic students in programs that involve stigma reduction is shown to be more effective than focusing on a single demographic because it will increase the likelihood that at risk asymptomatic people are more likely to seek help should they develop symptoms (Schomerus et al., 2009a) In addition, desire for social distance will reduce, and perceived public stigma will ultimately decrease, both of which are strong contributors to self-stigma (Schomerus et al., 2009a). A German 2009 population study using the Theory of Planned Behavior (TPB) pinpointed several aspects that influence willingness to seek help. TPB assumes that behavior is guided by intention, which is informed by behavioral beliefs (perceived consequences), normative beliefs (perceived expectations of others), and control beliefs (factors that affect the execution of the behavior; Schomerus et al., 2009a). The study concluded that having symptoms of depression or not having them does not impact an individual's attitude towards help-seeking behaviors (Schomerus et al., 2009a). The study employed hypothetical situations with customized intentions, attitudes, and expectations, because specificity has been found to be more persuasive than generalization (Schomerus et al., 2009a).

*3a. Programs should emphasize increasing contact between non-depressed and depressed individuals.*

Scholars have observed that interventions effective in reducing stigma focus on the promotion of increased social contact between stigmatized and non-stigmatized individuals (Evans-Lacko et al., 2011; Klin & Lemish, 2008). Contact, whether in person or over recording, is correlated with increased identification with the depressed individual (Chang, 2008). Schomerus and colleagues (2009b) state, “Personal treatment or knowing someone being treated may enhance knowledge and reduce negative stereotypes about psychiatric care” (p. 304).

One example of this involves a 2003 adolescent anti-stigma campaign for schizophrenia and was found to be successful in decreasing social distance and decreasing negative stereotypes (Schulze et al., 2003). The program was a week-long project implemented in secondary schools that brought in a person with schizophrenia of their age group to engage in discussions with the class in order to highlight that there are more similarities between people with schizophrenia and the rest of the population (Schulze et al., 2003). These discussions included topics such as illness information, treatments, and experiences of stigma (Schulze et al., 2003). The study found significant reduction in stigmatized attitudes and desire for social distance among students in the project group compared to the control group (Schulze et al., 2003).

*3b. Programs should promote self-efficacy through de-legitimation of personal responsibility in both cause and recovery of depressive symptoms.*

The focus should not be on a push towards a certain type of treatment, whether it be self-help or clinical measures, rather the focus should be on decreasing the notion that depression is an individual's personal responsibility both in cause and treatment. The aim should be to free someone of their shame and stigma so that they are able to pursue and explore different types of treatment. Personal responsibility is a type of stigma that functions to victim-blame so that the affected group is stripped of empathy and dehumanized (Smith, 2007a). Studies have consistently shown that high levels of personal responsibility decrease help-seeking intentions in symptomatic individuals and decrease sympathy towards them (Rickwood, 2007; Chang, 2008). It hinders the ability to admit symptoms and in the end only plays into the stigma it attempts to transcend (Boardman et al., 2011). Admitting symptoms to both the self and others is a skill that is less developed in young men, thus making personal responsibility an especially poignant topic for efforts relevant to that demographic (Rickwood, 2007; Michael et al., 2006). Meisenbach (2010) classifies this type of stigma coping strategy as evading responsibility.

Studies have shown that in college student populations, attributing symptom causes to biological factors has led to increased help seeking intentions while attributing symptoms to personal weakness and responsibility is related to a decreased willingness to seek help (Han et al., 2006). Depression is also regarded as more manageable than any physical illnesses, especially in terms of self-responsibility (Chang, 2008). A common perception of depression is that it will go away eventually and the individual experiencing the symptoms can take care of them (Chang, 2008). The concept of personal responsibility is especially relevant to college students who are at a point in their lives where they are actively pursuing autonomy and

independence (Rickwood, 2007).

