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No stigma, no shame: Reducing the stigma of mental illness in college freshmen dorms

Ashley R. Reynolds
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No Stigma, No Shame:
Reducing the Stigma of Mental Illness in College Freshmen Dorms
Ashley Renee Reynolds

A thesis project submitted to the Graduate Faculty of
JAMES MADISON UNIVERSITY
In
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Abstract

With a rise in college students who report symptoms of mental illness and the high number of college students who do not seek professional help because of the stigma of mental illness, it is evident that the stigma of mental illness on college campuses needs to be addressed. A health campaign that seeks to reduce the stigma of mental illness on campus was designed, implemented, evaluated. The Model of Stigma Communication, which explains how stigma is developed and reinforced, is a sound framework for exploring the stigma of mental illness and was used to guide the campaign. First, a survey was administered to learn more about the beliefs, attitudes, and behaviors of the target population. Next, focus groups dug deeper into student’s stereotypes about mental illness. Then messages were created and focus group tested. After formative research was collected and analyzed, the campaign was implemented in a dormitory on campus. An evaluation of the campaign followed, completed by a survey to students who live in the dormitory and those who do not. The evaluation survey showed that although the campaign was not statistically significant, it could have made an impact on student’s attitudes and behaviors about the stigma of mental health. Implications and limitations of the campaign will be discussed, along with recommendations and future directions for future campaigns and research.
CHAPTER 1: INTRODUCTION

Depression and anxiety among college students is growing at a rapid rate, with an increase in eating disorders (+58%), drug abuse (+42%), alcohol abuse (+35%), and suicide attempts (+23%; Kitzrow, 2003; Mowbray, et al., 2006). In the 2016 American College Health Association National College Health Assessment (ACHA, 2016), 20.6% of the college student population reported feeling overwhelming anxiety in the last 12 months and 16.7% felt so depressed that it was difficult to function. According to a national survey of university counseling centers, 94% of university counseling center directors reported an increase in the number of students with severe psychological problems, including bipolar disorder, anxiety, and major depression (Gallagher, 2014). These same university counseling center directors reported an 89% increase in anxiety, 69% increase in crises requiring immediate intention, 58% increase in clinical depression, and 35% increase in self-injury issues among their student population in the last 5 years (Gallagher, 2014).

The effects of depression and anxiety on college students can be detrimental to their college careers and transitions into adulthood. Depression and anxiety negatively impact students’ academic performance (Kessler, Foster, Saunders & Stang, 1995) and work productivity (Wang et al., 2007). Students with depression and anxiety often turn to alcohol or drug use in order to alleviate or diminish the negative feelings associated with their illnesses (Weitzman, 2004). Moving beyond their college careers, researchers have noted that depression during college can lead to aggression, substance abuse, and, for men, increased risk taking. Students also report feelings of hopelessness, lack of interest in hobbies, and persistent sadness and anxiousness (NIMH, 2016). Health communication
practitioners can create interventions, which aim to help reduce stigma and increase understanding of mental illness.

**Depression and Anxiety**

Several factors have been identified that put college students at risk for depression and anxiety. Additional risk factors of depression and anxiety include lower socioeconomic backgrounds (Eisenberg et al., 2007), breaking off relationships, low social support (Blanco et al., 2008), and sexual violence (Stepakoff, 1998). Genetics also plays a role in anxiety and depression, with recurrence and early onset as the most common risk (Levinson, 2006).

Suicide is one of the most pressing consequences for college students with depression and anxiety. The 2014 National Survey on Drug Use and Health (NSDUH) found that suicidal thoughts and behaviors were the highest among those ages 15 to 25 (SAMHSA, 2015). Today, suicide is the second leading cause of death among young adults between the ages of 15 and 24; college students are more likely to die from suicide than alcohol related deaths (CDC, 2015). From 2013 to 2014, the number of youth and young adult suicide deaths rose from 4,878 to 5,079 (CDC, 2015). In a national survey of undergraduate college students, 6.8% of college students had seriously considered suicide and 4.3% had intentionally cut, bruised, burned, or otherwise injured themselves in the last 12 months. In addition, 1.1% of college students reported attempting to take their own life (ACHA, 2016). Gender is also an important risk factor associated with suicide. Male college students are at a higher risk for suicide (Silverman, Meyer, Sloane et al., 1997), while female college students are at higher risk of experiencing major depression and anxiety disorders (Eisenberg, Gollust, Golberstein & Hefner, 2007).
Health Literacy

Given the low rates of health literacy among Americans, it is not surprising that studies have also found low rates of mental health literacy. Approximately 80 million Americans are considered to have limited/low health literacy (Berkman, Sheridan, Donahue, Halpern & Crotty, 2011). Health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (IOM, 2004, p. 2). When individuals have low health literacy, they are unable to find, comprehend, and use information necessary to make informed decisions about their health. Health literacy is of interest to many researchers in various fields, including health communication scholars and practitioners who seek to design interventions to encourage behavior change (Berkman et al., 2011; Parker, Baker, Williams & Nurss, 1995; Baker, 2006).

However, mental health literacy has been largely ignored (Jorm, 2000). Similar to general health literacy, mental health literacy consists of (1) recognizing mental disorders, (2) knowledge about risk factors and causes of mental disorders, (3) knowledge and belief and self-help intervention, (4) attitudes about professional help, (5) attitudes that influence help seeking, and (6) knowledge about how to receive mental health treatment (Jorm, 2000). Through this perspective of understanding, it is important for the public to have higher levels of mental health literacy for individuals with psychological symptoms and their close family and friends to manage their symptoms (Jorm, 2000).

Stigma

Although the number of college students who suffer from depression or anxiety continues to increase, many college students who experience symptoms of depression and
anxiety do not seek treatment (Hunt & Eisenberg, 2010). An estimated 37% to 84% of college students who experience symptoms of depression and anxiety do not seek professional help (Eisenberg, Golberstein, & Gollust, 2007). Hunt and Eisenberg (2010) found that less than a quarter of the students diagnosed with anxiety and/or depression sought treatment and only half of those diagnosed with mood disorders sought treatment. A number of campaigns that focus on awareness and education about depression and anxiety and the reduction in barriers to help seeking behavior have been implemented to increase the number of college students with depression and anxiety who seek help (Wright, McGorry, Harris, Jorm & Pennell, 2006); however, barriers still exist which impact help-seeking behaviors.

There are numerous barriers that prevent these young adults from getting the help they need centering on logistics of care and support. The major barriers include stigma (Corrigan et al., 2016), lack of time, privacy concerns (Givens & Tija, 2002), being unaware of services or insurance coverage, and skepticism about treatment effectiveness (Eisenberg, Golberstein & Gollust, 2007). Understanding how care works is only one part of the problem. There are also several supportive barriers which prevent young adults from seeking treatment, including lack of emotional openness (Komiya, Good & Sherrod, 2000) and lack of a perceived need for help (Eisenberg, Golberstein & Gollust, 2007). Despite efforts made by government agencies, researchers, and university health centers, these barriers continue to keep college students from seeking treatment (Eisenberg, Downs, Golberstein & Zivin, 2009).

The most significant barrier is stigma (Link, Struening, Neese-Todd, Asmussen & Phelan, 2001). Several studies have identified stigma as a barrier to seeking treatment
among college students (Givens & Tija, 2002; Wahl, 2012). Givens and Tija (2002) found that 30% of college students reported stigma associated with using mental health services as a barrier to seeking treatment. Other studies have found a relationship between stigma and lower help-seeking behavior (Eisenberg et al., 2009; Cooper, Corrigan & Watson, 2003; Link et al., 2001). In 1999, the Surgeon General’s Call to Action to Prevent Suicide recognized stigma as a treatment-seeking barrier for suicidal individuals. In addition to preventing individuals from seeking treatment, stigma can impact other areas of their and their families’ lives (Fink & Tasman, 1992), including difficulty finding a job (Rüsch, Angermeyer & Corrigan, 2005) and the internalization of stigma, which leads to feeling less valued (Corrigan, Druss, Perlick, 2014; Corrigan & Watson, 2002).

In 1963, Erving Goffman defined stigma as the dehumanization of individuals, which results in discrimination that hinders people’s quality of life and can ultimately cost them their lives. Goffman (1963) argued, “We use specific stigma terms such as cripple, bastard, moron in our daily discourse as a source of metaphor and imagery, typically without giving thought to the original meaning” (p. 5). Every day, common discourse creates and reinforces stigma. In turn, this stigma negatively influences individuals who are stigmatized. For this thesis, the researcher will be examining both personal and perceived stigma. These types of stigma will be discussed in Chapter 2.

Based on Goffman’s work, Smith (2007) expanded the concept of stigma with the creation of the stigma communication model, which focuses on “the messages spread through communities to teach their members to recognize the disgraced (i.e. recognizing stigma) and to react accordingly” (p. 464). Smith argued that stigma messages distinguish
and categorize individuals who are perceived as different. These stigmatized individuals are placed in a separate group from the normal population (Smith, 2007). Stigma communication offered the first theoretical framework for how communication creates and reinforces stigma (Smith, 2014).

Stigma communications consist of four possible messages choices: mark, group labeling, responsibility, and peril. Each message choice encourages the stigma attitudes and ultimately reinforces behavior. The behavior reactions lead to the second component of stigma: message reactions. Messages reactions include cognitive reactions, access relevant attitudes stereotypes, emotional reactions, fear, anger, and disgust. The final component of the stigma communication model is the message effect. If a message has a persuasive effect, then the stigma is formed or reinforced (Smith, 2007).

The components of the stigma communication model have been used to study various health conditions, such as a hypothetical infectious disease alert (Smith, 2012) and a hypothetical infectious person (Smith, 2014), but depression and anxiety has been vastly under researched with this model. The lack of application of depression and anxiety to stigma communication is a gap of knowledge that needs to be filled. This thesis will work through the application of the model of stigma communication to mental health, as well as guide the creation of campaign messages.

**Health Campaigns**

Health campaigns are organized communication activities and messages that attempt to educate or change individuals’ behaviors (Rice & Atkin, 2009). These messages come from a variety of channels and appear on individual, community, and public scales (Rice & Atkin, 2009; Rogers & Storey, 1987). Campaigns can focus on
preventing problematic behaviors, promoting positive behaviors, or a combination of preventing and promoting behaviors (Rice & Atkin, 2012). Stigmatizing depression and anxiety is a problematic behavior, therefore, this campaign will focus on decreasing stigma related to depression and anxiety. Campaigns also consist of informative messages and/or persuasive messages. Given the mental health literacy (Jorm, 2000) and the stigma that currently relate to mental health, this campaign will consist of both informative messages about depression and anxiety and persuasive messages that will aim to reduce the stigma.

Given the prevalence of depression and anxiety among college students and the number of communication channels they encounter daily, college campuses offer a unique setting for health campaigns. On James Madison University’s campus, there are thousands of students who encounter multiple channels daily. However, traditional print campaigns continue to be the most effective medium through which to communicate health messages (Corcoran, 2011). The purpose of this thesis is to design, implement, and evaluate a health campaign that will reduce the stigma of depression and anxiety among college students. To achieve this goal, a traditional print campaign will be placed in a dormitory on campus where hundreds on college students will encounter the campaign.

Chapter 2 will consist of an extensive review of the literature about depression and anxiety, shame associated with mental health, willingness to communication about health, and health campaigns that have sought to reduce the stigma of depression and anxiety, including depression and anxiety and the stigma that surrounds both. Stigma will be conceptualized and analyzed using Smith's (2007) stigma communication model.
Chapter 3 will provide a detailed account of the formative and summative research conducted during the campaign. This chapter will report about the demographic information found during both quantitative and qualitative formative research stages. Additionally, the evolution of the campaign messages will be presented because the campaign materials changed as a result of the formative focus groups. Finally, all final campaign material will be presented.

Chapter 4 will discuss information regarding the placement and implementation of the campaign materials. The methodology of the evaluation process and participant information will be discussed. Finally, the findings from the evaluation will be reported. Chapter 5 will discuss the implications and limitations of this thesis project, and suggest recommendations for future health campaign on mental health for college students.
CHAPTER 2: LITERATURE REVIEW

Mental Health

Mental illness impacts millions of American lives, but the impact their illness has on their lives varies depending on the diagnoses. Mental illness signs, symptoms, and duration are vastly different and affect everyone differently (NIMH, 2016). Licensed psychiatrist and clinical psychologist to diagnose patients use the Diagnostic and Statistical Manual of Mental Disorders (DSM). The current edition of the DSM, DSM-V, contains 297 mental disorder diagnoses (Morrison, n.d.). Common diagnoses include depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia. College students experience depression and anxiety more than any other mental disorder (Eisenberg, Gollust, Golberstein, & Hefner, 2007). Based on the high prevalence rates, this campaign will focus on reducing the stigma surrounding depression and anxiety.

