

**HISTORICAL, SOCIAL, AND PERSONAL NARRATIVES ON MENTAL
HEALTH: *HOW THE PERCEPTION OF STIGMA AFFECTS THE
LIKELIHOOD TO SEEK HELP***

by

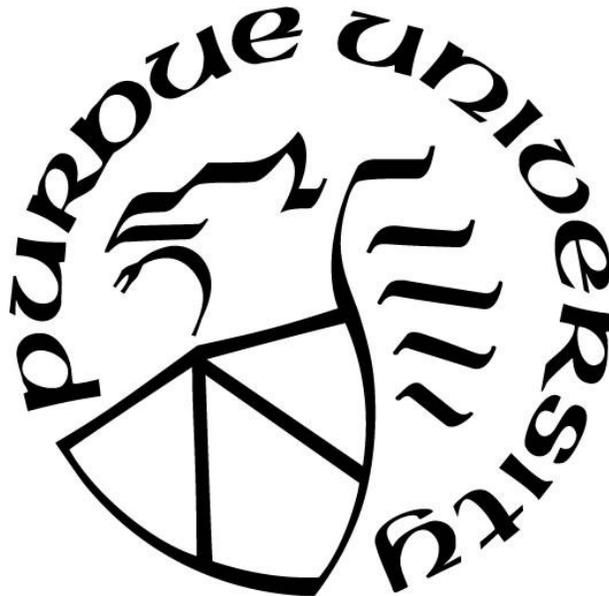
Olivia J. Schumacher

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THE PURDUE UNIVERSITY GRADUATE SCHOOL
STATEMENT OF COMMITTEE APPROVAL

Dr. Marcia D. Dixon, Chair
Department of Communication

Dr. Sarah S. LeBlanc
Department of Communication

Dr. Kerrie R. Fineran
Department of Professional Studies

Approved by:
Dr. Steven A. Carr

Commit. Persevere. Overcome.

Thank you to everyone who supported me on this journey: it's been one hell of a ride.

TABLE OF CONTENTS

ABSTRACT.....	6
LITERATURE REVIEW	7
Ch. 1 - My Narrative.....	7
The Night I Lost My Way – October 5, 2016.....	8
The Moment My Perception Changed – September 26, 2017.....	10
Adjusting Identity and Expectations.....	19
RATIONALE.....	21
Ch. 2 – A Brief History of Mental Health	22
Stigma Through the Ages	23
Illness as Entertainment.....	25
Progression of Diagnosis	27
Synopsis.....	28
Ch. 3 – Social Narrative.....	29
Entertainment.....	30
Social Media	33
Synopsis.....	35
Ch. 4 – Personal Narratives: The story we tell ourselves	37
Physiological Changes of Depression	37
Personal Narrative Explored.....	41
Synopsis.....	43
METHODS	45
Participants.....	45
Materials	46
RESULTS	49
DISCUSSION.....	53
Post Hoc.....	55
Limitations	57
Future Implications	57
CONCLUSION.....	59

APPENDIX A. SURVEYS.....	60
APPENDIX B. FULL T-TEST RESULTS	62
REFERENCES	63

ABSTRACT

Mental illness historically has had a stigma surrounding it. For years that was my understanding of mental illness as well. To be able to see mental illness and its treatments in a healthy way, I had to suffer a radical change to my life. The beginning of this paper is my story as to how I came to understand mental illness in a different light. Following that, Ch. 2 explores a brief history of mental illness and how it has been treated in society. Next, it delves into the current social narrative about mental health and what the entertainment industry is doing to either help or hurt the de-stigmatization. Lastly, the personal narrative is analyzed. The story an individual tells themselves is influenced by many different elements.

This is something on which more research needs to be done. Individual's perceptions about mental health impact their likelihood to seek help. To explore this, I surveyed 379 people to address their personal beliefs of mental illness. To analyze the data, I split the respondents into groups of those diagnosed and those that have not been diagnosed. Of the four hypotheses, only one group was supported. After that, I ran a post hoc analysis looking at perceived societal views and that came out much stronger. Additional research needs to be done on perceived societal views and how that impacts an individual's decision to express concerns or seek help for mental illness.

LITERATURE REVIEW

At first glance, the topics outlined here may seem unrelated. As we delve through layer by layer, I hope to show how an individual's understanding of the world can be interconnected with how they may perceive certain issues. Mental illness is an uncomfortable topic for many because they may be confronted with their personal biases and prejudices. Even though this topic is difficult, it needs to be discussed. The purpose of this thesis is to share my story about why I am passionate about mental illness, how history has formed our understanding of it, how society informs current perceptions of it, and finally, how an individual's personal narrative (the story we tell ourselves) influences the decisions surrounding it.

Ch. 1 - My Narrative

My journey of understanding depression, anxiety, personal narrative, and stigma started as a result of an event that I describe below. In fall 2016, my best friend and I survived a life altering car accident. The moment it happened; I knew our lives would never be the same. Intellectually, I understood the impact; however, the journey to accepting that I am now one of the statistics of mental illness has been, and continues to be, a difficult and eye-opening journey. Until 2016 depression and anxiety were issues with which "other people" dealt with but certainly not me. I figured I was immune as I observed friends and family members struggle with depression and/or anxiety. My "can-do" attitude would get me through any difficult situation that presented itself.

A twenty-one-year-old college senior, working two jobs to keep loans low and averaging a 3.8 GPA. Possessing strong perfectionist tendencies, I was – what felt like – suddenly being diagnosed with Major Depressive Disorder and Post Traumatic Stress Disorder (PTSD). Below is the story of my world being turned upside down and me coming face to face with my aversion to and biases about mental health.

The Night I Lost My Way – October 5, 2016

TRIGGER WARNING

BAM! Dazed. Confused. Scared. Responsible. I did this. But what is this? Is everyone OK? What happened? One second we're driving, and the next it feels like we hit a brick wall at fifty-five miles per hour. A horse? But in the road? That can't be right: I must be confused. I only glanced away from the road for a moment. I am starting to get my bearings, but it's so hard to make anything out in the darkness. There is no moon, and we are on a country road. My nostrils are assaulted with the mixed, pungent smells of airbag smoke, horse feces, and metallic, acrid blood. Oh God. Blood. Abby! Terror shoots through me as I look to my right. She hasn't made a sound. I am losing my bearings again; I know Abby isn't moving. My friend hasn't been making any noise. The damage to her body makes my stomach lurch. Her body is limp, her breathing labored and gurgling, and there is blood everywhere. So much blood. I reach out to touch her and a pain shoots through my hand, I ignore it and lightly touch her shoulder.

"Abby? ABBY?! Please say something to me...please! Abby, can you hear me? I need you to open your eyes. Abby!?"

*She's not responding. Panic is starting to take over. Get a hold of yourself, Olivia, I think. I just need something: please Abby, say something. I begin surveying her; the force of the impact has completely flattened her seat, so she is laying back. I can see a long, deep cut across her forehead where a lot of the blood is coming. I know logically that head wounds bleed more, but she is losing a **lot** of blood. The panic is setting. I try to straighten her out. But, from my seat behind the wheel and with my hand throbbing, I am unable to adjust her into a better position. I can hear my mother in my head, "Make sure her airway is clear, and her head and neck are stabilized."*

*I open my door and stumble out of the car, and I fall to the ground. "Fuck," I mumble as glass from the windshield is everywhere and dropping from my clothes. Disoriented, seeing stars, and shaking: the world is spinning. I sit in the middle of the road for a couple seconds trying to gain control of the dizziness. I **NEED** to check on Abby. I slowly stand up and start to walk around the front of the car. That is when the damage the horse had done really hit me. My rather small car barely resembled a vehicle at this point.*

The horse was so big that my hood was barely scratched. I guess I took it out at the legs. But the area that was supposed to protect the passengers was completely demolished. The roof of

my car was scrunched backwards over my back seat, perfectly folded like an accordion. The windshield – or what remained of it – is shattered across the front dash and sprayed across the car’s passengers. On Abby’s side of the car, the door frame was bent in, as most of the impact was on her side. Her airbag was popping out over the dash. A lot of good it did, I thought.

I glance behind the car to try and see the horse, but it is too far behind us and too dark. Reeling from the shock of the whole scene, my purpose to check on my friend rushes back to me. I gingerly open her door.

From this angle, the damage done to Abby’s motionless body seems even more ravaged by the impact than from the driver’s seat. I am trying to keep the panic at bay, but it is bubbling just underneath the surface, ready to overtake me at any moment. The overwhelming sense of responsibility is making it difficult to think clearly. I need to help her. I begin straightening her in the seat and adjusting her head, neck, and shoulders. I frantically search the car for something to stop the blood still flowing out of her forehead, but everything is covered in dust from the airbag and manure.

I can’t use any of this. It might lead to infection, I think.

I paw at the floor by Abby’s feet looking for our cellphones. Without the moon and what seemed like the darkest night, it was a futile attempt.

“Abby, if you can hear me, I need you to open your eyes. Abby, it’s Olivia. Do you know who I am? I need you to lay still, okay? I am going to go for help. If you keep squirming, you’ll get more hurt. Lay still.”

Pained noises and more gurgling. She wasn’t responding. I decide to run for help.

The house couldn’t have been more than 100 yards from the road, but it feels like minutes to reach the front door. The panic and terror of losing my friend is starting to rise in my throat threatening to choke me. I ring the doorbell. I feel guilty as I know they are probably sleeping but I need help. They come to the door, and I start talking. I am hoping I make sense...

“Please call the police! We hit a horse, and she’s hurt. The bleeding won’t stop, and we need help!” I frantically plead them to hurry! The poor woman is staring at me a little frightened...I had never stopped to consider in what condition I might look. I glance down and my bright blue sweatshirt is stained with dark red splotches of blood, my yoga pants have holes where the glass had been, and my face was smeared with a mixture of blood and horse poop. I attempt to slow down wishing they would register this information quicker and have a sense of

urgency. “Call 911, my friend is badly hurt and needs medical attention immediately!” The lady nods her head and walks away from the door. I stand there staring through the screen door, trying not to let the magnitude of what happened wash over me. It came more like a flood and had me on the ground again seeing stars. The dizziness was stronger this time, and I started uncontrollably shaking. This is not the time! I tell myself. Get it together and go back to the car and check on Abby!

I slowly stand up, hoping and praying the lady is calling the police, and sprint back to the car. Abby is still moaning and moving around unconscious of what was happening. “I’m here Abby, it’s Olivia. The police are coming, they are going to help. I need you to hold on. Can you do that? Please Abby, I need you to do that. Abby, do you know who I am? Can you open your eyes?” I keep asking her questions, knowing I won’t get a response. At some point I stopped asking them to her and started asking them for me. I will not give up. I hear sirens and see flashing lights: help is here. The panic, terror, guilt, and helplessness overtake me.

The night I lost my way.

The Moment My Perception Changed – September 26, 2017

I am sure by the scowl on my face the nurses can tell how happy I am to be sitting here. Mom and Dad have been telling me to do this for months, but there is NO WAY I am one of those people. The people who can’t handle being confronted with the hard stuff. It was a bad car accident.

SO WHAT!?

So what if I drink a little more now?

So what if I keep having the dreams?

They don’t affect them. It’s not like they were the ones in it. They are just a counselor and nurse. They don’t know shit.

I. AM. NOT. A. FUCKING. VICTIM. Are they the “victims?” No. Did it happen to them? No. So leave me alone. It’s almost been a year, and yet everyone still treats me differently (Goffman, 1963), more gingerly.

It’s infuriating.

Ever since last October, people walk on eggshells around me and act as though *I* am the weird one, the one with something wrong with them (Goffman, 1963). *Apparently, I have*

“changed” and need to get some “help.” Whatever that means. They can fuck off and mind their own damn business.

Rolling my eyes, I start to examine the room. It’s a typical small-town doctor’s office. Only about ten of those plastic pastel colored chairs for waiting patients. It smells of sterile, industrial grade cleaning supplies: it assaults my nostrils. My nose curls in disgust. *Another reason I hate doctors’ offices*, I think. They have toys for small children on a table in the corner. *I wonder when was the last time they cleaned those toys?* The thought grosses me out.