As Boardman and colleagues (2011) have demonstrated, it is important to extend this relinquishment of responsibility past the cause of depression to the treatment of depression as well. Resilience is a common coping strategy for depression stigma as an effort to prove normalcy with non-depressed individuals, but not an effective one for actual recovery and help seeking behaviors (Boardman et al., 2011). Individuals can hold beliefs that don't hold the depressed person accountable for causing their symptoms, but can still blame them for how they deal with it (Boardman et al., 2011).

Self-help is rarely used or discussed in mental health, but they argue it is not only a practical alternative, but also an effectively preventative one (Morgan et al., 2011). Morgan and colleagues (2011) are currently gathering data to study the effectiveness of a self-help behavior based e-mail prevention program aimed towards individuals with minor depression. They argue that self-help is ideal for minor depression because health systems are preoccupied with severe cases, and even many of those do not receive treatment (Morgan et al., 2011). There are both beneficial and harmful self-help behaviors. Harmful and ineffective behavior can include drug and alcohol use or abuse (Morgan et al., 2011). Beneficial strategies include regular exercise, regulating and getting more sleep, and doing fulfilling activities (Morgan et al., 2011).

Individuals who score in the range of major depression are not able to participate in the program and are directed to a web site that assists in locating the nearest professional health care facility due to the increased risk of complications (Morgan et al., 2011). The program sends participants two e-mails per week for six weeks with behavior modification messages informed by health researchers, theories of health communication, online communication, behavior change, and persuasion (Morgan et al., 2011). The control group receives passive information based

messages about depression and both groups are assessed three times for various measurements of depressive symptoms and others (Morgan et al., 2011).

Another possible tool to utilize evading responsibility could be biological education. A Taiwanese survey confirmed previous research that found biological education was positively correlated with help-seeking intentions, but destigmatization education was not (Han et al., 2006). Destigmatization education included researched and evidence-supported statements delegitimizing stigmatized beliefs concerning depression such as, depressed people are just as smart as non-depressed people, etc. (Han et al., 2006). Biological education provided information regarding the physiological processes of depression, heritability statistics, and other biological factors (Han et al., 2006). Possible explanations for these findings were that it was possible biological information is perceived as more empirical and less questionable, whereas the psychological information could have been perceived to be less concrete (Han et al., 2006). In Asia, specifically Taiwan, mental health services are not sought after as frequently because of stigma, and help-seeking behavior most often only occurs when physical symptoms appear (Han et al., 2006). Framing psychological pain as biological, and thus physical and consequently legitimate in nature, may be an avenue available to explore in combatting stigma in Asian-American student populations (Han et al., 2006).

*4. Programs should accomplish these aims through the use of narratives.*

Narratives are messages organized in a chronological order that communicates the relationship between the events that are occurring (Chang, 2008). They cause consumers to comprehend information on a complex level by integrating it with their previous conceptions and cognitively construct new understandings (Chang, 2008). Humans learn to acknowledge and comprehend narratives when they are young and they utilize this skill for the rest of their lives (Kopfman et al., 1998). Narratives are efficient at communicating large amounts of information, memorable, and helpful in aiding causation (Kopfman et al., 1998).

While there are many strategies that can be used including fear and guilt messages, specific attention has been paid to the issue of which is more effective, narratives or statistics (Kopfman et al., 1998; Feely et al., 2006). These topics have been studied with varying results however the general consensus is that narratives produce more affective reactions that are more positive and higher causal relevance (Feely et al., 2006). Narratives are rated as more realistic, but compared to statistical information are easier to dissociate from (Greene & Brinn, 2003). Narrative messages combined with statistical evidence have been observed to be more effective than either by itself (Allen et al., 2000). Narrative inquiry provides health messages with experience, relevance, and cultural validity by accounting for the relevance into the practice and norms of the population being interviewed (Hopfer & Clippard, 2011). Compared to statistical information, which is defined as “the use of quantitative information to support a conclusion” (Allen et al., 2000) narratives increase self-efficacy especially if the consumer relates to the protagonist of the story (Kopfman et al., 1998). Research has shown that communicating depression symptomology can be done more effectively with narratives as opposed to more informational approaches (Chang, 2008).