Depression. Depression, also known as major depressive disorder or clinical depression, is a serious mood disorder (NIMH, 2016). Signs and symptoms of depression vary from person to person, vary in severity, and vary in duration. Common signs and symptoms of depression include persistent sad, anxious, or empty mood, feelings of hopelessness, irritability, feelings of guilt, worthlessness, or helplessness, loss of interest or pleasure in hobbies and activities, decreased energy or fatigue, moving or talking more slowly, and feeling restless or having trouble sitting still (NIMH, 2016). In order to be diagnosed with depression, an individual has to experience several symptoms, including a low mood, most of the day, nearly every day, for at least two weeks (NIMH, 2016). Four factors contribute to depression: genetic, biological, environmental, and psychological.
There are several forms of depression: persistent depressive disorder, perinatal depression, psychotic depression, seasonal affective disorder, and bipolar disorder (NIMH, 2016). Persistent depressive disorder occurs when an individual experiences symptoms for at least two years. However, episodes of depression might alternate between major depression and less severe symptoms (NIMH, 2016). Perinatal depression, most commonly known as postpartum depression, occurs after a woman gives birth. Symptoms of perinatal depression include extreme sadness, anxiety, and exhaustion. Perinatal depression not only impacts the new mother, but can also interfere with her ability to take care of her newborn (NIMH, 2016). When an individual suffers from some form of psychosis in addition to their depression, they are experiencing psychotic depression (NIMH, 2016). Some individuals only suffer from depression symptoms during the winter months, which is known as seasonal affective disorder. Individuals who suffer from seasonal affective disorder typically experience social withdrawal, increased sleep, and weight gain (NIMH, 2016). Finally, someone with bipolar disorder may experience major depressive episodes (NIMH, 2016).

There are several risk factors that increase an individual's depression susceptibility (NIMH, 2016). For example, children who have high levels of anxiety experience chronic mood and anxiety disorders as adults. Middle aged and older adults can also experience depression with other medical conditions, such as diabetes, heart disease, cancer, and Parkinson’s disease. Additional risk factors for depression that have been identified include personal or family history of depression, major life changes, trauma, or stress, and certain physical illnesses and medications (NIMH, 2016).
Despite a grim diagnosis of depression, there are several treatment options that can treat the symptoms of depression (NIMH, 2016). One popular treatment option is antidepressant medications. No matter the diagnosis, medication is most effective if used in addition to psychotherapy. The effectiveness of medication alone is not concrete, but it shown to be more effective for individual with severe cases of mental illness (APA, 2009). In addition to no consistent effectiveness, medication also has many side effects, including nausea, increased appetite and weight gain, fatigue, insomnia, and sexual side effects (Mayo Clinic, 2016).

Psychosocial is another common treatment for mental illness. Psychosocial treatment combines psychotherapy and social and vocational skills training to those who are mentally ill and their families (NAMI, 2016). The various types of psychosocial include psychoeducation, self-help and support groups, assertive community treatment, supported employment, and case management. Fewer hospitalizations and less problems at home, school, and work are the many benefits of psychosocial treatment (NAMI, 2016). Individuals with depression can also receive psychotherapy as a treatment. Psychotherapy treatment involves the patient and a psychiatrist, where the patient and psychiatrist have a dialogue in order to improve the quality of life of the patient (APA, 2016). The main idea is to empower the patient that they have the ability to change their lives for the better (APA, 2016). Research has shown that on average 75% of people who enter psychotherapy experience some benefits (APA, 2016; Lambert & Archer, 2006). Psychotherapy is a common, effective approach to treating mental illness and can be used for adolescents who suffer from mental illness.
Anxiety. Anxiety disorders go beyond worry and fear. Anxiety disorders are characterized by intense feelings of worry, fear, and anxiety which negatively impact on someone’s life that it prevents them from performing well at their job or school work and maintaining relationships. The signs and symptoms of anxiety can last for long periods of time and be severe (NIMH, 2016).

Just as there are several types of depression, there are also several types of anxiety disorders (NIMH, 2016). One type of anxiety disorder is generalized anxiety disorder (GAD). Individuals who suffer from GAD experience restlessness, fatigue, irritability, muscle tension, sleep problems, and have difficulty concentrating and controlling their worry. In order to receive a GAD diagnosis, an individual has to have several symptoms and experience excessive anxiety or worry for months (NIMH, 2016). Panic disorders are another common anxiety disorder. Individuals who have a panic disorder experience recurrent periods of intense fear. This fear leads to sweating, sensations of shortness of breath, accelerated heart rate, and feeling of impending doom. Symptoms of a panic disorder include sudden and repeated attacks of intense fear, feeling of being out of control during a panic attack, and intense worry about when the next attack will happen (NIMH, 2016). Lastly, another common anxiety disorder is social anxiety. Social anxiety occurs when individuals have a fear of social situations and anticipate feeling embarrassed, judged, or rejected. Individuals who have a social anxiety disorder might experience feeling highly anxious about being with other people, feeling very self-conscious in front of other people, being afraid that other people will judge them, staying aware from places where there are other people, and having a hard time making friends and keeping friends (NIMH, 2016).
There are a number of risk factors associated with anxiety disorders (NIMH, 2016). These risk factors include a combination of genetic and environmental factors. Shyness in childhood, being female, anxiety disorder in close biological relatives, parental history of mental disorders, and elevated cortisol levels in the saliva in the afternoon are all genetic factors associated with anxiety disorder. Environmental factors include having few economic resources, being divorced or widowed, and exposure to stressful life events (NIMH, 2016).

Treatments for anxiety are similar to those used to treat depression: medications and psychotherapy (NIMH, 2016). In addition to medications and psychotherapy, anxiety can also be treated with support or self-help groups. While attending an in-person or online support or self-help groups, individuals will share their problems and milestones with others. Individuals with anxiety can also engage in stress-management techniques and meditation (NIMH, 2016).

Model of Stigma Communication

Erving Goffman first conceptualized stigma in 1963. Goffman (1963) argued that stigma dehumanizes individuals. This dehumanization leads to discrimination that interferes with an individual's quality of life. In some cases, the discrimination interferes with quality of life so much that it can ultimately cost someone their life. Stigmatizing language is everyday words and the individuals who use them do not understand the impact their words have on others’ lives.

Goffman breaks stigma into three categories: physical deformities, blemishes of character, and stigma based on race, nation, and religion (Goffman, 1963). Physical deformity stigma focuses on physical impairments that are clearly evident. Examples of
blemishes of character stigmas include unnatural passions, rigid beliefs, dishonesty, mental disorders, imprisonment, addiction, and homosexuality. Stigma based on race, nation, and religion are stigmas that are passed down through generations and impact all members of a family. Goffman (1963) argued that all types of stigma have a similarity: a specific trait led them to be stigmatized and without that trait, they would have been accepted into society. Once an individual has been stigmatized, their life chances have been reduced by “normals”; Goffman’s theory of stigma attempts to explain why someone with that trait is dangerous and inferior (Goffman, 1963; Riesman, 1951).

Using Goffman’s conceptualization of stigma, Rachel Smith developed a Model of Stigma Communication (MSC). Smith (2007) defined stigma as “a simplified, standardized image of the disgrace of certain people that is held in common by a community at large” (p. 464). She extended Goffman’s definition of stigma to define stigma communication as “the messages spread through communities to teach their members to recognize the disgraced (i.e., recognizing stigma) and to react accordingly” (p. 464). Smith’s MSC was crucial work in terms of understanding how communication creates and reinforces stigma (Smith, 2014).

Stigma communication consists of several concepts (see Figure 2.1). First, message choices allow others to quickly recognize someone who is “different” and encourages the stigma attitudes and ultimately reinforces behavior reactions (Smith, 2014). MSC focuses on four possible message choices: mark, group labeling, responsibility, and peril. Each of the message choices provides cues and content, which in turn forms and strengthens stigmas. The first message choice, marking someone into and categorizing him or her into a stigmatized group, is a quick response and typically
influenced by society (Smith, 2014). Mark consists of two components: concealment and disgust. When marks are visible, such as a tick or a wheelchair, they are harder to conceal and therefore attract more attention. Once an individual recognizes a mark, they experience a physiological response and categorize that individual into a stigmatized group. However, if an impairment or disability can be concealed, the response others have to it will be less severe and the individual will be less likely to be categorized in a stigmatized group (Smith, 2014). Cues that evoke disgust, such as “bodily substances like feces or urine, violations of personal cleanliness, ingestion of inappropriate substance like rats or severed fingers, cutting open the human body, contamination by unpalatable objects or ideas, and so on” (p. 469) lead others to avoid or reject an individual or morally evaluate them (Smith, 2007).

The second message choice is group labels and occurs when attention is brought to the stigmatized group and the group is treated as a separate group than the normal people in order to differentiate between the two groups. By separating out the groups, the normal group can categorize everyone in the stigmatized group by their attributes, instead of viewing them all as individuals (Smith, 2014). An example of group labeling is when an individual references someone else by saying, “that person is bipolar,” which denotes that the person is a disease. Instead, an individual should say, “that person has a bipolar condition” in order to imply that the person is affected by an illness. Responsibility in stigma communication comes from the notion that individuals decide that a stigmatized group chooses to have their stigmatized condition. Additionally, responsibility focuses on how much control a stigmatized person has over eliminating their condition (Smith, 2014).
Finally, perils are the signal words, hazard statements, hazard avoidance statements, and consequence statements used to highlight the threat that a stigmatized group has on the community (Smith, 2014). In the area of mental illness, members of society have often warned about dangers schizophrenic individuals pose on society. However, peril does not consist solely of verbal communication, but nonverbal communication as well. Often in the movies and television, individuals with mental illnesses are shown as dangerous, which is emphasized by music, sound effects, and camera shots (Smith, 2014).

The second component of stigma communication is message reaction. All of the possible message reactions (cognitive reactions, access relevant attitudes stereotypes, emotional reactions: fear, anger, disgust), lead to stigma and the reinforcement of stigma (Smith, 2014). When individuals react with fear, anger or disgust, they are more likely to experience cognitive reactions and ultimately attempt to remove the threat. In this model,
the threat is the stigmatized group. When messages or emotional reactions lead to cognitive reactions, the individual interprets the message with more effort. This increase interpretation is more likely to lead to a persuasive effect. The sharing of emotional reactions leads to social bonding. When individuals participate in social bonding, they pass along stories; especially those that are contain bad news. It is through the passing of stories, even false stories, where stigma messages are reinforced (Smith, 2014).

The final component of the stigma communication model is the message effect. If an individual realized they have been marked, they might withdraw from the community. Studies have shown that individuals who fear being stigmatized suffer constricted social networks (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989), low self-esteem (Wright, Gonfrien, & Owens, 2000), and difficulty communicating with individuals who might stigmatize them (Farian, Allen, & Saul, 1968). In addition, avoiding social interactions can also increase an individual's levels of stress and anxiety (Cioffi, 2000).

The model of stigma communication has been tested twice. In the first study, Smith (2012) applied the model to a hypothetical infectious disease alert. Participants were presented with one of 16 possible variations of a CDC newsroom story, all of which consisted of one of the four message choices from the model of stigma communication (mark, responsibility, peril, label) and completed a stigma-belief scale and dissemination scale. Smith (2012) found that the different message choices influences outcomes. Specifically, labels did not predict any reactions and outcomes and marks were related to dissemination of the alert. Additionally, Smith (2012) found that individuals with a more cynical worldview are more likely to stigmatize than others.
In her more recent study, Smith (2014) explored emotional and cognitive reactions, disgust, sympathy and frustration, and message content in relation to predicting how an individual attempts to regulate an infected person's interactions and lifestyle. The results showed that if a participant perceived an infectious individual as dangerous, they were more likely to regulate that individual's life and lifestyle through disseminating the individuals’ infectious status to the community. Frustration, susceptibility, and sympathy were used to explain why a participant would regulate contact with the infectious individuals and disseminate their infectious status (Smith, 2014). The results of these two studies demonstrate that the model of stigma communication can be used to predict and explain how stigma is created and reinforced.

**Shame**

Research by Gilbert, Bhundia, Mitra, McEwan, Irons & Sanghera (2007) has linked stigma and shame, finding that individuals who experience mental health problems also experience shame associated with their illness. Shame is “one’s experience of feeling inferior, worthless, inadequate, unlovable or powerless in some way, as having flaws, inadequacies, exposed as being an unattractive and undesirable self” (Matos et al., 2013, p. 480). The focus of shame is on the individual’s emotional reaction caused by a negative evaluation of the self (Lewis, 1971; Tangney et al., 1992). Shame has been vastly studied in various fields and different schools of thought have led to different definitions, theoretical approaches, and conceptualizations of shame (Gilbert, 1998).