My thoughts drift again. My focus has been completely shot lately, but that cannot be due to the accident. It has to be the extra stress I’ve been under. Graduate school and instructing classes are way out of the realm of what I had done previously. But is the stress really that different? Since sophomore year in high school, I worked two jobs and went to school full time. I thrive on stress. I completed my best work when I was on the precipice of losing my mind.

Can a car accident really affect you that much?

Abby’s mutilated face flashes through my mind. I suppose it could. But admitting to that would mean that I am...

A voice breaks through my thoughts, “Olivia!” The nurse calls my name and I pull myself back to reality. The crowd in the waiting room has grown. As I look and nod to the nurse, I notice an Amish family arrived while I was caught up in my thoughts. A flash of resentment courses through me. My stomach drops as I clench my jaw. It feels like my heart goes cold. The intensity of my reaction surprises me as goosebumps cover the exposed parts of my arms.

If it wasn’t for an Amish family, I wouldn’t be here.

If it wasn’t for an Amish family, I could be producing good work.

If it wasn’t for an Amish family, Abby and I would still be friends.

My heart becomes heavy, and a burden like bricks sits on my shoulders. The sadness washes in and replaces the resentment. The bitterness towards the anonymous family is almost tangible on my tongue.

When did I become this bitter person? This is new.

My new, constant friend, exhaustion, is back. It makes moving feel like a monumental task. I put on a brave face and a fake smile and use all my might to rise from the blue pastel chair. Little do I know, that the decision to follow the nurse into the exam room is going to change my life forever.

I approach and greet the nurse, following her through the door into the belly of the office. *No escaping now.* She pauses next to exam room #2 and motions me in. Despite being distracted, a hangover of sorts from my waiting room zoning out, I noticed that she was a small woman with greying hair. Her light grey scrubs made her blue eyes look like a smoky blue rather than a bright blue. I sit in the chair next to the computer because I was not going to sit on the bed like a sick person.

The nurse double checks my information and proceeds to ask the question I have been dreading since making this appointment. She asks me why I scheduled an appointment. I hesitate. Does she want my answer or what my parents want me to give?

“Umm, I guess this is a follow up appointment from my car accident” I stammer. “My parents told me I needed to check in because I have been having trouble concentrating and don’t have any motivation for school. You see, I am a full-time grad student and a college instructor. I’ve never had issues handling stress, but recently I can’t seem to get control over it.” I can feel my expression starting to look pitiful. The smile I placed on my face earlier is waning. My eyes can’t conceal the fatigue and slight panic I am feeling. I try to smile at her, but it doesn’t reach my eyes. The exhaustion is creeping up on me again. This time it is beyond my body: my soul felt tired.

How I wish I could just be in my bed hidden from the world right now.

“I am not sure what is going on.” I start to slump in the chair, as the mental and emotional exhaustion drains what little strength I have left. The words flow out of me like a faucet that won’t shut off. “I don’t think I have been sleeping well, my weight gain is out of control, and I crave junk food. I seem to be anxious. Well, I think that’s what you would call it. I’ve never really struggled with that before and can’t be sure that’s what it is. It’s all new to me and seems to be getting in the way. I am just so frustrated I can’t get over this. I should be able to make myself get over this.” I look at her with equal parts pleading and indignation in my eyes.

She nods her head and types along as I share. I trail off becoming conscious of how much she is typing. This is not good. If she is typing so much, I must be saying “trigger” words. *Why is she typing so much? I can’t be the worst person she has seen.* Did what I say just give her ammunition to see me differently? This is why I didn’t want to share what was going on in my mind. She now has a compassionate look in her eye that tells me she has made a decision to feel pity. I internally recoil at the idea. I don’t want her pity: I want to be able to work again. Broken

people get pity. Broken people get treated in a special way, like they have a bubble of stigma surrounding them we don't want to break. I. Am. Not. Broken. I am not in a bubble; I do not need to be treated delicately.

“Okay,” she says briskly, “I am going to go let the doctor know you are ready, and he will be in shortly.” I nod my head, not trusting my voice. Letting my eyes drift over the posters on the wall, a thought strikes me. *It would be easier if these issues were physical. I could get the bone set and move on, not have this cloud of uncertainty consume me.* The walls are beige with anatomical posters plastered up: one of muscles and one of a skeleton. *They say to break a femur is the worst physical pain a human can experience...But physical pain you can take medicine for. What about pain you can't quite identify? This is such bullshit. I'm sure the doctor will tell me I'm fine.* My gaze moves to the pamphlets next to the computer, they ask, “Have you gotten your flu shot?” *I have bigger problems than that. I am not worried about the flu. I am worried that I may never be the same person again* (Goffman, 1963). I get lost in my thoughts. Sometime during the five-minute wait for the doctor, my foot starts shaking.

Shake shake shake.

It starts as a little bobbing of my foot and slowly grows to aggressively shaking my whole leg. I sit and stare at my foot, consciously trying to stop it. *Stop shaking.* It won't stop shaking. *Stupid nerves.*

As I start to think about what the doctor has to say, my chest begins to tighten, producing shallow breaths. My heart rate increases. *No! I am not letting this happen here.* Before the car accident, I had never experienced a panic attack. I do almost anything I can to stop it from happening. I desperately search the room, hoping for something, anything, to distract me from the anxiety and panic swelling within me. Over the last year, the random onsets of panic began to grow into more consistent occurrences.

Shake shake shake.

Mom and Dad are convinced I have PTSD. *With Mom's trauma nurse background and Dad's counselor background, you'd think I would listen.* I roll my eyes thinking of how they are constantly trying to point out symptoms of PTSD I “apparently” present every day.

Me: “I didn't sleep very well last night.”

Dad: “PTSD can affect your sleep patterns. You become hypervigilant.”

Me: “I can't seem to find the energy to get my school-work done.”

Mom: “Depression is a huge indicator of PTSD.”

Me: “Man, I have gained a lot of weight lately.”

Dad: “Significant changes in weight can be a symptom of PTSD.”

Me: “I don’t want to go to that event. People try to talk to me, and I become so anxious. It makes me want to crawl under a rock and hide.”

Mom: “Social anxiety and avoidance of people who knew you before the accident can be indicators of PTSD.”

Every time they bring this up, I shut down. I am so sick of hearing how the accident has affected me. *I AM MORE THAN THE ACCIDENT!* The anxiety I feel with interacting with people is because they see me differently (Goffman, 1963). The stigma of trauma follows me like a foul stench... Well, that’s how it feels anyways. Dad got so upset one day when I began to walk away from the conversation. He said “Fine, if you don’t want to listen to your mother and me, I want you to go through the diagnosis of PTSD yourself.” He sat a laptop in front of me. A webpage sat open; it was the DSM-V page for PTSD. I shot a glare at my Dad and sat down to look at the page. “Fine,” I said. “I will do this, but that does not mean *anything!*” As I begin to scroll through the checklist my heart starts to quicken. My face is still stony. I am not going to show him any weakness. He wants me to “diagnose” myself. *I may have marked most of the symptoms. But until a doctor tells me I have a problem; I am just going to ignore it.*

Shake shake shake.

Just thinking of that conversation annoys me. Rolling my eyes, I let them drift through the room. *I am not someone who suffers from PTSD or depression. The mere notion is ridiculous and unfounded.* My foot bounces. *People like me do not get things like that. That is for the weak, and I am NOT weak. Get your shit together, Olivia!*

I jump at a quick rap on the door. I hear my Dad’s voice, “Hypervigilance is a symptom of PTSD.” *Whatever. I just need to stop getting lost in my thoughts.* My already quick heartbeat picks up the pace. This was it: the moment I’d been avoiding. The doctor enters the room. He is an older man, upper sixties, has a kind face that seems to look beyond the fake smile plastered on my face. Sitting across from me he asks, “So, the nurse says you’ve been experiencing some concentration and sleeping issues. Can you elaborate?”

The part I have been dreading was here. *What really is the definition of an “issue?” That’s totally subjective. It’s more of an annoyance.* “Over the last few months I’ve increasingly

been experiencing trouble sleeping. I am exhausted all the time and can sometimes take naps during the day. When it comes to sleeping at night, I can't seem to get comfortable or shut my brain off."

Shake shake shake.

My foot won't stop. *You traitor*, I think to my foot.

"Have you always struggled with getting to sleep or staying asleep?" He inquires.

I chuckle, "No! I love sleeping. I would sleep like a rock. Never really dreaming, I would fall asleep easily and feel rested when I got up. Now I'm lucky if I can even get out of bed in the morning." My mask starts to slip, and my face falls. In that moment, I feel like a helpless child hoping an adult can just fix whatever is going on. *I just want help*. I barely finish that thought before another one roars; *WE CAN DO THIS ALONE!* The warring thoughts make me lose concentration on the performance of being "okay," and I feel my despair and frustration showing on my face. I shift my eyes downward. I don't want this kind doctor to see the battling thoughts on my face. Being proud and hurt do not make finding help easy.

Checking myself, I put on a neutral expression. Even though I am tired of living in a constant state of exhaustion and slight panic yet lethargy, other people do not need to know that. He may be my doctor, but weakness is not something I show. A person with these issues has a black mark against them; a flaw that runs through the very fabric of who they are as a person (Goffman, 1963).

He looks at me, the wheels in his head turning. "Okay, now what do you mean by 'concentration issues'?"

By now my whole leg is shaking. "Honestly, this is more concerning to me than the sleeping issues." The words start gushing out. My voice raising a few notches edging into a slight panic and desperation. "All throughout my undergrad degree, I worked two jobs and was a straight-A student. Now I can barely write a single page reflection on an article we read. Come to think of it, I can barely get through the article! I know grad school is different and teaching is definitely a huge learning curve, but I feel like I am falling behind, And it's only four weeks into the semester! It worries me." My pleading eyes secretly asking for his help. *I...I just can't ask. Please hear me. Listen beyond my words.*

Shake shake shake.

“I can get up and go to class – both the classes I teach and the classes I take. But, when it comes to doing anything for either of those things outside of the classroom, I can’t find it in me to work. I lay on the couch watching Netflix and binge eating.”

“Are these new habits then?” he inquires.

Grimacing I say, “I didn’t have the best eating habits before, but now I seem to only crave junk food. I don’t have the energy to cook or ‘be healthy.’ I just do whatever is most convenient. Which since I work at a restaurant, it tends to be wings, French fries, sandwiches, or something like that. I get off work usually at 9pm and go home and eat, watch some TV, and try and get some sleep.”

Nodding his head, “And have you seen an increase in weight?”

“Yes!” The sound of the word clearly showing how annoyed I am with the fact that this THING has caused me to put on weight. “Almost thirty-five pounds. I know my eating and not working out is the reason, but I just don’t have the motivation to do it.”

Shake shake shake.

“I usually have the ability to just make myself do the things I know I should. It makes my anxiety worse because it feels like I don’t even know myself anymore. It’s really frustrating. I feel like I am going crazy. I don’t like this new person.”

He takes a moment and makes some more notes in my chart.

Shake shake shake.

Putting his pen down he looks at me. “I have an idea of what might be going on, but I want to ask a couple more questions to double check.” My anxiety at its peak, I am ready for any kind of relief he might be able to give. Still cautious I nod my head.

“Have you been experiencing strong negative emotions lately?”

“Honestly, I have always been angry when driving but definitely more so lately. I’m easily irritated with my family, especially when they bug me about anything concerning the accident or ‘getting help.’ It’s been almost a year. I’m fine.”

Nodding, he fires another question, “Have you been experiencing difficulty or strain in your relationships?”

My mind instantly brings up comments my family have made over the last week that stuck with me. *Apparently, I am really am different.*

Josiah (my little brother): “Olivia, sometimes it’s hard for me to be around you right now. You only listen to sad music. Plus, you don’t really talk to me anymore.”

Mom: “I just want you to share more with me – her eye welling up – You seem like you’ve closed yourself off to us. We want to help.”

Dad (the counselor): “You are starting to abuse your vices. You need help. You have PTSD. It is only going to get worse. How many times have you gone out this week? Go through these criteria and tell me you do not fit the diagnosis.”