Chang's (2008) study found that those who had exposure to narrative advertising as opposed to argument advertising were more likely to feel sympathy towards people with depressive symptoms. Narrative theory is the process by which a self-identity is developed through expressing, interpreting, and interacting with experience (Larkey & Hecht, 2010).

Building on the communication theory of identity, social constructivism, and psychological development of identity, the narrative process is one in which identities and sense of self are brought to life for others and enacted by the storyteller through social interaction (Larkey & Hecht, 2010). With regards to the medium, "personally delivered narratives largely have been replaced by media-generated narratives, some with real-time interaction, others posted online for others to view and comment upon. Paying attention to the source of the message so that it is a culturally familiar delivery mode becoming important in the planning of narrative health promotion campaigns" (Larkey & Hecht, 2010). It is also possible that narrative effects are more dependent on the characteristics than the mode of transport (Larkey & Hecht, 2010). Narrative programming is characterized by identification, perceived similarity, and parasocial interaction (PSI; Moyer-Gusé & Nabi, 2010). Identification describes the process of viewing the situation through the perspective of the protagonist (Moyer-Gusé & Nabi, 2010). Perceived similarity is similar to identification but consumer maintains their personal awareness and they compare how they relate to the protagonist (Moyer-Gusé & Nabi, 2010). PSI describes the bond that forms between the person and the protagonist based on social attraction and perceived similarities (Moyer-Gusé & Nabi, 2010). Narrative interviews should encourage someone to tell a story, not engage in a discourse (Larkey & Hecht, 2010).

Mediators are the means by which a narrative influences a person, whether by transportation, identification, or social proliferation (Larkey & Hecht, 2010). Transportation

(also called engagement or absorption) refers to the instance of living in the moment of the story removed from the present reality and identifying with the characters (Larkey & Hecht, 2010). Social proliferation (a.k.a. contagion or spillover effects) occurs after transportation and involves sharing the narrative or the intended message with others (Larkey & Hecht, 2010). Viral messages, internet messages sent across users, are an excellent example of social proliferation (Larkey & Hecht, 2010). Web sites such as *Tumblr* and *You Tube* allow users to expand upon, share, support, or dispute original messages to an infinite number of users. The outcomes, therefore, are to perceive certain social norms, feel intent to change, and thus change the behavior (Larkey & Hecht, 2010).

Hopfer and Clippard (2011) describe a valuable methodology to guide future programs that involve narratives. The study used a narrative based interview to study trends in women's perceptions of HPV vaccinations (Hopfer & Clippard, 2011). Among the goals of the study was to uncover the cultural and social framework employed by college aged women in their decision of whether to get the HPV vaccination or not (Hopfer & Clippard, 2011). The study interviewed 36 students that used a scripted list of questions, but was kept open to allow for participants to discuss issues that they felt were most important (Hopfer & Clippard, 2011). The base questions varied depending on the women had the HPV vaccine or not (Hopfer & Clippard, 2011). A sample question for someone who had been vaccinated was, "Let's talk a little bit about your decision to get the HPV vaccine. Will you tell me about how that came about?" (Hopfer & Clippard, 2011). The coding process involved categorizing recurrent sections through tagging, or gathering recurrent segments, the transcriptions and categorizing them (Hopfer & Clippard, 2011). Themes were determined by the most common and agreed upon statements (Hopfer & Clippard, 2011).

*4a. Narratives should be culturally grounded and tailored to two dimensions of identity:  
gender and race.*

Messages are never culture-neutral (Larkey & Hecht, 2010). Applying narrative theory to health interventions has shown promising results for accomplishing desired effects, but applying culturally grounded narratives has been especially promising for various groups (Larkey & Hecht, 2010). Programs including efforts involved in cancer prevention, HIV prevention, and school-based drug interventions have been effective among various cultures (Larkey & Hecht, 2010).