Gilbert (1998, 2002) discussed and identified several kinds of shame. One type of shame is external shame, which is associated with negative feelings of rejection or harm that others have against an individual. In other words, an individual perceives how others
might be judging them for a trait. In order to avoid external shame, individuals might attempt to hide their diagnosis or trait that will lead to judgment (Gilbert, 1998). For example, an individual with a mental illness might try to hide their diagnosis from their family, friends, or even strangers to prevent judgment. External shame is related to a concept called stigma consciousness. Stigma consciousness occurs when fear being labeled in a stigmatized group (Pinel, 1999). For instance, someone with a mental illness can fear being labeled “crazy” or a “psycho” because people with a mental illness are socially stigmatized.

Another type of shame defined by Gilbert (1998, 2002) is internal shame. Internal shame differs from external shame in that the individual is focusing on how they are evaluating themselves (Cook, 1996). Therefore, an individual might shame himself or herself for having a mental illness by directing the attention back onto themselves and negatively evaluating themselves. The last type of shame that Gilbert (2002) identified is reflected shame, which is the shame someone can bring to others or what others can bring to self. An individual with a mental illness can feel like they brought shame to their family because of their mental illness.

Shame leads to four common behaviors: (a) hiding behavior, (b) coping or hiding shame affect, (c) avoiding shame, and (d) secrecy (Gilbert, 1998). Hiding behavior occurs when individuals try to become invisible, blend into their environment, or hide when they believe they can be hurt. For instance, a child who is bullied in school might sit in a hunched posture and avoid eye contact with their bully. Coping or hiding shame is associated with an individual concealing their shame by expressing anger as a substitute
For example, an individual might lash out in anger about their mental illness instead of coping with their diagnosis.

There are two ways in which an individual can avoid shame. First, individuals can withdraw from situations in order to avoid shame. These situations include avoiding seeking help, socializing, and intimate relationships (Gilbert, 1998). In the case of mental illness, an individual might not seek treatment or create meaningful relationships where disclosure occurs in fear that they will be stigmatized or experience shame. Second, individuals can try to compensate for potential vulnerabilities (Nathanson, 1992). For instance, they can work hard or exceed standards. College students might try to compensate for potential vulnerabilities related to their mental illness by working hard on their academic work. Finally, shame leads to secrecy. Instead of announcing something they might be shamed for, they keep it a secret from their family, friends, or society (Gilbert, 1998).

Shame related to various health topics has been widely studied including eating disorders (Ferreira, Pinto-Gouveia, & Duarte, 2013), traumatic memory (Matos & Pinto-Gouveia, 2009), and depression (Matos, Pinto-Gouveia, & Duarte, 2013). In their examination on shame and depression, Matos et al. (2013) found that individuals who report memories of warmth and safeness also reported lower levels of levels of external and internal shame. These results demonstrate that individuals, who do experience safeness or warmth when they are younger, could play a role in feelings of shame later in life (Matos, Pinto-Gouveia, & Duarte, 2013). Another study conducted by Carmack, Nelson, Hocke-Mirzashvili, and Fife (in press) examining college students who experience anxiety or depression had several key findings related to mental illness,
shame, and communication. First, they found that college students who suffer from a mental illness experience higher levels of internal shame. Second, communicating about mental illness does not reduce shame.

**Willingness to Communicate**

Previous research has shown that there is a relationship between willingness to communicate and shame (Carmack et al., in press). Given that relationship, a relationship between willingness to communicate and stigma is possible. McCroskey and McCroskey (1986a; 1986b) defined willingness to communicate (WTC) as the “intention to initiate communication” when an individual is given the opportunity to do so. McCroskey’s conceptualization of WTC stemmed from Burgoon’s (1976) “unwillingness to communicate,” Mortensen, Arntson, and Lustig (1977) on predispositions toward verbal behavior (1997), and McCroskey and Richmond’s (1987) shyness constructs.

The first construct, unwillingness to communicate, is the idea that individual’s experience a strong tendency to avoid oral communication (Burgoon, 1976). In her research, Burgoon discovered that communication apprehension, a factor of unwillingness to communicate, is related to participation in small groups, and amount of information giving and information-seeking in small groups. However, unwillingness to communicate did not correlate with behavioral measure of communicating, suggesting that individuals do not experience an unwillingness to communicate and is not a valid instrument for measuring communication willingness (McCroskey, 1985).

The second construct, predisposition toward verbal behavior, suggests that individuals are predisposed to verbally communicate for a given amount of time, which is influenced by an individual’s situation (Mortensen et al., 1977). Mortensen and
colleagues (1977) developed a 25-item self-report scale to measure their construct. Despite the validity of the scale, McCroskey (1985) argued that the scale is not valid for measuring willingness or unwillingness to communicate due to the lack of questions that address this area. McCroskey and Richmond (1982) created the final construct, shyness, based on Leary’s (1983) construct: social anxiety. McCroskey (1985) argued that his construct of shyness and the scale he created to measure it are not valid measures of willingness or unwillingness to communicate. In the years following the conceptualization of WTC, McCroskey and Richmond developed an instrument to measure the construct (McCroskey & Richmond, 1987) and demonstrated the instrument's reliability and validity (McCroskey, 1992).

Over the years, researchers have argued that WTC is a predisposition trait that influences how individuals communicate in particular ways (Beatty, 1998). Therefore, individuals might experience WTC in some situations, but might lack WTC in other situations. Communication traits, including WTC, have become prevalent to communication research because they “account for enduring consistencies and differences in individual message-sending and message-receiving behaviors among individuals” (Infante, Rancer, & Womak, 2003, p. 77). This same argument can be applied to studying mental health issues in college students. For example, individuals with mental illness might experience willingness to communicate when discussing their diagnosis with a stranger, but not experience WTC when they are communicating with their family, friends, or healthcare providers.

Willingness to communicate about health plays a vital role in health behavior changes. If an individual is more willing to communicate about their health, then they are
more likely to make a positive behavior change. Topics studied related to WTC and health communication include physical exercise and health care cost (Pronk, Tan, & O’Conner, 1999), the effects knowledge, values, and attitudes has on individuals’ willingness to communicate about organ donation with family members (Morgan & Miller, 2002), and the relationship between attitudes, knowledge, and altruism and individuals willingness to communicate about organ donation within a family (Smith, Kopfman, Massi Lindsey, Yoo & Morrison, 2004). It is argued that if a college student with depression or anxiety is willing to communicate about their mental health, they may be more likely to pursue treatment and experience less stigmatization.

Other important findings from research connecting WTC and health behavior changes have determined that individuals are more willing to make a behavior change if they have given thought and intent to making a behavior change (Smith et al., 2014). Therefore if an individual has taken the time to think about their mental health status and intended to seek help, they will be more willing to communicate with their family and friends about their treatment plan. In addition, WTC has been positively correlated with perceptions of message credibility and negatively correlated with anxiety caused by a message (Smith et al., 2014). Translated to this thesis, if individuals perceive the current campaigns message as credible and it does not lead to an increase in anxiety, the participants should experience an increase in WTC about their mental illness.

It was not until Wright, Frey, and Sopory (2007) developed the Willingness to Communicate about Health (WTCH) measure that health communication scholars were able to reliably measure an individual’s willingness to communicate about health topics. Despite the high reliability of the scale, the measure has only been used twice since its
development (Bayrami et al., 2012; Clayton, Latimer, Dunn, & Haas, 2011). The WTCH measure has not be applied to examine individuals’ willingness to communicate about mental health.

One of the two studies that used the WTCH scale examined college students’ willingness to communicate health, but it was in relation to happiness (Bayrami et al., 2012). Although happiness is not inherently the opposite of depression and people who are depressed can experience happiness, the results of the study can provide insight as to college students’ willingness to communicate about their depression. Bayrami et al. (2012) found that students who did reported higher levels of happiness were more willing to communicate than students who reported lower levels of happiness. Additionally, attachment styles predicted happiness, with students who report secure relationship attachments being happier than students with insecure attachments. These results suggest that attachment styles influence happiness (Bayrami et al., 2012). These results can translate to this thesis. First, students who suffer from mental illness will be less likely to communicate about their diagnoses. Second, students who have secure attachment style will be less likely to suffer from depression and anxiety than those who have insecure attachment styles.

Mental Health Campaigns

Previous campaigns have examined the effects of positive and negative messages of mental illness on college campuses. Health campaigns and programs, including Sharing Our Lives, Voices, and Experiences (SOLVE), Active Minds, and “Manics Class” have been implemented into communities to reduce the stigma associated with mental health problems. Each program took a different approach, ranging from contact-
based programs to educational seminars. By reviewing past campaigns, we can understand what is effective and ineffective at creating a behavior change. Therefore, there is something to learn by reviewing the different models and theories that have guided previous campaigns and the types of campaigns that were implemented. Two campaigns that aimed at reducing the stigma of mental illness among college students will be reviewed. Additionally, a proposed model for reducing the stigma of mental illness will also be discussed.

SOLVE utilized an hour long, contact based program which focused on reducing the stigma of mental illness and promoting knowledge about mental illness (Corrigan, Gause, Michaels, Buchholz, & Larson, 2014). To achieve contact, the creators of the program shared stories about the challenges a person with a mental illness face. The goal of sharing the stories was to highlight “recovery, resilience, and achievement of personal goals” (Corrigan, et al., 2014, p. 636). In an evaluation of SOLVE, the program was considered effective due to the number of individuals who changed their perceptions about mental illness and no longer stigmatized those with mental illnesses (Corrigan et al., 2014).

Another effective intervention, called “Maniacs and Psycho Killers: Myths and Realities of Mental Illness in Pop Culture”, used education through seminars to reduce the stigma of mental illness on a college campus. Seminars met once a week for 7 weeks and covered topics such as defining mental illness, how to diagnose mental illness, and how to treat mental illness (Theriot, 2013). In a pre/post-test, the researcher found that students enrolled in the seminars showed a reduced attitude about the mental illness
stigma, showed fewer feelings of fear, and did not perceived individuals with schizophrenia as dangerous (Theriot, 2013).

Each of these campaigns created positive messages about mental illness in order to challenge the stigma that existed on the college campus. Therefore, the campaigns were attempting to remove the label associated with this stigmatized group, alter the reaction they have to those with mental illness, and ultimately change the effect the unmarked had on the marked. Using stigma communication to develop campaigns can provide more insight into how stigma is created and reinforced.

One study proposed the TLC4 model (Targeted, Local, Credible, Continuous, Contact, Change Goals) based on an existing model of stigma change, which could be used to reduce the stigma of mental illness (Michaels, Kosyluk, & Bulter, 2015). The authors proposed that capturing and maintaining attention, actively thinking about the information, having emotional appeal, and making the material relevant to each person could lead to a reduction in mental illness stigma. An evaluation of the campaign showed the TLC4 model could be effective at reducing the stigma of mental illness on a college campus (Michael, Kosyluk, & Bulter, 2015). This model is similar to stigma communication in that capturing the attention of the audience aligns with the message choice “mark.” Additionally, having an emotional appeal is similar to the emotional reaction that occurs in the messages reactions in the stigma communication model.

Following a model similar to stigma communication in order to reverse the stigma could be an effective way to reduce the stigma of mental illness.

**Summary and Campaign Directives**
By changing the messages college students come in contact with on campus, college students can be educated about mental illness and a change in attitude about mental illness can occur. Ultimately, positive messages about mental illness on college campuses could lead to the reduction of the stigma of mental illness on college campuses. To the author’s knowledge, no current research applies stigma communication to the issue of managing the stigma of mental illness on college campuses.

Given the high prevalence of mental health problems among college students and the commonality of stigma among those that have mental health problems, it is evident that a health campaign is necessary in order to reduce the stigma on college campuses. Therefore, the goal of this thesis is to design, implement, and evaluate a health campaign to reduce the stigma of depression and anxiety on a college campus. In order to accomplish this overarching goal, this campaign seeks to educate college students on the prevalence of depression and anxiety, educate college students about the facts of depression and anxiety, empower college students to look past someone’s depression and anxiety, and empower college students to look past their own depression and anxiety. The following aims and objectives guided the development of the campaign design:

**Overall Campaign Goal:** To reduce the stigma of depression and anxiety on a college campus.

**Aim 1:** To decrease the number of college students who believe negative stereotypes about depression and anxiety.

**Objective 1:** Decrease the number of college students who report personal stigma views about depression and anxiety.
Objective 2: Decrease the number of college students who report perceived stigma views about depression and anxiety.

Aim 2: To change students’ attitudes about depression and anxiety.

Objective 1: Decrease the number of students who have negative attitudes about depression and anxiety.

Objective 2: Increase the number of students who have positive or optimist attitudes about depression and anxiety.
CHAPTER 3: FORMATIVE RESEARCH

Formative research is a necessary step in the campaign process to ensure appropriate and effective campaigns are designed (Bauman et al., 2006; Atkin & Freimuth, 2001). Effective campaign design and implementation includes “a thorough situational analysis, develop a pragmatic strategic plan, and execute the creation and placement of messages” (Atkin & Freimuth, 2001; p. 126). According to Palmer (1981), there are two phases of formative research: pre-production research and production testing.