“Well, they are constantly telling me I’ve changed. It’s irritating, which makes me want to spend less time with them. No one wants to spend time with people who keep telling you to get help for your ‘anxiety’ and sleep issues. I should decide when it’s an issue. I am here to get my parents off my back.” Putting my brave face back on, I close off the emotion in my eyes and sit back in my chair. Defense. I wrap it around me like a blanket. In the back of my mind, a fear of what the doctor’s diagnosis will be keeps increasing as the appointment drags on. *He’s going to tell you you are broken, weak, and a failure* (Goffman, 1963).

Shake shake shake.

In all honesty, the total time is probably 10-15 minutes, but it feels like hours. Trying to rein in the erratic movements of my foot and keeping my facial expressions calm are draining me.

I. Am. Not. Broken.

The doctor looks at me and pauses, contemplating how to give me his thoughts. “From what you have told me, I am going to prescribe an antidepressant and refer you to counseling. The medicine will help you to concentrate and reduce your stress and anxiety.”

“Okay, so what is the counseling supposed to help with?” My skepticism and annoyance quite apparent.

He takes a breath and says “My final diagnosis for you is PTSD. The depression and anxiety are symptoms of it. The counseling will help you process the trauma of what happened.”

He keeps talking, but it starts to fade away.

PTSD? Depression? Trauma? How can this be? It was only a car accident. Granted, a horrific car accident, but a car accident, nonetheless. I thought PTSD was something that happened to people who have been through war or sexual abuse or appalling torture or even a

natural disaster. But a car accident? No, he must have this wrong. This is something that happens to other people. Not me.

Sitting there in a slight trance, I notice him pull a pamphlet from behind the flu ones. “Here are some local counseling centers if you want to look through this.”

I gingerly take the pamphlet as if it is a poisonous snake.

He stands and says the nurse will be right back in. *So what now? Am I just supposed to take some pills and talk to someone, and everything will be magically better?* My body feels numb. For the first time since I have come into the doctor’s office, my foot is still.

The nurse returns with a small packet of papers and hands them to me. “These two on top are about Major Depressive Disorder, the middle one is over PTSD, and the last is a description of your medication. If you ever have any questions about any of this, please feel free to call us.”

I just nod my head, not trusting my voice. My head is in a fog of disbelief.

Well fuck. I guess they were right. I am broken.

I stand and follow the nice nurse with smoky blue eyes out of the exam room.

September 29, 2017.

The day I lost my sense of self. The day I no longer knew who I was.

Mental illness? Diagnosis? Medication? Counseling? If those did not describe a broken, weak, damaged, unstable person, I don’t know what would (Goffman, 1963).

It felt like an out of body experience. Everything I understood and have learned of mental illness, depression, PTSD, antidepressants, and therapy started crowding my brain. *People will think I am broken. People won’t respect me after they find out* (Goffman, 1963). *But, I’m not suicidal or weak, I’m just tired of trying.*

I am drowning in uncertainty, fear, and the intrusive thoughts come one after another. As I walk out of the office, the realization hit me like a mac truck. I stop walking.

I am never going to be the same person.

In just a fifteen-minute doctor’s visit, my sense of self and understanding of who I am is totally shattered.

If I am not the person I knew, then who am I?

Adjusting Identity and Expectations

Depression manifests itself in many different ways. For some, it is a sudden loss of motivation, a dark cloud hanging over them, a slow creeping fog undetected for months, or an event that sparks the change in their mind (Harvinder, 2017). Like the latter, my depression had a catalyst. I was diagnosed with Post-Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (DSM 5, 2013), altering the notion of my identity from someone who was mentally resilient to someone who was not. My understanding of resilience was the ability to bounce back during hard times, like a rubber band. But suddenly, I felt as if I had snapped and knew nothing about how to cope. Adler (2012) discussed how during times of change – especially traumatic change – a person has to go through a process of “connecting the self from before the change to the self after the change” (p.369). For the year or so after my car accident, I could not reconcile who I was with who I had become. If anyone heard my story, what would they assume of me without meeting me? Knowing someone has gone through trauma affects their impression of that person (Horan, et al., 2009). I did not believe *anyone* should be privy to that information.

The slow onset of my mental illnesses was partly why the acceptance of my diagnosis was so difficult. I was experiencing extremely high levels of anxiety but nothing I could not handle. It was the realization of my personal bias and stigmatization of depression for which I was not prepared. Unbeknownst to me, I held deep seated prejudices about depression and the “type” of person who struggled with it. Goffman (1963) discussed how a person with an ailment of some kind (physical or other) becomes a discredited person in the sight of society. They no longer serve as part of the community because of the discomfort they bring to others. I believed that I had become a discreditable person: someone who’s ailment is not yet known. When people found out about my diagnosis, I would become “less than” in their eyes and would have to navigate social uncertainty (Goffman, 1963). I refused to tell people what had happen because I did not want to become a victim in their eyes. By admitting to a struggle, I automatically became a fragile/sick person to them (Horan, et al., 2009). The more difficult aspect was, if I admitted to them that I was hurting, then I had to admit it to myself.

The experience dealing with the acceptance of my mental illness and how I had to tease-out all of the perceptions I had about depression and the labels (stigmatization, biases, self-perception, and perfectionism) continues to be overwhelmingly difficult.

Why did I wait so long before seeking help for this crippling mental block?

Why did I believe the social stigma of depression, antidepressants, and counseling?

Why was I so afraid of what others would think about me?

How would people view me differently now that I became an “other?”

RATIONALE

I grew up with a nurse as a mother and a counselor as a father, yet I was so disgusted by the thought of suffering from (let alone being diagnosed with) a mental illness. Knowing the information was not enough for me to act on my struggles. It took addressing my own biases towards mental illness, diagnosis, medication, and counseling to be able to take the next step. Even though I was exposed to these ideas from a young age, the application was something I missed. There was a disconnect from intellectually understanding something and experiencing an application of it in your own life. This was what was missing for me when I wrestled with PTSD.

This was concerning considering I was exposed to it in a healthy way for years yet could not come to terms with being the “ill” person. Understanding other peoples’ perspective on mental health was extremely relevant. With the current state of the world (COVID-19 pandemic), there has been a major uptick in mental health issues in individuals since they have been isolated for weeks or months by themselves. Humans are social beings and crave interaction. Why else is it that isolation is used as a punishment in prisons and a torture technique? This pandemic is creating a situation of extreme isolation of individuals, which can have a direct impact on mental health (Kato, Sartorius, & Shinfuku. 2020). This is not just an issue that the United States will face, but the world. Gaebal and Stricker (2020) discussed how the United Nations is preparing for this global pandemic to turn into a global mental health crisis. The understanding of medicine, and mental health medicine specifically, is going to come under heavy scrutiny as ways to handle this possible crisis are challenged.

E-mental health is difficult as a major stigma still surrounds mental illness. However, understanding someone’s attitudes towards it can help us figure out what approach is needed to help. A moment’s hesitation can be enough for a person to convince themselves they are alright. I did it for almost a year after the accident. The hesitancy many people experience can impact their decision and likelihood to seek help. A person’s attitudes towards/about mental health can feed from subconscious ideas and beliefs about such. Often, people do not have the words to articulate how they feel or the rationale for why they believe something. This study is a tool to help us learn an individual’s concerns, struggles, obstacles, and stigmas surrounding mental health without vilifying them. It is a tool to start a conversation and explore ideas.

My experiences have given me a passion for exploring how to change the discourse of depression. As Ferreri, Scott, Einstein, and Ciarrochi (2018) point out, it is a massive problem many individuals refuse to acknowledge. Sharing my experience can help others become introspective and realize the toll these compounding emotions can take on a person. This story might help someone challenge the social construction of mental illness and the control these thought processes have on an individual. Seeking help took much longer than it should have because I bought into how society viewed mental illness. I had been conditioned to see it as a weakness, as a broken part of me, as a failing of character, something I had no control over.

This paper will explore three different aspects of mental health that are interdependent. The first area we will explore is a brief history of mental health and how it has been treated throughout the years. Cultures have approached the mentally ill differently for centuries. This could be by locking them up, kicking them out of the community, or treating them like animals. The next idea we will address is the social narrative of mental health: what type of entertainment we are consuming, and the messages of mental health are being depicted. Movies have fully embraced the idea of mentally ill characters to create drama (i.e. Joker – 2019, Fight Club – 1999, Rain Man – 1988, Black Swan – 2010). But, what messages do they send to our society? Finally, we will explore the personal narrative of mental health. Individuals have certain beliefs they hold about mental health based, in part, on society's treatment and the current social narrative about mental health. This personal narrative can impact whether they get help or not. The obstacle in their mind might be the biggest deterrent for seeking help than anything else. With an understanding of the history and social narrative about mental health, we will explore the literature and (via survey) the personal narrative and its impact on people's mental health.

Ch. 2 – A Brief History of Mental Health

Mental illness has been around for centuries, but how it has been treated has altered. To have a better understanding of how mental health is viewed by society today, the history of mental health needs to be unpacked first. Gaining a better understanding of how mental illnesses have been consistently stigmatized throughout the ages will help clarify why this research needs to be done. While there is a greater understanding of mental illness than before, it still holds a great deal of stigma for some individuals. This stigma did not develop suddenly but has been cultivated through the centuries as depicted below in a brief history of mental health.

Stigma Through the Ages

For centuries the people deemed “less than” in society have been pushed aside and removed from society. Stigma is an abstract idea that helps separate groups of people from being “normal” to being “discredited” (Goffman, 1963). Stigma is broken up into three areas: physical (abominations of the body), character (mental disorder, homosexuality, felon, etc.), and tribal (generational issues, family, religion, race, etc.) (Goffman, 1963; Meisenbach, 2010). Goffman (1963) explores the idea that individuals who do not fit the normative expectation have been ostracized from society and dehumanized. Through dehumanizing society justifies their treatment of people who have perceived flaws. Society rationalizes their inferiority and creates a macabre narrative to diminish their human value. Once someone is dehumanized, the rationalization of treating them disparagingly is an easy leap. They are not “normal” which makes them less than me, therefore, I treat them in such a way. Stigma infiltrates the mind in a way that seems effortless. The steps we take to rationalize harmful behavior are much easier to fall down than most people think.

Society has a contentious view towards people with any type of perceived stigma. Individuals with character blemishes, physical aberrations, or stigma passed down through generations (Goffman, 1963) have always been treated differently. “Normals” react to the stigmatized in an unnerved way because there is no precedent for how to interact with them (Goffman, 1963). For centuries, societies have encouraged groups to remove “marked” individuals from communities as punishment for straying from normative behavior (Smith, 2007). People are scared of the unknown and “different,” which leads to hiding the source of the shame: the broken and decrepit (Jones, 1972). Meisenbach (2010) discusses how drawing “distinctions between insiders and outsiders” is how society creates “solidarity” and community. Utilizing stigma as a tool for highlighting differences perpetuates the dehumanizing approach (Goffman, 1963; Meisenbach, 2010). Even to this day, physical ailments prevail over mental health issues. For society to view an individual’s plight as “valid,” not his/her own fault, the physical proof has to be apparent for confirmation (Goffman, 1963). Where a person with an invisible illness usually has to disclose their ailments, people with visible disabilities do not have such a luxury. People with visible disabilities are continuously at risk of losing face and being stigmatized (Phemister & Crewe, 2004). However, stigma spans more than just the physical realm.

If someone admits to mental health concerns, many people exhibit avoidance and discomfort in addressing it (Goffman, 1963; Larson, 2018). Larson (2018) pointed out that America is a society of quick fixes and avoidance of discomfort. When an individual presents a physical ailment, the “normals” create assumptions about how to appropriately interact with that person (Goffman, 1963). If there is a blind man, a normal may feel inclined to help lead them somewhere; but, Goffman (1963) observed that, with unseen illnesses, “normals” and stigmatized alike are likely to avoid interactions because of how uncomfortable uncertainty is.

Human behavior has consistently incorporated some type of normal and then some type of “other.” Whether that individual had a physical aberration or a mental illness it was enough to signal their “otherness.” Throughout the centuries, humans understanding of psychology, behavior, and communication have adapted and grown with technology. This idea of “madness” has had many different definitions throughout history, from biblical times to ancient Greece to the Middle Ages (Eghigian, 2017). Each era had a certain set of criteria that constituted someone as “mad.” Madness was many times categorized as someone who was unstable and presented a certain level of lunacy (Eghigian, 2017). While this may be the case, even before humans had specific definitions for what was going on with them, they create barriers and separated themselves from the “others.” Examples can be found woven through history books and religious artifacts alike.