The culturally grounded narrative model begins with cultures narratives and builds a curriculum from those stories, rather than adapting them to a current curriculum (Larkey & Hecht, 2010). The intent is to give a voice to the people who are excluded in ‘culturally neutral’ efforts and give them a voice (Larkey & Hecht, 2010). Narratives are especially effective and efficient because they act as a platform for a group to make their experiences meaningful from the members of that group (Larkey & Hecht, 2010). Identity is complex and multi-dimensional with aspects that intersect and overlap, but targeting one aspect of identity, particularly if that aspect is important to an individual, should be influential (Larkey & Hecht, 2010).

Larkey and Hecht’s (2010) culturally grounded narrative model as applied to strategic health messages views narrative as a dual-level communicative tool that articulates narrative characteristics, mediators, and outcomes/responses on a personal and sociocultural level. Narrative characteristics on a personal level involve engaging characters and story through various characteristics such as being realistic, relatable, and dramatic (Larkey & Hecht, 2010). Personal narrative characteristics are dependent on sociocultural factors, therefore it is important for the narrative to be culturally embedded through familiar characters, culturally relevant

events, and culturally resonant language (Larkey & Hecht, 2010). These are important for establishing identification, belonging, and importance in the story (Larkey & Hecht, 2010).

Culture must be included according to narrative theory. Culture is a broad and complex concept that intersects with many other areas of identity including gender, age, region, religion, class, or ethnicity (Larkey & Hecht, 2010). An example of a culturally grounded program that uses narratives is the *keepin' it R.E.A.L.* program, a culturally grounded substance use prevention program among middle school students (Hecht et al., 2003). It has been proven to be effective in reducing substance use (Hecht et al., 2003). The program incorporates Mexican American, multicultural, and European American/Black American versions of the curriculum with Mexican American and Multicultural being the most effective for the designated population (Hecht et al., 2003). Research from the study has found that including relevant information that adequately represents a culture is enough for it to be effective, compared to segregating ethnic groups into tailored curriculums (Hecht et al., 2003).

Another study examining reasons for seeking help is a valuable addition to Hopfer and Clippards methodology that incorporates culturally grounded analysis. The study explored help-seeking intentions of African American male adolescents employed a similar methodology of interviewing participants who were in treatment and not in treatment about their decisions to seek help (Lindsey et al., 2006). They were asked initial questions followed by probing questions that depended on the participant's responses (Lindsey et al., 2006). A replication of the sample questions used is in table #. The purpose of the study was to gain insight into the processes that influence mental health attitudes and what those processes are dependent on (Lindsey et al., 2006). The study found common patterns in the responses from how problems were experienced, to how they were dealt with (Lindsey et al., 2006). Of particular significance to this analysis is

the findings regarding stigma, sense of self, and the feeling of responsibility towards mental health (Lindsey et al., 2006). On participant who was attending treatment states,

“Because their friends might sometimes think like they’re crazy and stuff like that. Wouldn’t want to hang around them. And they’ll just sit there and make up more excuses to stay away from them. It [mental health treatment] would draw all that person’s friends away from him too. Then that person would just be, like, down in the dumps” (Lindsey et al. 2006, p. 54).

Another responded, “I guess a lot of them would think, well I don’t need it. I’m this. I’m from here. I can do this. I can do that. So they would...they have a certain feeling where they think they could get through it alone when they really couldn’t” (Lindsey et al. 2006, p. 54). One participant who was not in treatment stated, “(Referring to pride) Like I’m not, you know, I’m too good to go to a counselor. Like I don’t think I’m very sick or I don’t think nothing’s wrong with me. I act normal. I’m normal. You know, different things like that. False sense of themselves” (Lindsey et al. 2006, p. 54).

A particular poignant response regarding seeking help,

“[It] means that you’re gay. That’s what it means. That’s how they [African American adolescent boys] interpret it. It means—well I mean you go down the line. If you ask for help, or if you cry, or if you look emotional, if you feel depressed, that means you’re soft. If you’re soft, then you’re gay and you’re not hard and not tough.... You can’t let anybody know that you’re soft. I swear it’s like being in jail” (Lindsey et al. 2006, p. 54).