In the pre-production phase, emphasis is placed on understanding the target audience's needs and determining which behavior change are necessary. In order to do this, surveys are distributed to the target audience to gain background information about their perspective on the topic and focus groups are held to gain a deeper understanding of the target audience’s knowledge, beliefs, attitudes, values, priorities, efficacy, and skills. Furthermore, the pre-production phase is a time for researchers to narrow down which channels will be used to deliver the campaign message based on where the target audience receives messages (Atkin & Freimuth, 2001).

The second phase, pre-testing, consists of developing campaign materials and determining which messages are most effective (Atkin & Freimuth, 2001). The first step is to develop a concept, which consists of partial messages and sketches. The purpose of testing concepts is to weed out the concepts that are weak to focus on the stronger concepts. The second step in pre-testing is message execution. The goal of message execution is to show members of the target audience messages in order to determine if a message is effective. There are five elements measured in pretesting include attention...
value, comprehensibility, relevance, strengths/weaknesses, and sensitive or controversial elements. This chapter explains the process and results of both quantitative and qualitative formative research used in this campaign.

**Survey Research**

Data collection for this phase of the thesis took place in Spring 2016, after the researcher received Institutional Review Board (IRB) approval (IRB Approval # 16-0568; see Appendix A).

**Participants and procedures.** A total of 376 college students from a large mid-Atlantic university participated in this phase of the thesis. 3 students \((n = 373)\) were removed due to incomplete data. The majority of college students were between the ages 18-19 years old \((n = 346, 92.8\%)\) and 6.2\% were ages 20-21 years old \((n = 23)\). Most of the participants reported being White \((n = 273; 73.2\%)\). The remaining participants identified as African American \((n = 19; 5.1\%)\), Asian \((n = 39, 10.5\%)\), Hispanic \((n = 26; 7.0\%)\), Pacific Islander \((n = 3; .8\%)\), and other \((n = 11; 2.9\%)\).

First-year students made up 95.4\% of the participant samples \((n = 356)\). 2.7\% of participants \(n = 10\) were sophomores, .8\% were juniors \((n = 3)\), and .8\% were seniors \((n = 3)\). 92.2\% of the participants lived on campus \((n = 344)\). The remaining participants reported living off campus \((n = 29; 7.8\%)\). Over half of the participants reported being female \((n = 201; 53.9\%)\). 45.3\% reported being male \((n = 169)\) and 2 participants chose not to identify their sex.

Participants were asked questions about a diagnosis of a mental illness. 22.5\% of the participants reported being diagnosed with a mental illness \((n = 84)\) while 77.2\% of participants reported never being diagnosed with a mental illness \((n = 288)\). Out of the
participants who were diagnosed with a mental illness, only 9.4% were diagnosed while they were attending college ($n = 35$), while the remaining 90.3% were diagnosed with a mental illness while they were not attending college ($n = 337$).

Many participants who reported being diagnosed with a mental illness were diagnosed with depression ($n = 65$) and general anxiety disorder ($n = 61$). Other participants with a mental illness diagnosis reported being diagnosed with an eating disorder ($n = 15$) or a substance use disorder ($n = 9$). Treatment for participants who were diagnosed with a mental illness consisted of primarily the combination of prescription medication and cognitive behavioral therapy (CBT; $n = 34$). Twenty-seven participants receiving treatment were treated with only CBT and 20 were treated with only prescription medication.

Participants were recruited in introductory and upper division communication courses through the School of Communication Studies departmental SONA system. The SONA system is an online system that helps facilitate research studies and anonymously tracks student participation for class credit. Students of all majors take introductory communication courses, ensuring participants were recruited from all majors on campus. Students completed the online survey using Qualtrics, a web-surveysing software program.

**Survey protocol.** The online survey consisted of 22 questions assessing demographic information, mental illness diagnostic history, and attitudes and behaviors related to the stigma of mental health (see Appendix B for complete survey). Demographic questions include sex, age, class rank, and living arrangements.

The next set of questions consisted of three subscales from the Attitudes Towards
Mental Health scale (Gilbert et al., 2007): General attitudes subscale, external shame subscale, and internal shame. The general attitudes subscale was selected to gauge participants’ general attitude about mental health problems, while the external shame subscale was used because shame has been linked to stigma (Gilbert et al., 2007). The other subscale, internal shame, was not used in the formative research because shame brought to the family due to a mental illness was outside the scope of the campaign. All three subscales used Likert-type responses, where options ranged from 1 (strongly disagree) to 5 (strongly agree).

The General Attitudes subscale consisted of 8 statements, including “My friends see mental health problems as something to keep secret,” “My friends would tend to look down on someone with mental health problems,” and “My family would want to keep their distance from someone with mental health problems” (Gilbert et al., 2007). The reliability of the General Attitudes scale in this thesis was strong (α = .897).

The second subscale assessed participants’ external shame related to mental health problems, such as depression and anxiety. The external shame subscale included 9 statements that asked participants to respond to feelings of shame as if they suffered from mental health problems, such as depression (Gilbert et al., 2007). Participants were prompted to think about how they would feel if they suffered from a mental health problem. Statements included “I think my friends would look down on me,” “I think my family would see me as inadequate,” and “I think my family would see me as not measuring up to their standards” (Gilbert et al., 2007). For this thesis, the reliability of the external shame subscale was .963.

Depression stigma was measured using the Depression Stigma Scale, which
included two subscales: personal stigma and perceived stigma (Griffiths et al., 2004). Both the personal stigma and perceived stigma subscales consisted of 9 statements each and used Likert-type responses, with options ranging from 1 (strongly disagree) to 5 (agree). The personal stigma scale asked participants to think about their personal feelings about depression. Statements for this subscale included “People with depression could snap out of it if they wanted,” “Depression is a sign of personal weakness,” “Depression is not a real medical illness,” and “It is best to avoid people with depression so that you don’t become depressed yourself” (Griffiths et al., 2004). The reliability of the personal stigma subscale for this study was .890.

Participants were then asked to think about what they believe other people think about depression to complete the perceived stigma scale. The perceived stigma subscale statements from the personal stigma subscale were modified to reflect others opinions. These statements included “Most people would not vote for a politician they knew had been depressed,” “Most people believe that people with depression are dangerous,” and “Most people believe that people with depression are unpredictable” (Griffiths et al., 2004). The reliability for the perceived stigma subscale was .935.

Finally, participants completed a scale that assessed their willingness to communicate about health with a provider using the Willingness to Communicate about Health scale (Wright, Frey, & Sopory, 2007). The scale consisted of 10 questions that asked if participants were willing and felt comfortable communicating with healthcare providers about their health problems. “I am comfortable communicating with health care providers,” “I am a competent communicator when talking about health issues,” and “I experience difficulties communicating successfully with health care providers” were
among the scale’s statements. The scale used Likert-type response options, which ranges from 1 (strongly disagree) to 5 (strongly agree). The WTCH scale has exhibited sufficient measurement reliability (α = .71; Wright, Frey, & Sopory, 2007). The reliability of the WTCH scale for this study was similar (α = .798).

Results. Although formative research is not based on hypotheses, the researcher was interested in determining if external shame, general attitudes about mental health problems, and willingness to communication has a relationship with either personal or perceived stigma. Descriptive statistics were run on all five variables Pearson product-moment correlations were used to determine if there were any relationships between the scales. Additionally, one-way analysis of variance (ANOVA) were conducted to compare the effects of sex and population type on all five variables.

Means and standard deviations for each variable were calculated (see Table 3.1). The mean for willingness to communicate was 2.976 (SD = .597). These results suggest that participants do not experience extreme discomfort and difficulties or extreme comfort or ease when communicating with a provider about their health. The mean for external shame was 2.18 (SD = 1.045). Therefore, on average participants did not believe their friends or family would be ashamed of them if they suffered from a mental health problem. 2.28 (SD = .841) was the mean for general attitudes towards mental health problems, suggesting that participants’ family and friends have fairly positive attitudes toward mental health problems. Personal stigma had the lowest mean with 1.98 (SD = .747). On average participants do not stigmatize individuals with depression. Next, perceived stigma had a mean of 3.00 (SD = .885). Participants felt other people neither stigmatized nor did not stigmatized with depression.
Table 3.1. Means and standard deviation for willingness to communicate health, personal stigma, perceived stigma, and general attitudes.

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>WTCH</td>
<td>2.976</td>
<td>.597</td>
</tr>
<tr>
<td>Personal Stigma</td>
<td>1.98</td>
<td>.747</td>
</tr>
<tr>
<td>Perceived Stigma</td>
<td>3.00</td>
<td>.885</td>
</tr>
<tr>
<td>GA</td>
<td>2.28</td>
<td>.841</td>
</tr>
<tr>
<td>External Shame</td>
<td>2.18</td>
<td>1.045</td>
</tr>
</tbody>
</table>

Data were analyzed to determine the relationship between personal stigma, perceived stigma, willingness to communicate, and shame, as shown in Table 3.2. Significant positive correlations were observed between willingness to communicate and external shame ($r_{[372]} = -.113, p < .05$), general attitudes and external shame ($r_{[372]} = .706, p < .05$), general attitudes and personal stigma ($r_{[372]} = .531, p < .05$), general attitudes and perceived stigma ($r_{[372]} = .384, p < .05$), external shame and personal stigma ($r_{[372]} = .465, p < .05$), external shame and perceived stigma ($r_{[372]} = .461, p < .05$), and personal stigma and perceived stigma ($r_{[372]} = .288, p < .05$). No other significant relationships existed.

A one-way ANOVA was performed to determine if differences existed between male, females, and those who did not wish to identify their gender in relation to personal stigma. Results showed that the Omnibus F test was significant, $F = 19.201 (2, 369), p < .05$, indicated that significant differences between the males and females were present. The significant interaction between gender and personal stigma prompted the use of
Tukey post hoc tests to test for mean differences between groups. Tukey was used because the data met the assumption of homogeneity of variance. Significant differences were observed between males and females. No significant differences were observed between males and those who did not answer and females and those who did not answer. The mean for females was the highest ($M = 2.22, SD = .668$), followed by those who did not wish to answer the question ($M = 2.22, SD = .393$). The mean for males was lowest ($M = 1.77, SD = .059$).

Table 3.2 Correlations between willingness to communicate health, personal stigma, perceived stigma, and general attitudes.

<table>
<thead>
<tr>
<th></th>
<th>WTCH</th>
<th>GA</th>
<th>Ext. Shame</th>
<th>Personal Stigma</th>
<th>Perceived Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>WTCH</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GA</td>
<td>.080</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ext. Shame</td>
<td>.029*</td>
<td>.000**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Stigma</td>
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<td>.000**</td>
<td>.000**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Perceived Stigma</td>
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<td>.000**</td>
<td>.000**</td>
<td>.000**</td>
<td>1</td>
</tr>
</tbody>
</table>

*. Correlation significant at the .05 level.

**. Correlation significant at the .01 level.

A second one-way ANOVA was run to compare the effect of population type on general attitudes toward mental health problems in urban, suburban, and rural conditions. Results showed that the Omnibus F test was significant, $F = 6.566 (2, 369), p < .05$, indicated that significant differences between populations types were present. The significant interaction between population type and general attitudes prompted the use of Tukey post hoc test to test for differences between groups. Significant differences were
observed between those who live in suburban population and urban populations. No significant differences were found between rural and urban populations or rural and suburban populations. The mean for urban populations was highest \((M = 2.58, SD = .934)\), followed by rural populations \((M = 2.38, SD = .911)\) and suburban populations \((M = 2.18; SD = .781)\).

**Focus Group Research**

Focus groups were held to expand on findings from the survey portion of the formative research, to gain a richer knowledge about the stigma of depression and anxiety on the campus, and obtain feedback on campaign materials. Data collection for this phase of the thesis took place in Fall 2016, after the researcher received Institutional Review Board (IRB) approval (see Appendix A).

**Participants and procedures.** Seven focus groups were held with a total of 58 participants. Participants were mostly female \((n = 54, 93.1\%)\). Males represented 6.9% of the participants \((n = 4)\). Additionally, the majority of the participants were first year students \((n = 57)\) and Caucasian \((n = 45)\). Only one sophomore participated in the focus groups. 6.9% of the participants identified as Asian \((n = 4)\), 8.6% identified as Hispanic \((n = 5)\), and 3.4% identified as other \((n = 2)\). All of the participants \((n = 58)\) were 18 to 19 years old. When asked what public areas in their dorms they frequented the most, participants reported frequenting their dorms TV room \((n = 27)\), study room \((n = 24)\), and laundry room \((n = 22)\) the most.

The first four focus groups followed a semi-structured format and questions addressed areas related to the stigma of mental illness on campus (see Appendix D for focus group protocol). First, participants were asked about perceptions of mental illness
on the university's campus. This included asking participants if they believe there is a stigma of mental illness on campus, any misperceptions about mental illness they have heard, and if they know anyone who has been discriminated against on campus because of their mental illness. Next, students were asked to discuss perceptions of mental illness in general, not just on campus. Participants were also asked to discuss communication with healthcare providers about mental illness. Finally, half the focus groups were shown campaign material and were asked to provide feedback.