A famous biblical example of madness was King Nebuchadnezzar. Vartejanu-Joubert (2017) described this descension into madness as a loss of “judgment and discernment.” The bible continues on to say his mind became like an animal state: man transformed into a beast (Vartejanu-Joubert, 2017). You can find examples of madness in Ancient Rome and Greece. Ancient healers would assign certain mental illnesses due to the type of physical manifestations presented. In the Graeco-Roman era, many believed that madness was tied to the spiritual and was a manifestation of sin or an offended god (Thumigar, 2017). However, if you were a woman in this time, madness came because of the sexual frustrations and the “uterine melancholy” (Tasca, Rapetti, Carta, & Fadda, 2012). This is the era that emphasized bodily symptoms which still impacts our approach today (Thumigar, 2017). The first legal protections for “mad” people did not come until 1845 when the Lunatics Act was passed. This allowed a group of men to inspect asylums and hospitals to make sure they were caring for the patients properly (Jones, 1972). The commissioners were to make sure the hospitals and asylums were following proper

legal and medical care of patients. Under the Lunatics Act a hospital or asylum was mandated to have a certification to be allowed to house patients (Jones, 1972). Defining a lunatic was done with a broad brush, they were people who were “idiots or person of unsound mind” (Jones, 1972). With the licensing and certificates becoming more detailed and harder to procure, the people in charge had to come up with creative ways to pay the bills.

While biblical and Graeco-Roman times were touched on, the next example jumps to the 20th century. In the 20th century, there were more resources for doctors to communicate and share ideas about illnesses and remedies. However, this impacted the minority population as the doctors argued that their treatment should be different (Swartz, 2017). Mental health issues were still being “addressed,” but it was done with an ethnopsychiatric approach. Meaning, the doctors would treat each group differently based on their ethnicity (Swartz, 2017).

Illness as Entertainment

As societies progressed, so did their need for entertainment. The Romans had the coliseum, the French mademoiselle guillotine, and early 20th century North Americas asylums and prisons. As discussed above, an innate attraction is held for the macabre. It pendulums from haunted houses and circuses to making the mentally ill the center of entertainment. This chapter outlines how the use of mentally ill individuals for entertainment grew and is still a tactic employed today.

Before public asylums were built, families would deal with their “troubled” family members privately; or, if they had money, they would put them into a private hospital (Luchins, 1988). Besides the wealthy and royalty, very little is known about how communities cared for their insane (Grob, 2008). The first recorded mental health institution in the United States was the Eastern State Hospital in Williamsburg, VA (N.A. 2020). According to their website, it was created with the sole intent of treating those struggling with mental illnesses. The growth of towns and cities forced states to create more accommodation for the sick, both physically and mentally (Grob, 2008). When public institutions were constructed, they quickly became overcrowded with patients and pressured to accept more without the room for them (Luchins, 1988). In the 1840’s, states were compelled to build asylums for the poor after a series of essays written by Dorthea Dix (Luchins, 1988). She was an integral part in making mental health a concern at the legislative level. Dix depicted that hospitals were not equipped well enough to

handle these types of patients, and jails made them homicidal, suicidal, and destructive (Luchins, 1988). According to Luchins (1988), because the facilities were overcrowded the staff quickly became overwhelmed and understaffed. The understaffing became an immense issue as patients started slipping through the cracks due to staff being underpaid, working long hours, and having exhausting tasks (Luchin, 1988). Larson (2018) described a situation in 1943 where a patient was unsupervised and went into the kitchen to put rat poison in the scrambled eggs, which ended up killing forty-seven people. In 1948, Albert Deutsch cataloged the horrors that took place in the state hospitals and institutions in his book, *The Shame of the States* (Larson, 2018). With the financial hit of the Great Depression, Deutsch documented the “overcrowding, beatings, and a near absence of rehabilitative therapy” (Larson, 2018, p. 10). To help curb the struggles of being underfunded, the state hospitals and institutions explored different options for getting funding. Hospitals used society’s fascination with the “other” to start raising those funds.

Humans have always been attracted to the macabre and this was no different: come see the mad women and murderer (Rothman, 2013). The allure of the macabre can be seen throughout history: ancient Rome and the Coliseum, public executions and punishments, traveling circus of “freaks.” The curiosity and allure with the bizarre have always been there. As mental institutions grew, so did the fascination with them. Entertainment was limited in the early twentieth century, and freak shows and circuses did not circulate that often. So, they needed to find entertainment elsewhere. Visitors to asylums varied by motivation: a patient’s family member, a member of the clergy, and visitors from the general public (Mooney & Reinartz, 2009). Now, it was not always to walk through and view the patients, but it was a way to keep the public entertained and the institutions with donors. Patients of asylums were reduced to nothing more than props for entertainment, animals in cages. To create the personal experience in these institutions, the owners began to sell entrance tickets as if to a zoo or circus (Rothman, 2013). While the institutions might not have viewed it in this context, it was a way to make money and increase donations. It was considered “sport for the idle visitant” (Mooney & Reinartz, 2009).

As popularity of asylums and hospitals grew, so did the cost of maintaining them. The budgets of hospitals became excessive while patient care diminished and caused hundreds to die (Larson, 2018). To combat this financial struggle, the hospitals decided to open their doors to the public and sell tickets to observe patients just as the asylums did (Rothman, 2013). Putting the

mentally ill (insane and criminals) on parade to show how fragmented they were heightened the stigma surrounding the “insane” and different.

Being able to see deviant behavior was a spectacle and exciting, outside the ordinary (Rothman, 2013). For decades public punishment of criminals and the insane had brought crowds to watch the ostracization and public marking (Smith, 2007), which discredits them and stigmatizes them (Goffman, 1963). By discrediting a person, the public (or “normals”) are “justified” in their negative treatment of the “other.” The normals can separate themselves from the ostracized and feel superior to the other person. Throughout history humans categorized each other and labeled what is appropriate/decent to what is unacceptable/offensive.

Progression of Diagnosis

This next section will explore how the diagnostic understanding of mental illness has had to adjust according to new findings. The scientific understanding of mental health is far more positive than the societal perception of it. Society has grown in the understanding of such ailments, and so has the way we diagnose and treat them. As discussed above, mental illness was tied to a religious transgression and not a mental or physiological problem. The history of “cures” is not a positive one. It has “targeted specific populations such as immigrants, people of color, the poor, unmarried mothers, and the disable[d]” (Larson, 2018, p. 60). Cures in history have come in the form of eugenics, forced sterilization, electroshock therapy, and lobotomies (Larson, 2018). In the following section, it will show how the diagnostic tools used morphed as scientific understanding of mental health grew as well. It was not just a person suffering a tremendous loss, grief, or traumatic experience: it was also the everyday person.

One of the difficulties mental health professionals face is a misapplication of information. Some individuals may not understand the process of diagnosing. It is a process that is used to describe *what* is happening, not *why* it is happening. Diagnosis in and of itself is a clinical process. According to the Mayo Clinic Staff (2019), doctors follow similar steps of diagnosis. Most will begin with ruling out any physical reasons for symptoms showing up. This could include a physical and lab tests (checking hormone levels, etc.). Next, they would do a psychological evaluation. Here they would document any of the “symptoms, thoughts, feelings, and behavior patterns” that one is experiencing (Mayo Clinic Staff, 2019). After cataloging the

symptoms, they would then consult the DSM-V, which is the manual used by professionals to diagnose mental illness.

According to the American Psychiatric Association (APA), the need for mental health classification has been around since the start of medicine. The *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* (DSM-V) (2013) is the most accepted way of diagnosing and defining mental illnesses in America. The DSM-V was first created by the American Psychiatric Association in 1952 (Suris, Holliday, & North, 2016). According to the American Psychiatric Association website, the first version was short lived as the landscape of mental illness rapidly changed and evolved. APA published a second version shortly before World War II. But, as soldiers started to come home and more issues started to become evident, updates needed to be made. As most of these issues were being presented by the soldiers, the United States Army started to develop classifications for their servicemen and veterans. The DSM III-R (1987) had a short life span as more resources were used to research mental illnesses and classifications of such. In 1994 the DSM-IV was published. While this was used until 2013 (when the DSM-5 was published), the APA started working on the DSM-5 in 2000. Kendler (2013) discussed why it took almost 13 years to publish the new version, including that the authors had to overcome obstacles such as new categorization of illnesses and how to assess them. The DSM-5 was not published until 2013 because the APA wanted feedback on where the gaps in research were to revise those areas to better fit the rapidly changing mental health discipline.

Synopsis

Sometimes it feels ill-fated that society will have a negative view of mental health. It has been something that have been ridiculed and shoved to the fringes for centuries. Societal view of mental illness has been informed by religions, entertainment, and misunderstanding (and lack of knowledge) of a complex matter. This chapter covered how mental illness has been discussed for centuries from biblical times to Graeco-Roman to the twentieth century. Each group thought they understood the ailments better than the last; but, until modern medicine, there had only been supernatural explanations.

Often with things humans do not understand, we make it into a show. There is a history of making the macabre into a spectacle to behold. Mental illness was used as a source for entertainment whether in freak shows, circuses, or asylums that used tours as a source of

donations. Society has been making a profit off of the “weird” or “different” for ages. Slowly but surely, there has been a push for a better understanding of what makes “those people” so different. As medical practices modernized, a manual on how to address mental issues was created. The versions of the *Diagnostic and Statistical Manual of Mental Disorders* has gone through multiple revisions as the understanding of these diseases grow. While great progress is being made on how to diagnose and treat mental illnesses, there is still room to advance.

The next chapter deeper explores the social narrative and how society influences the understanding and interpretation of mental illness. Although our academic understanding of mental health may transform quickly, the societal understanding takes much longer to adjust. This change is much harder and more in-depth because our perspective begins forming as young children.

Ch. 3 – Social Narrative

To better understand how society influences an individual’s perception of a topic, this chapter is going to first define and discuss what a narrative is, then examine how narratives are used within films and social media platforms. The social narrative shifts and morphs; but, before exploring that, a definition of “narrative” is needed.

To understand the progression of narratives, we first have to understand what a narrative is. A narrative is how humans pass along events or beliefs in oral or written fashion (Fisher, 1985; Krebs, Jones, Aronoff & Shenhav, 2017). Some make the definition even simpler and define a narrative as a “representation of a course of events” (Krebs, Jones, Aronoff & Shenhav, 2017). Taking that definition, a social narrative is the way in which society represents and describes a course of events. It is the story we are told about how events transpired. As Fisher (1985) describes there is no jurisdiction over a narrative. No one person knows everything and therefore cannot reside over the narrative. While this may be, society has a way of creating the “group” narrative, the one consistently told. Societal narratives are told in a cyclical way until the story becomes “common sense” for society (Krebs, Jones, Aronoff & Shenhav, 2017). Narrative Sense Making is a growing field within the Communication Discipline. Many are hesitant to call it a theory as it is more of an approach. Even though there is conflict in the academic definition of Narratives, it is undeniable that people (and society as a collective) use them on a daily basis. Narratives are how “people build and communicate their relationships,

cultures, and identities, in part by story-telling” (Koenig Kellas, 2016, p. 253). It is a basic human need for connection. The way those connections are formed is by summarizing and organizing life events into manageable, conveyable stories (Koenig Kellas, 2010; Koenig Kellas, 2016).

Narratives are how we make sense of the world around us. Mechling (1991) described this phenomenon extremely well as “narratives are emergent, contingent, public, and contested; they reflect interests (such as class, gender, race, age) and [this makes them] ideological and political, even when they seem not to be” (p. 43). Humans are social beings and learn from social interactions. Academics make looking for narratives seem difficult; however, in reality, the way we view most aspects of life are because of the narratives we were taught as children. How did parents discuss (or not discuss) relationships, family, health, religion, hardships, self-efficacy, holidays? The stories parents tell create a narrative for how children start to perceive the world. Even the narratives they do not talk about create an understanding of that topic. The lack of a narrative is a narrative in and of itself. Children develop understanding of attitudes (positive and negative), hope, and despair through how parents interact with them on a daily basis (Koenig Kellas, 2010). The way a child is taught to understand and approach narratives helps to form their perception of society: it is one of the first forms of socialization a child has. These “family stories teach lessons about rules, rituals, and values inside and outside of the family” (Koenig Kellas, 2016, p. 255). The narratives a child is taught can create their first understanding of self-perception.