Other responses varied from discussing difficulty in trusting white doctors to family members beliefs, to talking to friends (Lindsey et al., 2006). Any future programs or research concerning help seeking behaviors and stigma therefore need to include culture specific cues in narrative eliciting. Cuing inclusion of in-group definitions with health messages is therefore necessary in order to promote health behaviors among all Americans (Oyserman et al., 2007).

Lindsey et al.'s (2006) study yielded valuable results, however many questions were left unasked and many factors were not included in the responses. This study is an excellent first step towards culturally-relevant anti-stigma initiatives in mental health, but it needs to be taken further. Individuals who identify with underrepresented groups need to share how they feel about getting help, and how they cope with the unique stigma's they face every day. This can be done when SMC is applied to narrative theory.

*4b. Narrative structure should have the common theme of stigma coping strategies as classified by the SMC model and include resolutions in order to increase efficacy.*

Eliciting questions should be constructed to include all of the possible coping strategies as categorized by the Stigma Management Communication model. They should fit into one of the possible strategies, accepting, avoiding, evading responsibility, denying, reducing offensiveness, and ignoring (Meisenbach, 2010). Standardizing coping strategies will not only allow for reliable research to be compared but will also serve as a type of Emotional Competence skill. Table 3 includes sample questions modeled after Hopfer and Clippard's (2011) and Lindsey et al.'s (2006) qualitative studies and are modified to generate responses according to SMC. Questions for eliciting narratives do not need to be culturally relevant, but culture should be a criterion to use while coding the responses.

For example, Boardman and colleagues (2011) study has already contributed to SMC research by finding that evading responsibility is more effective in increasing help-seeking intention, whereas transcendence is not more effective and even harmful. Meisenbach (2010) categorizes evading responsibility as shifting agency away from the self. Transcendence refers to how an individual calling attention to how the attribute of the stigma can become something commendable or valuable (Meisenbach, 2010).

Suggestions to overcome stigma in disclosure are online information based and involve instructions for successful selective disclosure, dealing with reservations, dealing with negative responses, how to interact with health professionals, and how to overcome guilt and shame (Barney et al., 2011).

*5. Programs should use messages that utilize cues that challenge stigma, and exclude cues that support stigma.*

As covered previously, challenge cues serve to contest stigma conceptions while stigma messages promote a stigma concept (Smith 2007b). Stigma and challenge messages never appear together, therefore programs that include an anti-stigma component must make sure that none of the messages include cues typically involved in stigma messages. The table illustrating the cues specific to challenge and stigma messages is located in Appendix C.

## FUTURE RESEARCH SUGGESTIONS

There is still much to be learned about stigma communication with regards to depression among college students. Therefore, this report includes the following recommendations for future variables to be studied:

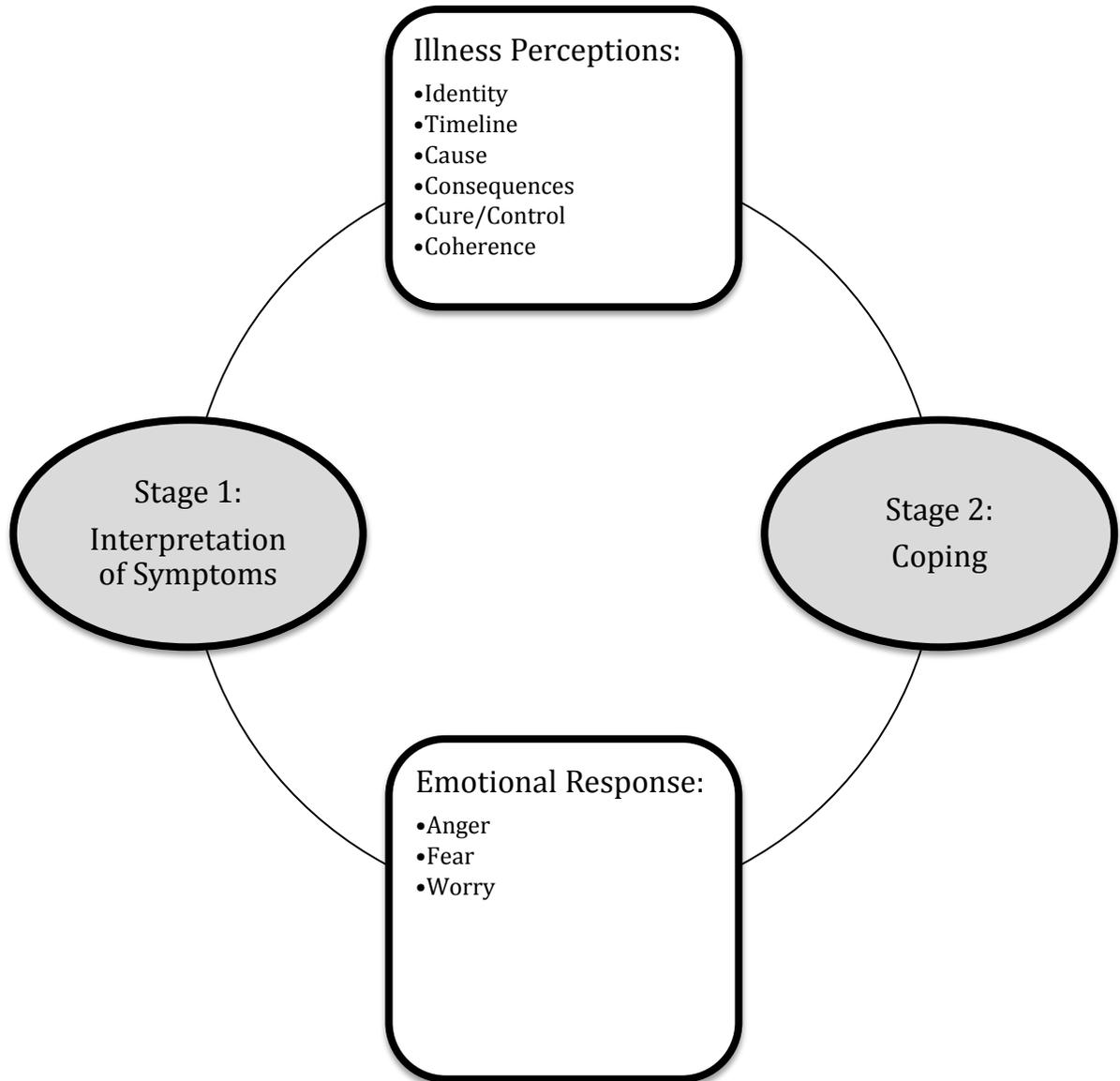
1. The prospect of including celebrity narratives should be explored and tested for effectiveness in stigma reduction. Involvement of celebrities with mental illness have been suggested to be important aspects of an effective intervention program (Klin & Lemish, 2008). The utilization of African American role models are promising sources to include in initiatives because they can serve as respected figures that are proof of rehabilitation, and that the condition is not just for “crazy people” but is in fact normal (Kranke et al., 2012).
2. SCM strategies should be tested for stigma-reduction effectiveness, and other possible related effects.
3. The use of health professional (general practitioner, psychologist, psychiatrist) narratives should be tested for stigma-reduction effectiveness and help-seeking intention effectiveness related to depression.
4. Online formats (e-mail, Website, blog, Facebook groups) should be studied for any variations in message efficiency and effectiveness.
5. Communication skill training for both patients and physicians during primary care visits should be examined especially in practices seeing patients with low socioeconomic status (Kravitz et al., 2011).