The last three focus groups also followed a semi-structured format and served two purposes: to confirm themes discovered in previous focus groups and to test campaign material. In these focus groups, participants were shown samples of campaign materials and were asked to provide feedback.

**Message design and testing.** The original slogan for the campaign was “No Stigma. No Shame.” The results of the survey inspired this slogan; external shame was positively correlated personal stigma, and perceived stigma and negatively correlated with willingness to communicate about health. These results implied that shame plays a major role in the stigma and communication surrounding mental health. Therefore, the researcher created a slogan that emphasizes and captures the attention of individuals who experience shame related to mental health. Focus group testing revealed that “No Stigma. No Shame.” was a catchy tag line and overall, it received positive feedback. However, there were a few participants who believed that the word shame had a negative connotation. Some felt that associating the word shame with mental illness would make those with mental illness experience shame. Pride or proud were proposed alternative words, however the new words lacked alliteration and was not as catchy. Despite the few
negative comments about the words shame, the slogan remained unchanged and was used on the final campaign materials.

The researcher first created the slogan, then created messages, and finally a tagline. Overall, 11 messages were shown to the various focus groups. Slight revisions were made between each focus group and some messages were not used. In the end, five messages were tested and approved.

**Message 1.** The first message for the campaign was “There’s no shame in having a mental illness. 1 in every 4 college students experience depression or anxiety. You’re not alone.” This message was based off discussion in the focus groups. One participant stated, “People don’t want to say they something like [disclose their mental illness] that because if there’s something wrong with me then they aren’t going to want to associate with them.” Another participant from a different focus group shared a similar viewpoint. She stated that in health class they were taught that mental illness is widespread and often undiagnosed due to individual’s fearfulness about getting help. Therefore, this message was created to combat individuals’ shame and potential shame they experience due to their mental illness.

Focus group testing revealed that participants could easily identify with this message and it provided a sense of comfort in that the fact they are not alone with their mental health problems. Participants recommended removing the first sentence to get straight to the point. Therefore, the message was shortened to “You are not alone.” The new message was also focus group tested and was well received by all participants who saw it. Again, the participants felt like the message was something they could relate to and was a powerful statistic. Based off the positive feedback from the focus groups, this
Message 2. The next message stated, “Just because no one can see you’re fighting, doesn’t mean they aren’t on your side. Tag someone in. You don’t have to fight mental illness alone.” Participants did not like this message in its entirety because it was “chunky” and needed to be more concise. It was suggested that the second sentence, “Tag someone in.” should be removed because it suggest the others are responsible for an individual's fight against mental illness and was confusing in the mental illness context. Since this message did not test well in focus groups, it was not used in the final campaign.

Message 3. “Asking for help doesn’t make you weak, it makes you human” was another message that received mixed results by focus groups. However, some participants felt that the word “weak” was too harsh and similar to shame and instead should be substituted for another word, such as “lesser.” Additionally, another participant stated, “I see it as if you’re not asking for help, it doesn’t make you human.” However, some participants thought the message was positive and reassuring. Due to the lack of consistency among participants, this message was not used in the final campaign material.

Message 4. Additional messages used a myth versus fact structure. The first set of myths/facts included “Myth: Mental illness is not real, it’s just an excuse.” This myth came from comments in the first set of focus groups, where participants believed that individuals with a mental illness use it as an excuse to get out of work. The fact used to counter this myth was “Fact: mental illness has real symptoms, just like a physical illness.” The fact came from a focus group, where several participants said, “There’s a lot
of ideas that mental illness aren’t as serious as physical illnesses.” Several participants who saw this message had never heard of the myth and thought it was irrelevant to college students because they believe all college students think mental illness is real. However, given the higher number of participants who had heard the myth, a similar message was used in the final campaign material.

In the focus groups, participants were asked if they believe individuals with mental illness are dangerous. Overall, participants believed that most people with a mental illness are not dangerous. A participant provided an explanation for the myth that people with mental illness are dangerous: “I think we perceive them as dangerous because of the very people who have mental illness and don’t get help so we assume everyone’s like that…the few people who make that group of people look really bad is why we think that.” Based off this information, the second myth/fact was “Myth: People with a mental illness, like schizophrenia or bipolar disorder, are violent or dangerous. Fact: Most people with a mental illness are no more likely to be violent than the general population.” Participants suggested that specific mental disorders should not be pointed out. Additionally, they suggested more specific statistics related to the fact in order to make it more concreted.

**Message 5.** The last myth versus fact message focused on gender and mental health: “Myth: Depression is just for girls. Fact: Rates of mental depression between girls and guys is nearly identical.” One focus group revealed they learned in their health class at the universities that women suffer more from mental illness because they are more expressive. Like the first myth, participants had not heard this myth before. They reported hearing the myth that girls are more emotional instead of suffering from a mental health
problem. Additionally, participants stated that they prefer messages with statistics. Ultimately, the researcher decided not to go with the myth versus fact format due to its lack of success in the focus groups.

**Final messages.** Five messages were focus group tested and used as campaign material. The first message states, “‘Stop being so dramatic. You’re just being emotional’” (Figure 1.) This message was aimed at the idea females are just too emotional and overreacting, instead of suffering from depression or anxiety. The copy of this messages reads:

> Often time girls with depression or anxiety are thought to be ‘overreacting’ or acting like they have depression or anxiety to get attention. By saying that someone is just being emotional, dramatic, faking, or overreacting places blame on the person and does not address the underlying cause. Take the time to really listen to someone with an open mind and believe what they have to say.
Figure 3.1. “Stop being so dramatic” poster used in campaign.

A message tailored for males, which was similar to the message tailored for females, was used. The message states, “You are not depressed. Stop being such a wimp.” Focus groups revealed that the stereotype that men are not allowed to show their emotions and therefore tend to mask their mental illness. To combat this stereotype, the following copy was added to the message: “Depression does not affect just girls, but guys as well. In fact, rates of depression and anxiety are similar in males and females. Instead of dismissing someone telling you that they have depression or anxiety, listen to what they have to say.”
The third message used in this campaign was “You are not alone,” which received positive feedback in the focus groups. The focus groups also agreed that startling statistics grabbed the audience's attention. Therefore, a startling statistic was incorporated into the copy of this poster: “1 in every 4 college students experience feelings of depression or anxiety. Chances are, someone in your class, dorm, or club is experiencing the same things you are.”
Due to several focus group participants stating that they do not want to hang out with someone who has a mental illness because they believe it will make themselves depressed, the researcher selected the message “Depression is not contagious” for the campaign. The copy for this message was “The guy in the picture could have depression and you would not know it. You also would not catch his depression. Unlike physical illness, like the flu or cold, depression is not contagious.” One participants, after viewing the poster, stated, “I think the message in itself is really important because … when you give a physical example because it puts it in more perspective.”
Finally, the message “Anxiety and Depression are Not an Excuse” with the following copy: “Individuals with depression or anxiety are often seen as lazy or weak. However, they experience physical symptoms just like physical illness, which might interfere with their social life and schoolwork. Overall, individuals with anxiety or depression live full, healthy lives.”
Figure 3.5. “Anxiety and depression are not an excuse” posted poster used in the campaign.
CHAPTER 4: IMPLEMENTATION AND EVALUATION

Implementation

After formative data collection was concluded and the campaign messages were finalized, the campaign was rolled out on campus. Hoffman Hall was selected as the campaign site. Hoffman Hall is a traditional dormitory set-up with rooms on both sides of the hall. Two students lived in a room, with two adjoining rooms sharing a private bathroom. There are 162 students spread over three floors of living space. 50 students live on the first floor, 56 live on the second floor, and 56 live on the third floor. Hoffman Hall houses the Psychology and Madison International Learning Communities. In addition to the students’ rooms, the dormitory contains a study lounge, TV lounge, kitchen, and laundry facility.

A total of 15 posters were hung throughout the dormitory. One poster was placed in the kitchen, two were placed in the TV lounge, two were placed in the study lounge, and one was placed on a bulletin board. The remaining posters were placed in the hallways where the students’ rooms were located. Each of the three floors contained three posters. The posters in the hallways were placed near elevators and stairwells. At the time of placement, there were no competing campaign posters containing messages about mental illness. Campaign material was rolled out in November 2016 and removed in February 2017.

Evaluation

Data collection for this phase of the thesis took place in Spring 2017, after the researcher received Institutional Review Board (IRB) approval (IRB Approval # 16-0568; see Appendix E).
Participants and procedures. A total of 329 college students from the same large Mid-Atlantic University as the formative research and campaign roll-out participated in the evaluation phase of the thesis. Thirty-two students \((n = 297)\) were removed due to incomplete data. 76.8% of the participants were female \((n = 228)\), while 22.6% were male \((n = 67)\). Two participants chose not to identify their sex. Most participants were between the ages 18-19 years old \((n = 280, 94.3\%)\). The remaining participants were ages 20 years old \((n = 13)\) or 22 years old or older \((n = 4)\). Majority of the students were freshmen \((n = 273)\), followed by sophomores \((n = 17)\), juniors \((n = 5)\), and seniors \((n = 2)\). Two hundred forty \((80.8\%)\) participants identified as White, 12 \((4.0\%)\) identified as African American, 21 \((7.1\%)\) identified as Asian, seven \((2.4\%)\) identified as Hispanic, two \((0.7\%)\) identified as Pacific Islander, 11 \((3.7\%)\) identified as multiracial, and four \((1.4\%)\) identified as other or did not wish to answer.

Participants were asked about their mental health history, including any mental health diagnoses and treatments. Only a small percentage of students reported ever being diagnosed with a mental illness \((n = 63, 21.1\%)\). The remaining participants \((n = 234)\) reported never being diagnosed with a mental illness. Of the 63 participants who have been diagnosed with a mental illness, 18 were diagnosed while in attending college. 40 participants have been diagnosed with depression, 49 have been diagnosed with general anxiety, six had been diagnosed with an eating disorder, and four had been diagnosed with a substance use disorder. Treatments for those participants that have been diagnosed with a mental illness include drugs \((n = 12)\), cognitive behavioral therapy \((n = 14)\), or a combination of drugs and cognitive behavioral therapy \((n = 30)\). However, 10 participants reported not receiving any of those treatments for their mental illness. Eight participants
with a mental illness had been hospitalized due to their mental illness.

Additionally, students were asked to identify if they live on campus and if so, which dormitory that reside in. These questions were used to identify which students lived in the dorm where the campaign material was placed. 92.9% of the participants lived on campus ($n = 276$). Of those who lived on campus, 18 lived in Hoffman Hall, the dormitory where the campaign material was placed. The other 258 participants resided in other dormitories from various parts of campus.

Next, participants were asked if they had seen messages about mental illness around campus. Common places where students saw these messages included posters ($n = 156$), flyers ($n = 106$), Potty Mouth ($n = 168$), events ($n = 61$), university counseling center ($n = 130$), speakers ($n = 46$), and from their dormitory resident assistant (RA; $n = 63$). Only 42 participants reported not seeing any messages about mental illness since the beginning of the 2016-2017 school year. Most students reported seeing messages about mental illness in the residence hall they lived in ($n = 180$) and in buildings on campus ($n = 155$). Other common places participants remembered seeing messages about mental illness include dining halls ($n = 31$), resident hall they do not live in ($n = 36$), and a library on campus ($n = 92$).

Students were also asked how many posters about mental illness they recall seeing on campus since the beginning of the 2016-2017 school year. Six participants reported not seeing any posters about mental illness on campus, while the remaining participants reported seeing anywhere from two to 10 or more posters ($n = 1$). Most students reported seeing two ($n = 66$) to three ($n = 60$) posters. Seventeen participants reported seeing one poster, 41 reported seeing four posters, 34 reported seeing five
posters, 20 reported seeing six posters, five reported seeing seven posters, and five reported seeing eight posters. Only one participant reported seeing 10 or more posters about mental illness on campus.

**Survey protocol.** The online, evaluation survey varied for participants depending on their dorm placement. Student participants were divided into two groups: control and experimental. The experimental group consisted of students in Hoffman Hall, where the campaign rolled out. The control group consisted of students from other dorms on campus. Students in the control group completed a 21-question survey. Their survey included questions about demographic information, including sex, age, class rank, dorm placement and mental health diagnosis history. In addition, they completed two subscales from the Griffiths et al. (2004) Depression Stigma Scale: personal stigma and perceived stigma. Both subscales were reliable in this phase of the research (personal stigma subscale, $\alpha = .824$; perceived stigma subscale, $\alpha = .875$). Lastly, the control group was asked to identify if they had seen any posters about depression and anxiety and where they had seen those posters.