My family loves and values me therefore I am valuable.

My family told me I was not wanted therefore no one will want me.

My family told me to stop eating so much therefore I must be fat.

These thoughts are construed to the child by the narrative the parents tell them. They base their understanding of themselves off of what has been told to them, not necessarily reality. Our realities are warped by what we see, hear, and consume. None of that changes when it comes to entertainment and media.

Entertainment

As discussed in Chapter 2, mental illness has been a form of entertainment for centuries. In the beginning of the twentieth century, the first movie with a lead character suffering from a

mental illness was filmed, *The Escaped Lunatic* (Scheider, 2004). Below is a description of the movie.

In January 1904, a mental patient dressed as Napoleon protests the food served in his hospital room by throwing it at the attendant. Shocked, the attendant summons two others to give the patient a beating. Left alone, the patient escapes from his cell and flees the sanitarium. He is chased through the countryside by the three attendants, skillfully evades them, and quietly returns to the hospital. The battered attendants limp back to find him calmly reading a newspaper. – Scheider (2004)

The anecdote above “is the first depiction of a mental patient in the movies” (Scheider, 2004, p. 1239). The entertainment that is produced is what society is asking for and consuming. As the world becomes more connected, so does our entertainment (Blakely & Center, 2001). There is a huge movement that is globalizing the world’s entertainment. In 2001 the American movie industry was an \$8 billion industry, which has only grown (Blakely & Center, 2001). In August 2020, the “International Movie Database” listed the highest grossing movies of all time. From the list of 100, I compiled a list of the movies that were centered around characters that suffered from a mental illness; fourteen of the 100 have overt mental illness themes. Half of the movies that portray mental illness portrayed those characters as the “villain” of the film. Half the movies representing mental illness are done in a way that creates a “normal” vs. “different.” Well-adjusted people would *never* act the way that character is. That must mean there is something wrong (bad) with them (Goffman, 1963).

The list mentioned above is the movies that have been the highest grossing in history, not the highest grossing movies about mental illness. The list of top-rated movies about mental illness is a little bit smaller. Of the list of twenty-five movies with the themes of mental illness, eleven of the movies are categorized as thrillers, murder mystery, crime, or drama (*Top Films Featuring Mental Illness*, 2013). The majority of those movies are rated R (Restricted - for mature audiences only). Most of the R ratings describe “disturbing and graphic behavior” displayed by these characters. The message that is sending is that mental illness is so dark and disturbing that society should now allow children to experience it in any way. Some of those movies are: *Fight Club* (1999) – Dissociative Identity Disorder; *Girl Interrupted* (1999) – Borderline Personality Disorder; *Rain Man* (1988) – Autism; *Black Swan* (2010) – Obsessive Compulsive Disorder; *Joker* (2019) – many but unspecified; *A Clockwork Orange* (1971) – Antisocial Personality Disorder; and the list continues (*Top Films Featuring Mental Illness*,

2013). A common theme throughout movies about mental illness is that it is a graphic and disturbing scene, something that should be hidden. Entertainment plays up the unsettling duality of the mentally ill character that portrays a “normal” person in society, then switching into this crazed maniac (Packer, 2017). The majority of portrayals of mental illness “has been dominated by depictions of violence, isolation, loss, misery, homelessness, personal failure, and ineffective health and social services” (Hensen et al., 2009, p. 554). Entertainment does little else than bringing out a culture’s fears surrounding mental illness (Packer, 2017). Often time the videography of mentally ill individuals is different as well. They are often shot along and uncomfortably close up giving the audience an eerie feeling (Rubenking & Campanella Bracken, 2015). If this is what society is telling us how to treat mental illness, who would want to be labeled with that?

For a person who has never encountered someone who suffers from a mental illness, entertainment is one of their only sources of education (Caputo & Rouner, 2017). This exposure could create their perspective of mental health. This is incredibly important because our media informs our understanding of mental illnesses (Ferguson & Credo, 2016). Social media is messy: there is no written textbook on how to interpret information or how personal we should take the comments (Humphrey, 2018). Ritterfeld and Jin (2006) substantiated their hypothesis that a positive movie portrayal of a schizophrenic woman was more impactful than that of an educational trailer. As already discussed, we are a narrative society, so we naturally connect best to a narrative form exploring mental illness. Using film to engage the public in a positive conversation about mental illness would be very beneficial as film entertainment is an already established infrastructure (Knifton, 2012). Scotland holds an annual Mental Health and Illness Film Festival that encourages artists to use their own experiences of mental health to create a platform to discuss and answer questions (Knifton, 2012). While there are movies with a positive narrative (*Girl, Interrupted*; *A Beautiful Mind*; and *The Aviator*) of mental illness, there is a lot of research showing that a concerted effort to put it in a more positive light is being made (Kondo, 2008). While they are significantly more sympathetic approach than the usual thriller or horror movie, there are still flaws and room for improvement. The downside to mental illness being a growing topic is that our entertainment about mental illness extrapolates the negative aspects of it, which in turn influences the way we as a society discuss it. One of the major platforms where we discuss this issue is social media.

Social Media

Social media is a way many Americans receive their news and information about mental health. Most news sources are owned by a few large companies and Facebook (Kennedy & Prat, 2019; Rubenking & Campanella Bracken, 2015). The news that individuals receive is not unbiased, and that has the power to influence. Society is surrounded by a constant feed of information – whether true or not – but each person has to decide for themselves what is true and what is not. This is not only happening with the news, but how to perceive oneself as well.

Due to how social media has grown in the last few years, there are only a few communications academic studies looking at mental illness stigma. Most of the research focuses on the “selling” point of media. For media to stay relevant to society, it needs to morph and change as the times do. Social media platforms (Facebook, Instagram, TikTok, Snapchat) are how fads are established and spread through society. If media starts producing content that is not consumed, it becomes irrelevant and fades to the background (Ferguson & Credo, 2016). Many people see the positives of social media such as keeping connected with people they would have otherwise lose contact (Barry, Didoti, Briggs, Reiter, & Lindsey, 2017). What many people do not see or consider is the toll of these constant changes and demands on the average consumer. Social media changes so quickly that new standards of what is acceptable and what is not is constantly changing. Mental health is growing into a fad that is used to connect to the “common” people on social media.

New concerns of how social media is affecting the younger generation are increasing; however, there is little to no longitudinal research surrounding it. Parents see their children dealing with their problems in an unhealthy way while the children have a significant fear of missing out (FoMo) and perceived loneliness (Barry, et al., 2017). What researchers found was that if an adolescent was experiencing these negative feelings their social media consumption would increase, only exacerbating the issue. This is very concerning as adolescent mental health issues (and suicide) are on the rise (Sheridan, Zhu, & Fink, 2019). Suicide, mostly by consumption of substances, is the third leading cause of death among this age group (Sheridan, Zhu, & Fink, 2019). While adolescents understand the “risks” of social media, it comes out more as a parroting of what they have heard adults, politicians, and society consistently warning (O’Reilly, et al., 2018). Mishna, et al. (2018) conducted a study where more than 30% of college students experienced some level of cyber aggression in the past six months. These types of

aggression can impact a student's mental health when controlling for all other stressors (Mishna, et al., 2018).

American society is obsessed with consuming and portraying the perfect life. We are constantly absorbing media (photos, stories, movies, shows) of attractive people living a lavish life. But how does this excessive exposure to the "perfect" body and life impact us? Do people take a moment to observe how it feeds their self-talk? I believe that the media we consume and our self-perceptions are intertwined. While there is not a lot of data or research specifically on social media consumption and mental health, there is some in neighboring fields of thought that show concerning results. Humans have a fundamental need to compare themselves and see which is the stronger specimen (Vogel, Rose, Roberts, & Eckles, 2014). Before social media, social comparison, was done at parties and in people's homes; but now, individuals have access to it almost nonstop. Society is exposed incessantly to an upward social comparison which means a constant message of "not good enough" is being told (Vogel, Rose, Roberts, & Eckles, 2014). The more often someone is exposed to an idea, the more it becomes imbedded in their thought processes (Caput & Rouner, 2011). It may be at the point that the individual is doing the self-criticism subconsciously. The access to the internet and electronics is now a staple in most homes. That means children are accessing social media at younger and younger ages. A study done by Valkenburg et al. (2017) showed that adolescents who were actively on social networking sites fluctuated in their self-esteem depending on if they were receiving positive or negative feedback. This is drawing a dangerous link between an adolescent's self-esteem and self-perception to the feedback of strangers on a social media platform.

In decades past, society had socialites that would set the trends of the decade. Today, we have Instagram/YouTube Influencers. The difference between socialites and influencers is that influencers now have a platform to reach millions. Each influencer has a brand that they push. It could be a healthy living, luxurious living, pranking, comedy, or makeup. The options for platforms are seemingly endless. The perfection they portray sells because it is often a dream life for people: perfect body, perfect home, perfect relationship, perfect job. Perfection is what people want to consume, and perfection is what the influencers give them. However, perfection has a cost. As nice as that sounds, it creates a cycle. Posting on social media and receiving validation produces a feel-good response in the person, which needs to be met more often. According to Ferguson & Credo (2016), social comparison theory suggests that that our self-

evaluation is relative to our evaluation to others. If an influencer is always putting the best photo, interesting caption, cool idea, or perfect perspective of their lives on social media, this impacts the way individuals perceive their own lives. The closer they become to living the life the influencer perfectly portrays the closer they are to “normal.” By elevating an individual’s own status, social comparison theory suggests that they evaluate their status by comparing to others. The only way that we can evaluate ourselves, is by comparing ourselves to others (Festinger, 2016). There is no standard without society.

Individuals are inundated by the standards that society creates. Even if the individual does not agree with the message being told, it is a constant bombardment of information and opinion. Having a constant narrative of what is good and what is bad can subconsciously influence someone. While I had no personal negative experience with mental illness, I had decided that it was something to be feared and something for the weak. The messages were clear: only the weak struggle with that. The social narrative (both from my family and social media/entertainment) created different levels of stigma I did not even recognize as bad. Conversations around difficult topics are being had more often on social platforms, but does that mean it is being done in a healthy way? Time will tell.

Synopsis

Chapter 3 dove into how a social narrative is created and the impact it has on society. Narratives are the way people make sense of the world around them. This is the way children are taught in society, by stories. Families help to build a foundation of a narrative, and society fills in those cracks as the child ages. It is filled in by news, social media, music, and entertainment. How the world displays and reacts to certain situations further informs the child. Entertainment is still a negative proponent of mental illnesses and often vilifies those that suffer from it. The entertainment that is consumed is driven by societies demands for it. Often times those demands are voiced on social media. This last section is a daily aspect for many people. Social media plays a starring role in the lives of many and influence perceptions and biases. Because social media is ever evolving and morphing, research over these platforms is difficult but essential to changing the social narrative of the stigma surrounding mental health. The last couple chapters have explored my personal narrative, the historical look at mental illness, how changes in diagnosis have come about, the social commentary of it in entertainment, and the way social

media plays a part in influencing an individual's perceptions. The next chapter talks about the personal narrative. What is the story an individual is telling themselves to get help or not?

Ch. 4 – Personal Narratives: The story we tell ourselves

The previous chapter explored how the social narrative plays a role in forming an individual's understanding of societal constructs. Society informs on how to perceive different aspects of life. While that is true, it comes down to the individual and the narrative they tell themselves. This chapter will look at how a person's personal narrative can change because of the effects of mental illness and how memories are formed around them.

Mental illness has a broad spectrum of diagnoses that cannot all be covered within this thesis. This thesis will cover one of the most pervasive: depression. Depression is a mental illness that affects many Americans, and the number is climbing. According to the United States Department of Health and Human Services, 8.1% of Americans aged twenty and over experienced a depressive episode at least once during 2013-2016 (Brody, Pratt, & Hughes, 2018). That number has increased significantly due to COVID-19. During this pandemic, the number of people with prevalent symptoms of depression increased over three-fold: 8.1% to a staggering 27.8% (Ettman, et al., 2020). This statistic is so concerning because people who have never dealt with any mental illness issues are now suffering from a disease they are ill-equipped to handle.