## CONCLUSION

This thesis research examined the complexity that is clinical depression, mental-illness stigma, help-seeking behaviors, and the effect that each has on the other. The result is a proposal for future research and a guide for future programs. By adapting culturally grounded narrative theory to encompass Stigma Management Communication, the stories of the individuals that survive stigma can be studied and shared with both depressed and non-depressed individuals. Through online dissemination everyone has an equalized opportunity to view the information in a confidential, personalized, and efficient manner. Researchers can code the stories students share to learn more about coping strategies, and combine them with data to learn which strategies might be more effective. There is still so much that can be done to help students struggling with depression, and an important step is figuring out how they struggle and survive.

## APPENDIX A

Stage 1 and 2 of the Self-Regulation Model of Illness Behavior (Elwy et al. 2011)



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TABLE 1

Cues unique to stigma and challenge messages as observed by Smith (2007b).

Challenge Message Cues		Stigma Message Cues	
1	Speak Directly about the health subject.	1	Depict the person as the health concern.
2	Promote social inclusion with words and pictures.	2	Use diagnosing marks.
3	Use images of optimism.	3	Attribute responsibility for the illness.
4	Use images of hope.	4	Include markers to depict normalized exclusion.
5	Fight a common problem and support each other.	5	Peril associated with the concern.
		6	Elicit feelings of shame and disgust.
		7	Encourage people to avoid and/or isolate those affected by the illness.

TABLE 2

The Stigma Management Communication (SMC) strategies as theorized by Meisenbach (2010).

		Stigma Application to the Self	
		Accepting Self	Challenging Self
Public Understanding of Stigma	Accept Public	1	2
		<ul style="list-style-type: none"> <li>• Accepting                             <ul style="list-style-type: none"> <li>○ Passive Acceptance</li> <li>○ Display/Disclose Stigma</li> <li>○ Apologize</li> <li>○ Use Humor</li> <li>○ Blame for negative outcomes</li> <li>○ Isolate self</li> <li>○ Bond with stigmatized</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Avoiding                             <ul style="list-style-type: none"> <li>○ Hide/deny attribute</li> <li>○ Avoid stigma situations</li> <li>○ Stop stigma behavior</li> <li>○ Make favorable comparisons</li> </ul> </li> </ul>
	Challenge Public	3	4
		<ul style="list-style-type: none"> <li>• Evading Responsibility                             <ul style="list-style-type: none"> <li>○ Provocation</li> <li>○ Defeasibility</li> <li>○ Unintentional</li> </ul> </li> <li>• Reducing offensiveness                             <ul style="list-style-type: none"> <li>○ Bolster/refocus</li> <li>○ Minimize</li> <li>○ Transcend</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Denying                             <ul style="list-style-type: none"> <li>○ Simply</li> <li>○ Logically                                     <ul style="list-style-type: none"> <li>▪ Discredit discreditors</li> <li>▪ Provide evidence</li> <li>▪ Highlight logical fallacies</li> </ul> </li> </ul> </li> <li>• Ignoring</li> </ul>

TABLE 3

Initial	Probe
Let's talk about your decision to seek help. Will you tell me about how that came about?	How did you know that you needed to get help?
	Was there anyone who helped you to recognize or identify the feelings that you were having?
	Whom did you turn to first for help?
Are there other things you tried to do to help you feel better?	How did those other things work?
Are there people that you feel comfortable talking to about getting treatment?	Who, and why?
Are there people that you don't feel comfortable talking to about it?	Why would you say you're not comfortable telling them?
	What happens if counseling or depression gets brought up in conversation with them? What do you do?
	Would you like to talk about it with other people someday? OR Is there anything you would like to be able to talk about in the future?
Do you think about the cause of your depression? Can you tell me about it?	
What about treatment, can you tell me about your motivation for that?	
Have you ever had your depression go away, and then come back (more than one episode)?	YES: What did you think the first time you felt better? What about when the second episode happened? What do you think now?
	NO: How do you think you will feel if it goes away? How do you think you will feel if it never goes away, or if it comes back?
If you could go back in time and speak to yourself before you got help, what would you say?	What might you tell someone who was in a similar situation?

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