Students in the experimental group completed the same survey as the control group, as well as 30 specific questions about the campaign material (see Appendix F for evaluation survey). In total, the students in the experimental group completed a 52-question survey. The additional questions consisted of showing the campaign posters one at a time and asking them the following about each poster: 1) Have you seen this poster” 2) Where on campus did you see this poster? 3) Did this poster influence your attitudes about depression and anxiety? 4) How did this poster influence your attitude about depression and anxiety? 5) Did this poster influence your behavior related to depression
and anxiety? and 6) How did this poster influence your behavior related to depression and anxiety?

**Results.** Personal stigma had a mean of 1.8 ($SD = .58$), which suggests that overall, participants do not report stigmatizing individuals with depression. The mean for the personal stigma subscale for the evaluation was slightly lower than the mean for the same scale used in the formative research, which was 1.98. However, the mean for the perceived stigma subscale was higher in the evaluation research, with a mean of 3.16 compared to the formative research mean of 3.00. Participants neither felt they would be stigmatized or not stigmatized if they had depression. In addition, a Pearson’s correlation revealed that significantly positive correlation between personal stigma and perceived stigma ($r[297] = .211$, $p < .01$).

The researcher hypothesized those students in the experimental group would report lower levels of both personal stigma and perceived stigma than students in the control group. A one-way ANOVA was run to determine if campaign message exposure had an effect on personal and perceived stigma. Participants were in one of 5 dormitories: Hoffman Hall, Eagle Hall, Hillside Hall, Potomac Hall, or other. The first ANOVA revealed that there was not a significant effect of campaign exposure on perceived stigma, $F = .611$ (4, 271), $p = .655$.

A second ANOVA that examined personal stigma indicated that significant differences between dormitories were present, $F = 3.132$ (4, 270), $p < .05$. The significant interaction between dormitories and personal stigma prompted the use of the Tukey post hoc test to examine mean differences between groups. A significant difference was detected between Potomac Hall and participants who lived in other dormitories on
The post hoc test revealed no statistical difference between individuals who live in Hoffman Hall where the campaign material was placed and other dormitories in relation to personal or perceived stigma. Potomac Hall had the highest mean with a mean of 2.15 ($SD = .754$). Next, Eagle Hall ($M = 1.8996$, $SD = .537$) and Hillside Hall ($M = 1.895$, $SD = .546$) had similar means. Hoffman Hall had a mean of 1.814 ($SD = .754$). Finally, the lowest mean was the “other” option, which participants selected if they did not live in one of the dormitories above ($M = 1.806$, $SD = .565$).

Students who lived in Hoffman Hall were shown pictures of the campaign material and asked questions about their attitudes and behaviors. The first poster, which read “Stop being so dramatic.” 12 participants recalled “you’re just being emotional.” Out of those participants, nine correctly recalled seeing the poster in the residence hall they lived in while the other participants incorrectly recalled where they saw the poster. One participant recalled seeing the poster in a dining hall and two participants recalled seeing the poster in a resident hall they did not live in. Four of the 12 participants reported that the poster influenced their attitude about depression and anxiety. One participant stated, “The poster made me think about people that I thought might have been being dramatic about something when really they were just anxious.” Out of the 12 participants, five of them reported that the poster influenced their behavior related to anxiety and depression. When asked how the poster influenced their behavior related to anxiety and depression, one participant stated, “It encouraged me to have my friend open up to me about her anxiety and depression.” Another one said, “Made me realize that others feel it too.” Finally, one participant said, “I just keep thinking that depression sometimes has a bad social stigma but shouldn't be that way.”
Next, students were shown the poster with the message “You are not alone.” Fourteen of the 18 participants recalled seeing the poster, while the remaining four participants did not. Out of those 14 participants, nine correctly remembered seeing the poster in the dormitory they lived in. When asked if the poster influenced their attitudes toward depression and anxiety, six participants stated that the poster did influence their attitude, while eight did not. One participant stated, “Made me realize that there are many kids out there that have depression that most don't even realize.” Despite the six participants who stated their attitudes were influenced, only two participants reported that the poster influenced their behaviors related to depression and anxiety.

The third message participants in the campaign dormitory were asked to evaluate stated, “You are not depressed. Stop being such a wimp.” Only four of the 18 students recalled seeing the poster, with only three of the four participants correctly recalling seeing the poster in their dormitory. Out of the four participants who recalled seeing the poster, half ($n = 2$) reported that the poster influenced their attitude toward depression and anxiety. The other two participants reported that the poster did not influence their attitudes. Additionally, one half of the participants ($n = 2$) reported that the poster influenced their behavior related to depression and anxiety, with the other participants ($n = 2$) stating that the poster did not influence their behavior.

Next, participants were shown the message “Depression is not contagious”. Six of the 18 students in the campaign dormitory recalled seeing the poster. Of those six, five correctly recalled seeing the poster in their dormitory. The other participant incorrectly recalled seeing the poster in a dining hall. When asked if the poster influenced their attitudes about depression and anxiety, half stated that the poster did influence their
attitudes \( (n = 3) \) and the other half stated that the poster did not influence their attitudes \( (n = 3) \). In relation to their attitude change by the poster, one participant stated, “It reminded me you can’t judge someone by appearances. Anyone could be experiencing it and it may not be obvious.” The last question for this poster asked students if the poster influenced their behavior related to depression and anxiety. Three of the participants stated that the poster did influence their behavior, while the other three participants stated that the poster did not influence their behavior. Participants reported that their behavior was changed because it “opened my eyes to how many people who are depressed hide it” and that they “might be more willing to help someone if I’m sure depression is not contagious.”

Finally, participants in Hoffman Hall evaluated the last message “Anxiety and depression are not an excuse.” Only three of the 18 participants recalled seeing the poster. The remaining 15 participants did not remember seeing that particular poster. One participant correctly remembered seeing the poster in the dormitory they lived in. Another participant incorrectly recalled seeing the poster in a library on campus and a third participant recalled seeing the poster in a campus building. None of the participants reported that the message influenced their attitude about depression and anxiety. One explanation as to why the poster did not influence their attitudes was due to the belief that the caption did not suit the picture. Lastly, when participants were asked if the poster influenced their behavior related to depression and anxiety, one participant reported that the poster did influence their behavior, while the remaining two participants stated that the poster did not influence their behavior.
CHAPTER 5: DISCUSSION

The purpose of this thesis was to design, implement, and evaluate a campaign attempting to reduce the stigma of mental illness, specifically depression and anxiety, on a college campus. This chapter will discuss the implications of the findings from the formative research and the evaluation of the overall campaign.

Formative Research

The survey portion of the formative research produced several significant results. First, the findings showed that general attitudes about depression was significantly positively correlated with both external shame, personal stigma, and perceived stigma. Therefore, as an individual perceives family and friends’ attitudes about mental illness become more negative, they would be more likely to perceive that their family and friends would shame an individual for having a mental illness. Additionally, when an individual believes their family and friends would be more likely to stigmatize someone they believe has a mental illness and an individual who has family and friends who have negative attitudes toward people with mental illness are also more likely to stigmatize as well. When individuals generalize their perceptions about others’ attitudes, they are creating a justification as to why their own attitudes are acceptable. This cultivates a culture where it becomes commonplace to stigmatize others, thus making it more difficult to break that stigma later on.

These findings can be explained with Smith’s (2007) model of stigma communication (MSC). According to the model, message choices, such as mark, peril, group labeling, and responsibility, influence message reactions, including social attitudes
and stereotypes and emotional reactions such as shame. When individuals have negative general attitudes about mental illness, they will have message effects. These message effects are where stigma is developed and reinforced (Smith, 2007). Using the MSC as a theoretical lens, we can conclude that if an individual has a negative general attitude about mental illness, they will stigmatize people with a mental illness. Therefore, preventing or changing an individual’s general attitudes about mental illness can reduce stigma. A change in the discourse that surrounds mental illness is one way to change individual’s general attitudes.

Previous research can also explain the findings that external shame was significantly positively correlated with willingness to communicate with providers. Individuals, who believe that their family and friends will shame them for having a mental illness, might suspect that a provider will also shame them. Therefore, those individuals would experience less willingness to communicate with a provider. A culture has been created where young adults are so concerned about what others, even their doctors, think of them. This concern of being judged can have detrimental impacts not only on their health, but also on future relationships. By not opening up about their mental health condition to family and friends, individuals are not allowing themselves a support system. In order to receive the support and treatment necessary to treat their mental illness, individuals must ignore the shame and be willing to communicate with a provider.

The last statistically significant correlation was a positive correlation between personal stigma and perceived stigma. The correlation between both subscales is consistent with previous research (Griffiths et al., 2004). Individuals who stigmatize
those with a mental illness associate with family and friends who also stigmatize people with a mental illness. This suggests that individuals learn to stigmatize from the people they are surrounded by, which is supported by the MSC (Smith, 2007). The MSC states that stigma is shared among networks. In addition, previous research has shown that individuals who have lower levels of exposure of depression report higher levels of personal stigma (Griffiths et al., 2004). It is possible that students are not exposed to individuals who have depression, leading to higher levels of personal stigma towards individuals with depression.

Gender differences between males and females were found to significantly impact personal stigma, with women reporting higher levels of personal stigma. These results are inconsistent with previous research (Eisenberg, Daniel, Golberstein & Zivin, 2009). Research has examined teenage boys and girl’s knowledge about stigma and found that boys are less knowledgeable about mental illness and are more likely to experience stigma (Chandra & Minkovitz, 2006). Several studies have shown that knowledge is negatively correlated with stigma, including stigma about mental illness (Nyblade, 2007; Byrne, 2000). These gender differences can carry on into adulthood and can impact if they stigmatize those with mental illnesses. It is possible, then, that gender roles influence males’ and females’ personal stigma of mental illness. Women are often taught to be nurturing and caring of individuals, which can result in fewer stigmas. On the other hand, men are taught to be tough and not be emotional. Therefore, men might perceive those with a mental illness as weak, thus leading to higher levels of stigma. By creating a culture with more fluid gender roles, it is possible that individuals with mental illness will be less stigmatized.
Population type, specifically suburban and urban conditions, were found to significantly influence general attitudes about mental illness. Previous research has examined mental health diagnoses and measures in rural versus non-rural areas (Eberhardt & Pamuk, 2004). Stigma toward mental illness has been shown to be higher in rural areas (Hoyt, Conger, Valde, & Weihs, 1997). However, no research has shown differences in stigma towards mental illness in suburban versus urban populations. The lack of consistent results could be due to a reduction in rural populations' stigma of mental illness. It is also possible that individuals who live in suburban areas come into contact with more individuals who have mental illness, resulting in their attitudes about mental illness to be more positive. Populated cities could also have a culture that is more focused on the individual than the community due to the high volume of people and fast paced lifestyles.

**Evaluation**

Analysis of the evaluation data showed that students who lived in the experimental group dormitory did not experience personal or perceived stigma significantly different than students who lived in other dormitories on campus. These results suggest that the campaign was not effective in reducing the stigma of mental illness. There are several challenges to evaluating a campaign (Coffman, 2002). Campaigns typically seek outcomes on three levels: environmental change, community change, and individual change. These varying levels create horizontal and vertical complexity. Another challenge to evaluation is unpredictability, such as competing messages. Similarly, competing messages can result in the environment interfering with campaign evaluation. Finally, a lack of control group that does not come in contact with
the intervention can make it challenging for researchers to evaluate their campaign (Coffman, 2002).

One reason the findings for this campaign were not significant could be due to the small number of participants who participated from the study that lived in the campaign dormitory. Of all the participants in the evaluation portion, only 18 were from the experimental dormitory. The use of quota sampling could have eliminated the extreme difference between groups. Another reason for insignificant findings could be due to the number of visitors the dormitories receive from outside guests. It is possible that participants who did not live in the campaign dormitory frequently visited the dormitory and saw the campaign materials, therefore having an effect of their personal or perceived stigma. The insignificant findings could also be due to the timing of the campaign. The campaign was placed in dormitory during early November of the Fall 2016 semester and removed in February of the Spring 2017 semester. While the campaign was in place, the university was closed for a total of a month due to Thanksgiving and winter breaks, resulting in an environmental factor influencing the campaign results.

Lastly, the campaign effectiveness could have been compromised because of competing campaigns about mental illness on the university’s campus, leading to a challenge of unpredictability. A majority of the students who completed the evaluation portion of the campaign reported seeing a range from 2 to 10+ posters, including other messages about mental illness. At the end of the implementation period, two other campaigns from the same department that also sought to reduce the stigma of mental illness on the university's campus were rolled out. Therefore, the students who are not in the dormitory where the campaign was placed also received similar messages about the
stigma of mental illness, which could have interfered with the current campaign.

Overall, students who live in the dormitory and were moderately effective in changing participants’ attitudes and behaviors related to anxiety and behavior recalled the campaign message placed in Hoffman Hall. Based off students’ qualitative comments about the messages, it is evident that the poster expanded participants’ knowledge about depression and anxiety and encouraged them to communicate with individuals who might have a mental illness, including one participant stating that the poster made them think about the “bad” stigma that surrounds depression and anxiety. The MSC could be used as a possible explanation for this finding. MSC states that individuals access relevant social attitudes and stereotypes when they see a message that labels or marks someone (Smith, 2007). It is possible that seeing a campaign message that challenges stereotypical messages about mental illness resulted in students’ social attitudes and stereotypes about mental illness also being challenged. Thus, participants might have had a thoughtful semantic reaction to the message and reduce the stigma.