Before being able to explore how our personal narratives on mental health hinder seeking help and healthy coping mechanisms, we first must understand how depression and anxiety effect an individual. When someone is afflicted with depression, it may begin to warp their perceptions of reality. Depression can systematically affect an individual. It is not just something in their mind (Glannon, 2003; Praag, et al., 2004). Depression is a disease that has the potential to cause impairment and work difficulties every day. Although, how it manifests in every individual is different (Brody, Pratt, & Hughes, 2018). To understand why depression can affect a person's world perspective, we first need to understand the symptoms of it: physiological, mental, and emotional.

Physiological Changes of Depression

The body is a system that typically self regulates; however, events in an individual's life (such as a car accident) can disrupt the balance. In my story, I went from a high functioning individual to someone who could scarcely do the bare minimum. Suddenly, my motivation was

gone, and I thought I was going crazy. After being diagnosed, I did some research to help educate myself on what was going on in my body. Glannon (2003) writes about how the body reacts to trauma and stress. Typically, when a person experiences stress or a strong emotion, there is a physiological response happening outside of conscious awareness (Glannon, 2003). Following the interruption of the hormone balance with a perceived risk, the body determines how to reestablish equilibrium (Praag, et al., 2004).

Depression is something that effects the body as a whole. Not only can it change an individual's perceptions about themselves and others, it can impact the immune system as well (Glannon, 2003). With trauma our bodies are set to react to stressors by releasing hormones to tell us how to act. When we are presented with a "risk," our brains must assess the risk and decide the best course of action (Praag et al., 2004). PTSD show us how these processes are survival instincts on which our bodies rely to help us through difficult situations. However, they can become hypervigilant after a traumatic experience and can be difficult to "reset" (Glannon, 2003). If it is depression, anxiety, or PTSD, the brain strives to be at a homeostatic level. This can cause the brain to fatigue because it is working overtime reestablish a balance (Praag et al., 2004).

Depression is a multi-faceted mental illness that may present itself very differently depending on the individual. Often times an imbalance of hormones or a shifting personality temperament of an individual can be misdiagnosed as depression (Parker & Stranton, 2002). Because it can manifest itself in many ways, it can be mistaken for (or mask) the real problem. People who suffer from depression may be dealing with reoccurring cycles of depression, which inhibit productive work and self-care (Incze, 2019). The individual may have moments of elevated spirits but then will be triggered back into a state of depression. These cycles are considered to be part of clinical depression (Parker & Stranton, 2002). Parker & Stranton (2002) make a point to discuss how depression can be triggered by certain stressors. Stressors are specific to the individual and can take many forms. Some might be triggered by transitions and relational turbulence, while others may struggle when their work life is hitting a roadblock (Theiss & Knobloch, 2014). Changes in a relationship create uncertainty, which can then heighten the mental issues someone is battling. There is no *one* stressor for each person's experience

During 2017 the National Institute of Mental Health recorded that 17.3 million Americans suffered from at least one depressive episode: that is 7.1% of American adults. Of that 7.1% who experienced a depressive episode, 4.5% reported severe impairment of their daily lives. There are varied manifestations of depression, which can present quite a problem. The setbacks of experiencing a depressive episode could be: consistent feelings of sadness, loss of interest, difficulty focusing on the task at hand (work, school, relationships) (Jin, 2016), appetite change (weight loss or gain), fatigue/loss of energy, trouble falling asleep, excessive sleeping, being easily agitated (Banihashemi et al., 2016; O.Tropy, Burke, & Glass, 2010), lowered self-esteem, mood swings, impaired concentration and memory, lowered ability to handle change and worries, and increased hopelessness/pessimism (Parker & Stranton, 2002). The ways depression presents itself depend on the person. When an illness has such a wide scope of symptoms, it can be easily misdiagnosed (Parker & Stranton, 2002). For some depression is completely debilitating. They are unable to perform daily tasks (Parker & Stranton, 2002). However, it is possible for an individual to accomplish daily tasks but lose enjoyment in previous hobbies or become withdrawn (Parker & Stranton, 2002). When these feelings extend past two weeks and become a consistent, daily occurrence, one likely meets criteria for Major Depressive Disorder (American Psychiatric Association, 2013). Many times, depression does not come alone.

Often depression exists simultaneously with an anxiety disorder: this is called comorbid (Malhi & Hale, 2000). While depression dampens the majority of your senses, anxiety – “the tense, unsettling anticipation of a threatening but vague event; a feeling of uneasy suspense” (Rachman, 2004, p. 3) – is heightened. Often times fear and anxiety are used interchangeably; however, there are some distinctions. Fear can be assigned to a specific identifiable danger (emotional or otherwise), while anxiety is a consistent feeling of uneasiness that does not have a discernable origin (Rachman, 2004). Like depression anxiety disorders have a broad range that can vary with the diagnosis. There are many anxiety disorders that do have specific triggers and set of coping behaviors – Social Anxiety Disorder, specific phobias, Obsessive Compulsive Disorder, Panic Disorder, Separation Anxiety, etc. (American Psychiatric Association & Parekh, 2017). With General Anxiety Disorder, the feelings anxiety brings can often be very puzzling and increase the uncertainty a person is experiencing due to the ambiguity or irrationality of it (Bound, 2004; Rachman, 2004). Comorbidity is very common among depressive and anxiety disorders; and they hardly ever present themselves in pure forms (Beesdo, Pine, Lieb, &

Wittchen, 2010). Zimmerman (2019) argues that depression is one of the most disabling medical illnesses because of the high comorbidity rates.

Because of the ambiguity around these two disorders, many people try to ignore or diminish the symptoms and/or the severity of what they are feeling. This downplay of emotional health could be done for a myriad of reasons, some of which England (2016) describes in her detailed self-disclosure. England (2016) decided to control the narrative being told about her and her illness and disclosed her bipolar diagnosis to her coworkers. By doing so, she took ownership of the narrative and the words describing her mental illness. Controlling her narrative, England said she felt like her work performance was enhanced by not having to put a façade of “being okay” up all the time. Although her narrative is about bipolar disorder and not specifically depression and anxiety, she sheds light on many obstacles and fears individuals face when determining whether or not to seek help. The common theme England (2016) discusses is that of stigma.

For years she hid her diagnosis and battled in secret because of the stigma surrounding mental illness. Before she could decide on the narrative she wanted to share with others, she had to work through the emotions she felt about the diagnosis. While trying to navigate her personal narrative, wading through her own personal stigmas about dependency on medication and therapy (England, 2016). The narrative she told herself had to change in order for her to positively engage her community in a conversation surrounding it. England was scared to disclose the information because the “stigma that surrounds mental illness is still prevalent in academia and society as a whole” (p. 227).

She describes her hesitation so eloquently; it was as if she as describing my own experience back to me. I was hiding my struggles because I feared the backlash. What would happen if I showed people a “weakness” in my character (Goffman, 1963)? Would I still be accepted or ostracized from my community? Taking charge, I decided I needed to organize a personal narrative I wanted to share. What I had been through was not a weakness, but an asset; my empathy for struggling people grew. A realization hit me: we connect to others through stories and those relationships help us navigate life; without the relationships I had during my dark time, I would have been even more lost (Horan et al., 2009).

Personal Narrative Explored

Describing the aforementioned mental illnesses is important because of how they may impact an individual's likelihood to seek help. This paper has already discussed a brief history of mental health and the social narrative of mental health. Now it is time to explore the personal narrative: the story we tell ourselves. As we discussed in the Social Narrative chapter, stories are important in how societies and families function. This is the way that we (as a society) pass along our understanding of the world and how we perceive certain aspects of it – specifically emotions (Gruhn, Bettis, Murphy, et al., 2019). Personal narratives are the way in which we describe our understanding of the world to ourselves and others.

They are memories that are retold as stories and intertwined with our perspective of the world (Lea Gaydos, 2005). Lea Gaydos described personal narrative “as a form of autobiographical storytelling that give shape to life experience” (2005, p. 225). That idea lends gravity to the stories we are telling others. These stories can be positive and negative, it depends on the authors perception of themselves. Goffman makes a point to describe different types of narratives someone could be telling: victim, hero, normal, stigmatized, inferiority, etc. (1963). Distinguishing between these narratives can help us understand from where some of the hesitation a person may be experiencing may come. There may be many obstacles (mental, emotional, financial, or physical) that an individual must overcome to seek help. In my experience, I would reinforce my understanding of mental illness by continuously supporting my stigma around it. It is common for a person to reinforce their way of thinking, and a person with a narrative of stigma around mental health is less likely to seek help (Cheng, McDermott, & Lopez, 2015).

One of the most common concerns for exploring mental health issues is the concept of being “labeled.” A diagnosis is a label by any other name. Does that mean it is negative? Not necessarily. It in and of itself is not a positive or negative thing; however, society assigns the stigma to that label. Diagnoses (labels) help make sense of what was unexplainable before, a hidden enemy. Naming gives the individual an external enemy to be battling with, not themselves and can bring peace to a tired mind. By being given a label, that person is effectively separating themselves from “normal” society and acknowledging and accepting a stigmatized role (Goffman, 1963; Vogel, Wake, & Haake, 2006). Goffman (1963) describes stigma as “a blemished person, ritually polluted, to be avoided, especially in public places.” These rules are

never explicitly said, but many individuals internalize that discomfort and exclusion, which perpetuates the act of separation (England, 2016; Goffman, 1963; Meisenbach, 2010).

Depression can lower an individual's self-esteem and create feelings of inadequacy. It can warp their thought processes and create internal conflict (Glannon, 2003; Parker & Stranton, 2002). The disorders influence the way this individual perceives and processes interpersonal – and intrapersonal – exchanges. Chronic depression effects an individual's cognitive functioning ability. Even if the person was previously very rational, this disorder can cause confusion and misconceptions (Glannon, 2002). These mental illnesses can literally mess with the mind as they challenge how an individual perceives and processes information. Along with harmful perceptions of interactions, depression can change an individual's perception of themselves; especially, if diagnosis was involved. As we discussed earlier, England (2016) had to work through accepting her diagnosis and how she wanted to disclose the information. Ferreri, Scott, Einstein, and Ciarrochi (2018) found that “depression is widely considered a global health epidemic” (p. 2); and in the United States, an estimated 56 million people suffer from it (Harvinder, 2017). With such a high number of people struggling with this daily, why is it still such a taboo topic?

For many people, how and when to share information is taught at a very young age through the family structure. You are conditioned to understand what is appropriate to share and when. The ways that families interact and establish the groundwork for communication can affect a child's perception of information sharing (Segrin, 2006). This phenomenon is explained by Communication Accommodation Theory (CAT). CAT argues that families construct identities to present to society (Soliz & Warner Colaner, 2018). This “family identity” is potentially destructive as it teaches children what words to use and how to talk about difficult topics. Parents have the capacity to help their children talk about difficult topics – such as mental health – by giving positive or negative reinforcement when a conversation arises (Soliz & Warner Colaner, 2018; Segrin, 2006). This explains the social pressure individuals feel when trying to communicate their struggles. Children watch their families to understand how to interact with society. If the family is not emotive and diminishes “emotional talk,” it shapes the child's perspective of what is appropriate and what is not (Soliz & Warner Colaner, 2018; Segrin, 2006). Social pressure and familial obligation of not tarnishing the family identity are large obstacles someone must overcome to seek help. Not only does a person have to address

their personal narrative and biases about mental health, they also have to wade through the possible stigma their family/community has placed on it.

Synopsis

With mental illness being such a wide topic to discuss, it was difficult to narrow down the scope of discussion. Narratives of how we should perceive the world are constantly bombarding us from the moment that we are born. History informs how we think, current entertainment and media informs how we think, and our own experiences and prejudices inform how we think. The paper started with a narrative of my experience, both the accident and the diagnosis. These were not included to garner sympathy, rather to lay a framework of understanding possible obstacles and self-talk individuals may have when struggling. I immediately dismissed any mention of depression, anxiety, or PTSD for almost a year out of sheer pride. It was not until I was not functioning properly on a day-to-day basis that I resigned myself to getting help. Getting help was not a spontaneous decision for me: it was a last resort. The first chapter was groundwork to create perspective for what followed. Chapter 2 was a very brief description of mental illness and how they were handled in the past. Our current belief and understanding stems from how people with undesirable qualities (both physical and mental) were treated – and then ostracized – for centuries. The understanding and conditional acceptance of differences is a fairly new revolution in our society. After the history, we delved into our current social state and view on mental illnesses. This is where society (as a whole) and individuals diverge.

Chapter 3 examined the social media and the conversation around mental health how it is growing. Just because the conversation is growing does not mean it is a useful conversation. It has become faddish to flaunt a mental illness status and expect others to treat that individual differently because of it. Labels are important in our society: they help to categorize people. By learning to what “category” a person belongs, we (as a society) have a level of expectations to which we then hold them. The last area this paper considers is the personal narrative, or the story we tell ourselves. Self-talk is such an important part of our daily experience that often goes unnoticed. However, this is where the attitudes and beliefs are shaped and solidified. It may come from a comment of a passing stranger or the persistent narrative a family teaches to a child,

which then becomes the child's narrative. Sometimes individuals do not even realize they have a deep-seated stigma.

Creating a stigma in one's mind is not all that difficult; it can come from a comment of a passing stranger or years of avoiding topics. Identifying my own stigmas and views of mental health was extremely challenging but very rewarding. In my family, one deals with one's own issues and moved on. In my mind, talking about my struggles was considered a weakness and pathetic. Before I could address the reality of what was happening with me, I had to reevaluate my thought processes and beliefs about mental illness. In a few moments, my world was completely changed, but it took me years to unravel and wade through my negative, tightly held, beliefs around mental illness and the images it conjured in my mind.

After going through all the research above, four hypotheses supported by the research guide this study. The initial hypothesis that was created had to do with how an individual's understanding of mental health is closely tied with how society views it.

Below we will explore the findings this survey procured and how personal attitudes and beliefs influence a persons' approach and understanding of mental illness.

METHODS

To test the hypotheses, I published an anonymous survey with five scales on Qualtrics with being of legal age (18) the only requirement for participation.

Participants

I created a fifty-one question survey in Qualtrics and administered it randomly. The survey was anonymous, and a link was distributed on several social media platforms (Facebook, LinkedIn, & Instagram), as well as distributed on a Midwest regional campus. I used snowball sampling by posting the link to Facebook, Twitter, Instagram, and LinkedIn. If they chose to take the survey, I requested that they "share" the link on their personal social media pages. By having an open link posted on multiple profiles, it helped expand the demographics taking the survey. I also asked the Interim Chair of the Communication Department of a Midwest regional campus to send the link and message below to the department's instructor Listserv. This email list includes instructors of general education courses, which have wide demographics of students. Because it was sent through multiple COMSERV lists to instructors, I was unable to track who shared the link. How they would share the link was up to the instructor/professor. Instructors will not know who has chosen to participate in the study.

The following text was posted on the social media platforms and sent to students by professors.

Please take this 5-10-minute survey to help us better understand our approaches to mental health. This survey is designed to explore people's thoughts about mental health issues. It is anonymous. While we do collect demographic information, we do not collect personally identifiable information or IP address. This survey is for people 18+ years of age. If you have any questions or concerns, please email Olivia Schumacher (schuoj01@pfw.edu), Dr. Marcia Dixon (dixson@pfw.edu), or Purdue IRB (irb@purdue.edu).

The 379 participants ranged in age from 18-78. Females (250) heavily outweighed the remaining respondents; males (85), and other (3). Out of the respondents, four had some high school, 34 received a high school diploma, 104 some college, 40 an associate degree, 97 Bachelor's, 70 a Graduate degree, and 15 a Post Graduate degree. The socioeconomic

perceptions were heavily towards middle class (280), only a small fraction considered themselves to be a part of the lower (73) or upper (11) economic classes. Areas the participants grew up in were identified as Rural (214) and Urban (146). Almost half of the participants identified as married (164) and the rest were split between single (95), in a relationship (83), and divorced (20). Out of 379 respondents, only 41 considered themselves not Caucasian (African American/Black – 4, Hispanic/Latino – 18, Asian – 8, Other – 11). The last two questions that were asked were: Are you a military veteran (7), Are you a student athlete (6).

Materials

For a scale to be considered reliable (consistently measuring the same thing), it needs to have a Cronbach alpha of .7 or greater. The table below shows how each scale performed against this measure.

The survey I created had five different scales (attached in the Appendix A). Each question is measured on a Likert scale of 1-5. The scales are as follows:

Likelihood to Seek Help measured how comfortable a person may be in looking for help beyond friends and family. The person may want to get help, just not from someone in their immediate circle (ex. *I would not seek help because professionals push medication*). In this scale, the higher the numbers the participants chose, the more likely they were to seek help. A possible influencer for this scale is their knowledge about professional mental health and medication.

Likelihood to Share Concerns measured if an individual would be comfortable with sharing how they are feeling with someone in their close circle (ex. *I would talk to a close friend about my feelings*). Like the scale above the higher numbers in this scale mean they have a more positive view on it and are more likely to share their concerns. However, if someone is surrounded by people who have negative views of mental health, it could hinder the sharing of concerns.

Attitudes of the Individual. This scale gives us insight on how the individual views mental health. If they have a positive or negative view of mental health, it can influence their answers on the other scales (ex. *People with depression are just too sensitive*). Unlike the two above, this scale is measured from 1-5 but the higher the

number answered the greater their negative view. When a participant answers a 5 to these questions, it says that they have a strong negative attitude towards this.

Attitudes of Society. This scale looks at how an individual perceives society’s narrative on mental health. Society says mental health is positive or negative. (ex. *People may be viewed as broken if they admit to suffering from mental health issues*). The Attitudes of Society scale is created similar to the Attitudes of an Individual. When a participant measures a high number on this scale, it shows that they have a strong negative attitude or belief.

Fears and Barriers scale measured what obstacles might be keeping someone from exploring mental health concerns more (ex. *I would be rejected from my community if people found out about my struggles*). If a participant answers a 5 to these questions, it would indicate they have perceived this fear or barrier to be a significant factor in why they are not getting help. The higher the number, the greater amount of fears and barriers they have towards mental illness.

Scale	Cronbach Alpha	N of Items
Likelihood to Seek Help	$\alpha = 0.722$	11
Likelihood to Share Concerns	$\alpha = 0.5$	7
Attitudes of the Individual	$\alpha = 0.835$	6
Attitudes of Society	$\alpha = 0.821$	5
Fears and Barriers	$\alpha = 0.758$	7

As shown above, 4 of the 5 scales used have a satisfactory to very good reliability (0.7 or greater). One of the scales – Likelihood to Share Concerns – produced a poor reliability. This low Cronbach alpha could be for a multitude of reasons; however, I believe the idea of “sharing” would need to be further defined. Every person has a different idea of what sharing looks like. Without explicitly defining “share” and “concern,” I believe that ambiguity played a role in the low reliability.

Before I ran the correlation on the hypotheses, I first ran a pre-analysis of the subscales based on responses to the question: *Have you ever been formally diagnosed with a mental illness?* The frequency count yielded almost an equal split (Yes: 145, No: 179). When someone is personally impacted by something, a logical assumption is that their perspective on that item is

influenced. Individuals that have been personally impacted by mental illness (by diagnosis) would have an altered perception of mental health; whether it is a positive or negative influence is unclear. Therefore, I ran a series of t-tests to check this assumption about differing perceptions.

Scale	Participants Diagnosed	Mean	Standard Deviation	t	Sig. (2-tailed)
Likelihood to Seek Help	Yes	34.895	6.657	3.597	<i>p</i> = .000
	No	32.242	6.458	3.597	<i>p</i> = .000
Likelihood to Share Concerns	Yes	19.336	4.791	-1.149	<i>p</i> = .252
	No	19.931	4.357	-1.149	<i>p</i> = .252
Attitudes of Society	Yes	18.042	4.313	3.45	<i>p</i> = .001
	No	16.455	3.924	3.45	<i>p</i> = .001
Attitudes of the Individual	Yes	8.317	2.838	-4.508	<i>p</i> = .000
	No	9.888	3.435	-4.508	<i>p</i> = .000
Fears and Barriers	Yes	20.345	5.319	0.219	<i>p</i> = .828
	No	20.22	4.856	0.219	<i>p</i> = .828

Full t-test results in Appendix B

Because of the significance we found between participants who had been diagnosed and who had not been, I decided to run correlations to test the hypotheses separately for each group. In the next section, I break down each hypothesis by how the participant answered The Diagnosis Question (51), and whether or not the data supported the hypothesis for each group.

RESULTS

To test the hypotheses, I ran bivariate correlations on the scales included in each hypothesis.

Hypothesis 1: The attitudes and beliefs of an individual will positively correlate with their perception of societal attitudes of mental health.			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	0.003	$p = .971$	Not Supported
Participants who have NOT been formally diagnosed	-0.061	$p = .415$	Not Supported

While Hypothesis 1 was not supported, the people who were formally diagnosed did have a slight positive correlation. While those that have not been diagnosed were negative. The more negative their individual views, the more negative they believe societies beliefs to be. While the correlation was in the direction of the hypothesis, it was not significant. Therefore, we cannot draw conclusions from the data.

Hypothesis 2: The attitudes and beliefs of an individual will negatively correlate with their likelihood to share their concerns with family members/friends.			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	-0.059	$p = .484$	Not Supported
Participants who have NOT been formally diagnosed	-0.076	$p = .317$	Not Supported

Hypothesis 2 is interesting because it is an outlier in the pattern of the other three results. This is the only hypothesis that both the diagnosed and undiagnosed have the same direction of correlation. Both answered negatively. That would mean that both parties would be less likely to share their concerns with friends and family as their personal beliefs around mental health declines. While the correlation was in the direction of the hypothesis, it was not significant. Therefore, we cannot draw conclusions from the data.

Hypothesis 3: The attitudes and beliefs of an individual will positively correlate with their perceived fears/barriers to seeking help for mental health concerns.			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	0.087	$p = .298$	Not Supported
Participants who have NOT been formally diagnosed	-0.004	$p = .957$	Not Supported

As with the two previous hypotheses, Hypothesis 3 was not supported as well. Following the pattern of diagnosed participants aligned with the hypothesized correlation. By having a positive correlation, this says that as the diagnosed subjects' negative attitudes and beliefs around mental health grows so does the fears and barriers around seeking help for mental health concerns. While the correlation was in the direction of the hypothesis, it was not significant. Therefore we cannot draw conclusions from the data.

Hypothesis 4: The attitudes and beliefs of an individual will negatively correlate with their likelihood to seek help/treatment for their mental health concerns.			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	-0.201	$p = 0.16$	Supported
Participants who have NOT been formally diagnosed	0.014	$p = .857$	Not Supported

Hypothesis 4 was the only one that was partially supported in this study. The diagnosed individuals negatively correlated and were found significant. Meaning the more negative their personal beliefs of mental health were, the less likely they are to seek help.

The initial correlations revealed that, while most of our hypotheses were headed in the correct direction, they were not significant. Given the analysis did not support my original hypotheses, I considered why this might be the case. The research shows that the majority of the study was not supported; however, the group that had been formally diagnosed did follow the proposed correlation. When the hypothesis anticipated a positive correlation, the diagnosed group followed the assumed pattern. While it was not an extremely strong correlation, it gave me room to further explore the data. I decided to look at the data not from an individual's perspective but from what an individual believes society's perspective to be. With this in mind, I decided to run some post hoc correlations and adjusted the point of view of the comparing scale.

Instead of running it against the individual’s perspective, I ran the scales against the perceived societal perspective.

Post Hoc Analysis: Attitudes of Society v. Likelihood to Seek Help			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	-0.234	$p = .0005$	Supported
Participants who have NOT been formally diagnosed	-0.096	$p = .202$	Not Supported

As was common with the results of the hypotheses, the diagnosed individuals responded differently than the those who have not been formally diagnoses. The individuals who have not been diagnosed had a negative correlation but was not significant. Those who have been diagnosed were found significant and had a negative correlation. This says that as the negative perception of society’s attitudes and beliefs increase, the less likely they are to seek help. While part of these findings was significant, these are post-hoc and must be cautiously interpreted. A more in-depth study would need to be done to gain more confidence in these conclusions.