Despite some participants’ attitude and behavior changes about depression and anxiety, not all of the posters equally impacted the students. It is possible that the students’ stereotypes of mental illness were too strong to be weakened or challenged by the seeing the posters. Another possible explanation could be that the stereotypes addressed in the posters did not reflect the stereotypes that the students hold for mental illness.

**Recommendations**

Based on the findings from this campaign, several recommendations can be made to campaign advocates and researchers who design and implement campaigns about the
stigma surrounding mental illness. First, the finding that females have higher levels of personal stigma suggest that campaigns should find ways to specifically target females. This can be done by using images of females in campaign material and creating messages that females can relate to. For example, messages about caring for those in need or creating a sisterhood can speak to women's more nurturing and caring side. By increasing interactions and creating a bond that results in women helping other women with mental illness, females might reduce their stigma about those with mental illnesses.

Second, campaign advocates can design campaign material that encourages individuals to think independently. Formative research for this thesis showed that family and friends’ general attitudes about depression was positively correlated with personal stigma. Developing campaign messages that teach students how to think about mental illness outside of how their family and friends speak of it could help to break their stigmatizing beliefs and attitudes. Messages could also show inappropriate beliefs that their friends and family have about depression and anxiety and demonstrate how those beliefs are wrong.

Third, campaign advocates should focus on the different types of mental illness. Depression and anxiety were not highly stigmatized for this sample, but it is possible that other serious mental illnesses are more stigmatized on college campuses. It is also possible students see depression and anxiety differently (Carmack et al., in press), so designing separate campaigns for these mental illnesses could also be helpful in reducing stigma. When designing formative research surveys, campaigns can assess which mental illnesses are stigmatized the most and make those the center of their campaign.

This campaign focused on individuals who stigmatize others for their mental
illness. Future campaigners should also design and implement campaigns that target individuals who are stigmatized by others because of their mental illness. In the focus groups, participants shared stories of when they were discriminated and stereotyped because of their condition. It is important for researchers to create campaigns that address their attitudes and beliefs related to being stigmatized because stigma is such a large barrier to seeking treatment. Campaigns for those who are stigmatized could focus on teaching them techniques on how to manage being stigmatized, create events where they can meet other people who also suffer from a mental illness, or encourage them to reach out to a provider for support. Interactions with those who have mental illnesses could also be beneficial between providers and their mentally ill patients. Having an outlet for individuals to discuss and learn about their mental illness could lead to increased willingness to communicate, less shame, and less stigma. Additionally, if individuals become comfortable discussing their mental illness with a provider, they might also become comfortable discussing their illness with others, such as family and friends.

Limitations and Future Directions

There are several limitations associated with this thesis. First, a major limitation was related to participant demographics. All phases of data collection consisted of mostly female participants. Although the ratio of female to male participants does reflect the female to male student ratio at the university where the data was collected, the results of each phase of the campaign could have varied if more males participated in the study. The majority of students also reported being White. Although the participant sample did include some diversity and accurately represented the university’s diversity ratio, a more diverse sample would have most likely yielded different results because minorities are
often stigmatized for their mental illness (Gary, 2005). Another limitation is the low number of students who reported being diagnosed with a mental illness. Given that the thesis aimed to reduce the stigma of mental illness, it would have been more beneficial to hear how individuals with mental illness are being stigmatized. Future research should attempt to collect a more diverse sample of students for all portions of their campaign. Mental illness and the stigma that surrounds it does not impact only White, females who are first year students in college. Therefore, campaigns should seek to find develop campaigns that help other students in need.

Additionally, the results from the formative research showed that the mean for personal stigma, perceived stigma, and external shame were all relatively low, suggesting a ceiling effect may have occurred; it is possible students completing the formative and evaluation surveys already have lower stigma rates, although these lower reported rates are counter to previous research (Eisenberg et al., 2009). It could also suggest students are not accurately sharing their perceptions of stigma, or that previous research inflates the prevalence of stigma on college campuses. Future research should ensure that a stigma of mental illness is present among the population they are studying by using scales previously used to measure stigma on college campuses.

Due to time required to conduct formative research, design and test campaign materials, implement the campaign, and evaluate the campaign, the researcher collected the quantitative portion of the formative research in a separate school year than the year the campaign material was placed. It is possible that the rates of stigma and negative attitudes about those with mental illnesses could have varied between the two groups of first-year students. Future research should time the workload so that the target population
for the formative research should be the same target population for the campaign.

Future research should look into applying Smith’s (2007) Model of Stigma Communication to other components of mental illness stigma. For example, researchers can address specific message choices, such as individuals who are or have been recently hospitalized for their mental illness and individuals with specific mental illness, to understand the message reactions and message effects related to those conditions. In addition, health communication researchers should explore the application of the Willingness to Communicate about Health scale to specific mental illnesses. Finally, future research should look to study the stigma of mental illness in specific marginalized populations, such as minorities, homosexuals, and immigrants.

**Conclusion**

Despite evidence that shows the campaign was not effective in reducing the stigma of mental illness on a college campus, this thesis did provide valuable knowledge about the stigma of mental illness. First, this thesis expanded on the application of the Willingness to Communicate with a Provider scale. Second, this thesis demonstrated the validity of the model of stigma communication and how it relates to the stigma of mental illness. Third, the survey portion of the formative research showed that general attitudes about depression plays an important role in influencing college students personal stigma, perceived stigma, and external shame. Continuing to develop campaigns that seek to reduce the stigma of mental illness will contribute to the growing literature about stigma and will hopefully increase the number of college students who seek treatment for their mental health needs.
Appendix A

IRB Approval Notification:

Morgan, Cindy - morgancs <morgancs@jmu.edu>
Thu 4/14/2016 2:09 PM
To: Reynolds, Ashley Renee - reynolar
CC: Carmack, Heather Janelle - carmachj

Dear Ashley,

I wanted to let you know that your IRB Protocol entitled, "Stigma of Mental Illness in College Dorms: A Health Campaign," has been approved effective from 4/14/2016 through 4/13/2017. The signed action of the board form, approval memo, and close-out form will be sent to you via campus mail. Your protocol has been assigned No. 16-0568. Thank you again for working with us to get your protocol approved.

All research must be conducted in accordance with this approved submission, meaning that you will follow the research plan you have outlined in your protocol, use approved materials, and follow university policies.

Please take special note of the following important aspects of your approval:

- Any changes made to your study require approval before they can be implemented as part of your study. Contact the Office of Research Integrity at researchintegrity@jmu.edu with your questions and/or proposed modifications. An addendum request form can be located at the following URL:
  http://www.jmu.edu/researchintegrity/irb/forms/irbaddendum.doc.

- As a condition of the IRB approval, your protocol is subject to annual review. Therefore, you are required to complete a Close-Out form before your project end date. You must complete the close-out form unless you intend to continue the project for another year. An electronic copy of the close-out form can be found at the following URL:
  http://www.jmu.edu/researchintegrity/irb/forms/irbcloseout.doc.

- If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating a renewal, along with supporting information. An electronic copy of the close-out form can be found at the following URL:
  http://www.jmu.edu/researchintegrity/irb/forms/irbextensionrequest.doc.
● If there are in an adverse event and/or any unanticipated problems during your study, you must notify the Office of Research Integrity within 24 hours of the event or problem. You must also complete adverse event form, which can be located at the following URL: http://www.jmu.edu/researchintegrity/irb/forms/irbadverseevent.doc.

Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

Thank you again for working with us to get your protocol approved. If you have any questions, please do not hesitate to contact me.

Best Wishes,
Cindy

Cindy Morgan
Administrative Assistant, Office of Research Integrity
James Madison University
MSC 5738, Blue Ridge Hall, Room 342
601 University Blvd.
Harrisonburg, VA  22807
Phone:  (540) 568-7025
FAX:  (540) 568-6409
Email:  morgancs@jmu.edu
Office Email:  researchintegrity@jmu.edu
Appendix B

Formative Survey Questions

Please respond to the following questions.

1. Please indicate your sex:
   a. Female
   b. Male
   c. I do not wish to answer

2. Please indicate your class rank:
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
   e. Graduate Student

3. What is your age?
   a. 18-19
   b. 20-21
   c. 22-23
   d. 24-25
   e. 26+

4. Please indicate your sexual orientation:
   a. Heterosexual
   b. Homosexual
   c. Bisexual
   d. Other
   e. I do not wish to answer

5. Please indicate your ethnicity:
   a. African American
   b. Asian
   c. Hispanic
   d. Pacific Islander
   e. White
   f. Other
   g. I do not wish to answer

6. Do you currently live in a residence hall on campus?
   a. Yes
   b. No
7. If you currently live in a resident hall, which resident hall do you live in?
   a. Logan
   b. Spotswood
   c. Wayland
   d. Bell
   e. Hillside
   f. McGraw-Long
   g. Eagle
   h. Shorts
   i. Chesapeake
   j. Potomac
   k. Shenandoah
   l. Chappelear
   m. Dingedine
   n. Frederikson
   o. Garber
   p. Hanson
   q. Huffman
   r. Ikenberry
   s. Weaver

8. Which socio-economic status would your family fall into?
   a. Lower-class
   b. Middle-class
   c. Upper-class
   d. Prefer not to answer

9. Do you currently have health insurance?
   a. Yes
   b. No

10. Are mental health treatments covered under your health insurance?
    a. Yes
    b. No
    c. I do not know
    d. I do not currently have health insurance

11. What type of population did you grow up in?
    a. Urban
    b. Rural
    c. Suburban
The following questions are going to ask you about your personal experience with mental illness and messages about mental illness.

12. Have you ever been diagnosed with a mental illness, such as depression or generalized anxiety disorder?
   a. Yes
   b. No

13. Were you diagnosed with a mental illness while attending college?
   a. Yes
   b. No

14. If you have ever been diagnosed with a mental illness, which diagnosis were you given? *(Please select all that apply)*
   a. Depression
   b. General anxiety disorder
   c. Eating disorder
   d. Substance abuse
   e. Other: ______
   f. I have never been diagnosed with a mental illness

15. If you have been diagnosed with a mental illness, what type of treatment did you receive?
   a. Drugs
   b. Cognitive behavior therapy (talking with a psychiatrist)
   c. Both
   d. Neither
   e. I have never been diagnosed with a mental illness

16. Have you ever been hospitalized for a mental illness?
   a. Yes
   b. No
   c. I have never been diagnosed with a mental illness

17. What type of messages about mental illness have you come across on the JMU campus? *(Please select all that apply)*
   a. Posters
   b. Flyers
   c. Potty Mouth
   d. Events
   e. Counseling center
   f. Speakers
   g. RA program
   h. Other: _____
The following questions are going to ask about your attitude toward mental illness.

1-Strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree

**General Attitudes:**

For these questions, please think about how your friends and family view mental health problems such as depression and anxiety in everyday life.

1. My friends see mental health problems as something to keep secret
2. My friends see mental health problems as a personal weakness
3. My friends would tend to look down on someone with mental health problems
4. My friends would want to keep their distance from someone with mental health problems
5. My family see mental health problems as something to keep secret
6. My family see mental health problems as a personal weakness
7. My family would tend to look down on someone with mental health problems
8. My family would want to keep their distance from someone with mental health problems

**External Shame/Stigma Awareness**

For these questions, please think about how you might feel if you suffered from mental health problems such as depression and anxiety in your everyday life.

1. I think my friends would look down on me.
2. I think my friends would see me as inferior.
3. I think my friends would see me as inadequate
4. I think my friends would see me as weak
5. I think my friends would see me as not measuring up to their standards
6. I think my family would look down on me
7. I think my family would see me as inferior
8. I think my family would see me as inadequate
9. I think my family would see me as weak
10. I think my family would see me as not measuring up to their standards

The following questions are going to ask about the stigma associated with depression.

1-Strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree
For these questions, please think about your personal feelings about depression.

**Personal Stigma Subscale:**
1. People with depression could snap out of it if they wanted
2. Depression is a sign of personal weakness
3. Depression is not a real medical illness
4. People with depression are dangerous
5. It is best to avoid people with depression so that you don’t become depressed yourself
6. People with depression are unpredictable
7. If I had a problem with depression, I would not tell anyone
8. I would not employ someone if I knew they had been depressed
9. I would not vote for a politician if I knew they had been depressed

For these questions, please think about what you think other people think about depression.

**Perceived Stigma Subscale:**
10. Most people believe that people with depression could snap out of it if they wanted
11. Most people believe that depression is a sign of personal weakness
12. Most people believe that depression is not a real medical illness
13. Most people believe that people with depression are dangerous
14. Most people believe that it is best to avoid people with depression so that you don’t become depressed yourself
15. Most people believe that people with depression are unpredictable
16. Most people would not tell anyone if they had depression
17. Most people would not employ someone they knew had been depressed
18. Most people would not vote for a politician they knew had been depressed

The following questions are going to ask about your willingness to communicate with a healthcare provider about mental illness.

1-Strongly agree, 2-agree, 3-neutral, 4-disagree, 5-strongly disagree

1. While participating in a conversation with my doctor, I felt nervous.
2. I look forward to talking with my doctor about my medical needs
3. When talking with my doctor, my posture feels strained and unnatural.
4. I am tense and nervous while talking with my doctor.
5. I have no fear of expressing myself in front of my doctor.
6. I feel that I am less fluent when talking to my doctor than most other patients are.
7. Look forward to expressing my opinions to my doctor.
8. Conserving with my doctor causes me to be fearful and tense because of his/her status and authority.
9. Although I am nervous about talking to my doctor before arriving at his/her office, I soon forget my fears and enjoy the experience.
10. I feel relaxed and comfortable while speaking to my doctor about my medical needs.
11. I feel self-conscious when asking a question by my doctor.
12. I face the prospect of talking with my doctor with complete confidence.

Willingness to Communicate About Health (Wright et al., 2007)

1-Strongly disagree, 2-disagree, 3-neural, 4-agree, 5-strongly agree

1. I am comfortable communicating with health care providers.
2. I am a competent communicator when talking about health issues.
3. I experience difficulties communicating successfully with health care providers. (R)
4. I am quick to make an appointment to talk with a health care provider when I’m not feeling well.
5. When I don’t feel well, I don’t want to talk to a health care provider. (R)
6. I frequently talk to health care providers.
7. I actively seek out health care providers.
8. I am comfortable talking about my health with a variety of people, not counting physicians.
9. When I don’t feel well, I don’t want to talk. (R)
10. I frequently talk about health issues.
Appendix C

IRB Addendum Approval Notification:

Morgan, Cindy - morgancs <morgancs@jmu.edu>
Fri 8/16/2016 2:57 PM
To: Reynolds, Ashley Renee - reynolar
CC: Carmack, Heather Janelle - carmachj

Dear Ashley,

I want to let you know that the addendum request for your IRB protocol # 16-0568 entitled, "Stigma of Mental Illness in College Dorms: A Health Campaign" has been approved.

This Addendum Request approval is for the following protocol changes:

- The addition of focus groups to data collection.

Your Close-Out Form must be submitted within 30 days of the project end date. If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating a renewal, along with supporting information. Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

Thank you again for working with us to get your protocol addendum approved. We look forward to receiving your project close-out form upon completion of your study.

Best Wishes,
Cindy

Cindy Morgan
Administrative Assistant, Office of Research Integrity
James Madison University
MSC 5738, Blue Ridge Hall, Room 342
601 University Blvd.
Harrisonburg, VA 22807
Phone: (540) 568-7025
FAX: (540) 568-6409
Email: morgancs@jmu.edu
Office Email: researchintegrity@jmu.edu
Appendix D

Focus Group Demographics Questions:

1. Please indicate your sex:
   a. Female
   b. Male
   c. I do not wish to answer
2. Please indicate your class rank:
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
   e. Graduate student
3. What is your age?
   a. 18-19
   b. 20-21
   c. 22-23
   d. 24-25
   e. 26+
4. Please indicate your ethnicity:
   a. African American
   b. Asian
   c. Hispanic
   d. Pacific Islander
   e. White
   f. Other
   g. I do not wish to answer
5. What public areas in your dorms do you frequent the most?
   a. TV Room
   b. Game Room
   c. Kitchen on your hall
   d. Kitchen on other halls
   e. Study Rooms
   f. Laundry Room
Appendix E

Focus Groups Protocol:

I. First, I would like to discuss your perceptions about mental illness in general.
   A. What are your initial thoughts about mental illness?
   B. What do you think stereotypically mentally ill person look like?
   C. Do you perceive those with mental illness to be weaker or dangerous?
      a. Why or why not?
   D. Do you feel comfortable when you are around someone you think has a mental illness?
      a. Why or why not?
   E. Do you think that the media distorts mental illness?
      a. Why or why not?
   E. Have you or anyone you know been judged or discriminated against because you have a mental illness or the person judging you thought you did?
      a. What was this experience like?

II. Next, I would like to discuss perceptions and experiences of mental illness on campus.
   A. Do you think there is a stigma of mental illness on campus?
      a. Why or why not?
      b. Do you have any examples?
   B. What are some misconceptions about mental illness that you’ve heard on campus?
   C. If you thought a friend or someone you knew had a mental illness, would you have a conversation with about it?
      a. What would this conversation look like?
      b. Would you ever make the first move?
      c. How would this conversation make you feel?
   D. If you had a friend who was suffering from a mental illness, would you support them?
      a. How would you achieve this support?
   E. Do you know where on campus you or a friend can receive support for mental illness?

III. Moving on, I would like to discuss communication with healthcare providers about mental illness.
   A. Do you consider yourself open to talking with your provider about various medical conditions?
      a. Are you generally comfortable speaking with your provider?
   B. What kinds of conversations have you had with providers about mental health issues?
      a. How did this conversation make you feel?
         i. What type of emotions did you experience?
      b. Did this conversation make you feel uncomfortable?
         i. Why or why not?
C. What are some reasons, if any, that you keep you from talking with a provider about mental illness?
D. What would make you feel more comfortable about talking with a provider about mental illness?
V. Is there anything that I left out or did not cover that you would like to discuss?
VI. This focus group is one of a series we are holding, so any suggestions you could make for improving it would be very helpful.
Appendix F

IRB Addendum Approval Notification:

Morgan, Cindy - morgancs <morgan@jmu.edu>
Mon 2/13/2017 2:41 PM
To: Reynolds, Ashley Renee - reynolar
CC: Carmack, Heather Janelle - carmachj

Dear Ashley,

I want to let you know that the addendum request for your IRB protocol # 16-0568 entitled, "Stigma of Mental Illness in College Dorms: A Health Campaign" has been approved.

This Addendum Request approval is for the following protocol changes:

- Adding a survey for research evaluation collection.

Your Close-Out Form must be submitted within 30 days of the project end date. If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating a renewal, along with supporting information. Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

Thank you again for working with us to get your protocol addendum approved. We look forward to receiving your project close-out form upon completion of your study.

Best Wishes,
Cindy

Cindy Morgan
Administrative Assistant
Office of Research Integrity - James Madison University
601 University Blvd., Room 342
MSC 5738
Harrisonburg, VA  22807
morgancs@jmu.edu
(540) 568-7025
Appendix G

Evaluation Survey Questions:

Please indicate your sex:
- Female
- Male
- I do not wish to answer

Please indicate your class rank:
- Freshman
- Sophomore
- Junior
- Senior
- Graduate Student

What is your age?

Please indicate your ethnicity:
- African American
- Asian
- Hispanic
- Pacific Islander
- White
- Multiracial
- Other
- I do not wish to answer

What population do you live in?
- Urban
- Rural
- Suburban

The following questions are going to ask you about your personal experience with mental illness.

Have you ever been diagnosed with a mental illness, such as depression or generalized anxiety disorder?
- Yes
- No
Were you diagnosed with a mental illness while attending college?
- Yes
- No

If you have ever been diagnosed with a mental illness, which diagnosis were you given?
Please select all that apply
- Depression
- General anxiety disorder
- Eating disorder
- Substance abuse
- Other: ______

If you have been diagnosed with a mental illness, what type of treatment did you receive?
- Drugs
- Cognitive behavior therapy (talking with a psychiatrist)
- Both
- Neither
- I have never been diagnosed with a mental illness

Have you ever been hospitalized for a mental illness?
- Yes
- No
- I have never been diagnosed with a mental illness

The next set of questions will ask about your personal feelings about depression and anxiety.

Personal Stigma Subscale: For these questions, please think about your personal feelings about depression.

Please indicate the degree to which you agree with the following statements between 1
(strongly disagree) to 7 (strongly agree)
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I would not employ someone if I knew they had been depressed and anxious

I would not vote for a politician if I knew they had been depressed and anxious

Perceived Stigma Subscale: For these questions, please think about what you think other people think about depression.
Please indicate the degree to which you agree with the following statements between 1 (strongly disagree) to 7 (strongly agree):

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<th>Statement</th>
<th>1 (SD)</th>
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Most people believe that it is best to avoid people with depression and anxiety so that you don’t become depressed yourself

Most people believe that people with depression and anxiety are unpredictable

Most people would not tell anyone if they had depression and anxiety

Most people would not employ someone they knew had been depressed and anxious

Most people would not vote for a politician they knew had been depressed and anxious

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</tbody>
</table>

What type of messages about depression and anxiety have you come across on the JMU
campus since the beginning of the 2016-2017 school year? Please select all that apply.

- Posters
- Flyers
- Potty Mouth
- Events
- Counseling center
- Speakers
- RA program
- Other: _____

- I have not seen any messages about depression or anxiety on JMU's campus

Where on campus did you see the posters about depression and anxiety?

- Dinning Hall
- Residence Hall you live in
- Resident Hall you don't live in
- Library
- Campus building
- Other

How many total posters from various campaigns about depression and anxiety do you recall seeing on campus since the beginning of the 2016-2017 school year?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- Other

How many different types of campaigns about depression and anxiety do you recall seeing on campus since the beginning of the 2016-2017 school year?

- 1
- 2
- 3
- 4
- Other
What type of messages about depression and anxiety have you come across on the JMU campus since the beginning of the 2016-2017 school year? Please select all that apply.

- [ ] Posters
- [ ] Flyers
- [ ] Potty Mouth
- [ ] Events
- [ ] Counseling center
- [ ] Speakers
- [ ] RA program
- [ ] Other: __________________

Can you recall what the messages about depression and anxiety said?

- [ ] Yes
- [ ] No

What were the messages on the poster(s)?

The next two questions will ask if about your living arrangements.

Do you live on campus?

- [ ] Yes
- [ ] No

Which dorm do you live in?

- [ ] Hoffman Hall
- [ ] Hillside Hall
- [ ] Eagle Hall
- [ ] Maple Hall
- [ ] Potomac Hall
- [ ] Other __________________

The next set of questions will show your images. Please respond honestly to the questions associated with each image.
Have you seen this poster?
  ○ Yes
  ○ No

Where on campus did you see this poster?
  □ Dining Hall
  □ Residence Hall you live in
  □ Resident Hall you don't live in
  □ Library
  □ Campus building
  □ Other ____________________

Did this poster influence your attitudes about depression and anxiety?
  ○ Yes
  ○ No

How did this poster influence your attitude about depression and anxiety?
Did this poster influence your behavior related to depression and anxiety?

- Yes
- No

How did this poster influence your behavior related to depression and anxiety?

Have you seen this poster?

- Yes
- No
Where on campus did you see this poster?
- Dining Hall
- Residence Hall you live in
- Resident Hall you don't live in
- Library
- Campus building
- Other ____________________

Did this poster influence your attitudes about depression and anxiety?
- Yes
- No

How did this poster influence your attitude about depression and anxiety?

Did this poster influence your behavior related to depression and anxiety?
- Yes
- No

How did this poster influence your behavior related to depression and anxiety?

"YOU ARE NOT DEPRESSED. STOP BEING SUCH A WIMP."

They are more than their depression and anxiety.


Have you seen this poster?
- Yes
- No
Where on campus did you see this poster?
- Dining Hall
- Residence Hall you live in
- Resident Hall you don't live in
- Library
- Campus building
- Other ________________

Did this poster influence your attitudes about depression and anxiety?
- Yes
- No

How did this poster influence your attitude about depression and anxiety?

Did this poster influence your behavior related to depression and anxiety?
- Yes
- No

How did this poster influence your behavior related to depression and anxiety?

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The guy in the picture could have depression and you would not know it. You also would not catch his depression. Unlike physical illness, like the flu or cold, depression is not contagious.

They are more than their depression and anxiety.
Have you seen this poster?

- Yes
- No

Where on campus did you see this poster?

- Dining Hall
- Residence Hall you live in
- Resident Hall you don't live in
- Library
- Campus building
- Other ____________________

Did this poster influence your attitudes about depression and anxiety?

- Yes
- No

How did this poster influence your attitude about depression and anxiety?

Did this poster influence your behavior related to depression and anxiety?

- Yes
- No
How did this poster influence your behavior related to depression and anxiety?

Have you seen this poster?
- Yes
- No

Where on campus did you see this poster?
- Dining Hall
- Residence Hall you live in
- Resident Hall you don't live in
- Library
- Campus building
- Other ____________________

Did this poster influence your attitudes about depression and anxiety?
- Yes
- No

How did this poster influence your attitude about depression and anxiety?
Did this poster influence your behavior related to depression and anxiety?

- Yes
- No

How did this poster influence your behavior related to depression and anxiety?
References


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