Post Hoc Analysis: Attitudes of Society v. Likelihood to Share Concerns			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	-0.252	$p = .0005$	Supported
Participants who have NOT been formally diagnosed	-0.64	$p = .397$	Not Supported

Again, the participants that were formally diagnosed had a negative correlation and was supported. This tells us that, as the negative attitudes of society increase, the participants likelihood to share concerns decreases. The undiagnosed individuals had a negative correlation; however, it was not supported. While part of these findings was significant, it is post-hoc and must be cautiously interpreted. A more in-depth study would need to be done to to gain more confidence in these conclusions.

Post Hoc Analysis: Attitudes of Society v. Fears and Barriers			
Participants	Correlations	Significance	Supported
Participants who have been formally diagnosed	0.419	$p = .000$	Supported
Participants who have NOT been formally diagnosed	0.431	$p = .000$	Supported

The attitudes of society and fears and barriers were supported by both the formally diagnosed and those who have not been diagnosed. Both groups had a positive correlation which shows that, as negative perceptions of society's attitudes and beliefs grow, so do the perceived fears and barriers with seeking help for mental health concerns. While the findings were significant, these are a part of a post-hoc analysis and must be interpreted cautiously. A more in-depth study would need to be done to have confidence in these results.

DISCUSSION

While this study did not produce the results I expected, I believe it still helps close the gap in mental health research. The consistent findings were that people like to believe they have a healthier view on mental illness than society. Society is the bad guy stopping people from getting help. It is easier to blame the issues of mental illness growing and becoming alarmingly common on a broader problem than addressing our own biases and prejudices. Some people may not even know they hold these beliefs because it is so imbedded into their thought processes. The flow of hypotheses was deliberate as I wanted to simulate how we, as individuals, progress in our understanding of a topic. Our firsthand experiences impact our perceptions, which informs our understanding of something. The first step was to determine how an individual perceives mental health (in a positive or negative way). This was the scale that I would compare each other scale against. Once that scale was established, I then compared a participant's individual beliefs with their perceived beliefs about a "societal" view of mental illness. Society's perceived attitudes and beliefs affect an individual's attitudes. This in turn affects our likelihood to seek help, likelihood to share concerns, and perceived fears and barriers. Every person may have an established perception of mental illness, but that does not mean it is removed from influence. This is how I created the following three hypotheses. Individuals have reasons for keeping information to themselves, so comparing the individual's beliefs and their likelihood to share mental health concerns with their friends and family was a needed comparison. This idea tees up the next hypothesis of individual perspective versus perceived fears and barriers of seeking mental health help. Lastly, I hypothesized that an individual's attitudes and beliefs would impact their likelihood to seek help or treatment for their mental health concerns.

Before I ran the correlations, I saw a difference in how people who had been formally diagnosed were answering versus those that had never been diagnosed. Therefore, I split the data by these two groups (diagnosed, not diagnosed) and ran the correlations by each group. Below, I am going to walk through each hypothesis and discuss the outcomes and postulate why the diagnosed participants answered differently than the undiagnosed.

Hypothesis 1: The attitudes and beliefs of an individual will positively correlate with their perception of societal attitudes of mental health.

Each hypothesis showed different aspect of an individual's perspective on mental health. This first one highlights how our understanding is tied with society's perspective. The participants that were not diagnosed had a negative correlation to this hypothesis. This means they believe as society's view become more negative, their personal attitudes and beliefs towards mental illness actually begins to be more positive. This contrasts with the formally diagnosed participants as they had a positive correlation. This hypothesis was not supported, but the differences in correlations still gives us an area to further research. There could be many reasons as to why the data was not supported. An individual may perceive their own beliefs to be less harsh, which in turn makes society's less positive. Another possibility is that an individual's diagnosis could impact their understanding of mental illness.

Hypothesis 2: The attitudes and beliefs of an individual will negatively correlate with their likelihood to share their concerns with family members/friends.

While this hypothesis was unsupported, it did have some interesting ideas for future studies. In three of the four hypotheses, the diagnosed and undiagnosed have opposing correlations. The diagnosed participants followed the postulated correlation, while the undiagnosed participants appeared with the opposite correlation. The outlier was Hypothesis 2. Both groups produced a negative correlation. This means that the more negative their views of mental health became, the less likely they were to share their concerns with friends or family. This says that, if an individual has an adverse understanding of mental illness, they are more likely to shy away from reaching out to their support system for help.

Hypothesis 3: The attitudes and beliefs of an individual will positively correlate with their perceived fears/barriers to seeking help for mental health concerns.

As with the first two hypotheses, Hypothesis 3 was not supported but yielded interesting results. Depending on an individual's experience, each person perceives "danger" differently. There are different fears, obstacles, or barriers that keep us from engaging in different activities. Sometimes that is beneficial, and other times it is not in our best interest. This hypothesis looks at perceived fears and barriers that arise from seeking help for mental health concerns. As we have discussed, an individual's understanding of mental illness will factor into this decision. But, for diagnosed participants, so will the perception of barriers. These respondents had a positive correlation with fears and barriers for seeking help for mental health concerns. The more fears,

barriers, or obstacles that they perceived to be, the less likely they would be to seek help. Those obstacles to seeking help could be anything a person determined to be a threat. Participants that were not formally diagnosed had a negative correlation, which shows that the greater the fears and barriers the more likely they would be to seek help. If they have more to lose, the more likely they would be to try and address their concerns.

Hypothesis 4: The attitudes and beliefs of an individual will negatively correlate with their likelihood to seek help/treatment for their mental health concerns.

The undiagnosed participants' correlation was not significant and was positive. Their personal beliefs would urge them to seek help or treatment for mental health concerns. This is not the case for the diagnosed individuals. This correlation was significant for those that had been formally diagnosed. Their attitudes and beliefs negatively correlated with their likelihood to seek help or treatment for their mental health concerns. If a person has a strong negative belief towards mental health or the treatment for it, they are less likely to explore possible treatment plans for it. This finding is important. If an individual has already been diagnosed and had a bad experience with medication or treatment, that will influence their personal attitude towards the mental health discipline. The perception of diagnosed individuals is significant to this growing field. When a person has a negative experience, it can not only influence them but also the network of people around them. As explored in the literature review, our personal beliefs of mental illness can be influenced by a variety of elements. People who have been formally diagnosed have a higher chance of being stigmatized than those who have not been diagnosed. A diagnosis is a clear distinction that "you are different." And, if you let people know that, they can see you as an "other." This information tells me that people who have been diagnosed see society's view of mental illness more clearly as it is a reality with which they have to live. For all four hypotheses, the correlations of diagnosed participants followed the direction of the hypothesized correlations. A diagnosed participant's views of mental health followed a negative pattern perspective.

Post Hoc

The hypotheses above were measured against the individual's perception of mental health; however, the results for the post hoc analysis of each scale against "society's" perception

was illuminating. While the post hoc findings are significant and fascinating, they would need to be run as a separate study. The hypotheses I proposed did have a lot of research to substantiate them; however, what was found in the post hoc analysis changes our understanding of mental health perception. Originally, I ran the individual attitudes and beliefs against the other scales (Seek Help, Share Concerns, Fears and Barriers). Post hoc I ran the grouped participants (diagnosed, not diagnosed) from a societal perspective. What I found was that there is a harsher understanding of society's perception and individuals believe themselves to have a more positive insight. People believe their views on mental health are more positive than that of society. How society as whole presents an idea to its audience has an impact or effect on an individual. It might make the person more inclined to their beliefs or make them start to question their understanding. Because of this, I decided to look at the data differently: from an individual's understanding of society's stance on the subject. I re-ran the bivariate correlations with Attitudes of Society as the main perspective instead of the Attitudes of an Individual, and it returned stronger reactions and consistently more significant.

The first correlation I ran was between perceived societal beliefs and likelihood to seek help. With this correlation, the diagnosed participants were found to have a significant negative correlation. Meaning, the more negative they perceive society's view in mental health, the less likely they are to seek help for concerns. This says an immense amount about how our understanding of societal perception influences a hurting person to seek help. The participants that were not diagnosed had a negative correlation as well but was not found to be significant.

Next, was perceived societal attitudes and beliefs with likelihood to share concerns. As the one before it, participants that had been formally diagnosed had a significant negative correlation. Again, we see that the perception that an individual hold of society's view of mental health interferes with their likelihood to share concerns with friends or family. If society is constantly telling you that people with mental illness are weak and broken individuals, why would someone share that possible character flaw with anyone? Mental illness is still viewed as a blemish, a black smear across your character.

In the last correlation ran, both the diagnosed and undiagnosed were found to have significant positive correlations. This last correlation was perceived societal beliefs and perceived fears and barriers to seek helping. This data showed that both groups of people are far less likely to seek help because of the obstacles present in seeking help. Throughout this project,

diagnosed participants and participants that were not diagnosed had opposite understandings of mental illness, yet in this they coincided. The fears and barriers keeping someone from seeking help are far and wide. It could be physical ability to get help, emotional or mental struggle, fear of being ostracized, fear of medication, financial inability, and the list goes on. These cross boundaries with both groups, yet they are still there and still prominent. If society has a negative view of mental health and those that suffer from it, making yourself vulnerable to seek help becomes that much harder.

The data consistently found that diagnosed people and undiagnosed had differing points of view on how society views mental illness. The participants that were diagnosed perceived society's views to be very negative and see (and maybe have experienced) greater backlash for seeking help or discussing their concerns. Perceived societal attitudes and beliefs towards mental health has a greater command on individuals than perhaps we credit.

Limitations

Each study has its limitations, and this one was not different. This study grossly underrepresented people of color and lower economic participants. It should be done with a larger group to solidify its findings. One of the scales (Likelihood to Share Concerns) was not found reliable with a Cronbach alpha of .5. This scale would have to be redone and tested for a more significant reliability. While the post hoc analysis was fascinating, its significance would need to be tested in a full study. To continue this research, the subscales would need to be run through more rigorous testing for validity. Researcher bias of mental health experience could color understanding of data. There seems to be such a large gap that finding current research to supplement is difficult. Academic understanding of stigma and mental health education needs to be updated.

Future Implications

The implications for this research are exciting. If we are able to further narrow down how society's negative representation of mental health influences individuals, we could know how to address it. Each person has their own experiences that influence their decision making. My perception as an individual who suffered from mental illness and as a researcher are very

different. More exploration should be done with an individual's perceived understanding of society's view on mental health/illness. As outlined in the literature review, society has a complicated relationship with how it portrays mental illness to its audience. In entertainment the majority of the time it is shown as a thing that has been vilified, while there are contradicting messages on social media to "take care of yourself." To be able to address those mixed messages, more research needs to be done about how we perceive society's attitudes. Additionally, there is a gross imbalance of sex differentiation in the mental health information available. Historically women's health has been written off as hysterics or "hormone" issues. Future research should analyze mental health diagnoses based on sex differences. Moving forward, academic research needs to address the stigma tied to mental illness that is portrayed by society. While it will be academic research, it needs to be accessible to the public to help educate and lessen the stigma.

CONCLUSION

While this study did not have the results expected, I had to address my own biases and prejudices to be able to look at this study with hope. The history that society has with mental illness is not a happy one; however, the literature shows that there are steps to making that right. Stigma is something that might never go away, but I do believe that with education and exposure there will be enough advocates for it to be more generally accepted. People are influenced by how history has portrayed mental illness, how society currently portrays it, and the fears and stigmas that have been built around it. I do not believe this paper will change the course of perceptions about mental health, but it does address the gap in research about narratives and mental health stigma.

APPENDIX A. SURVEYS

Updated Mental Health Perspective

Demographics

- Likelihood to seek help**
- Attitudes of society**
- Attitudes of individual**
- Peer/colleague**

Welcome to the research study!
 This survey is designed to explore people's thoughts about mental health issues. It is completely anonymous and only for people 18 years of age or older. Your participation is voluntary. You may choose not to participate or withdraw your participation at any time. If you choose to participate, completion of the survey indicates your consent to use your information as part of this research project. There are minimal risks or discomforts. The survey should take approximately 5-10 minutes. If you have any questions or concerns, please email Olivia Schumacher (schuol01@purdue.edu), Dr. Marcia Dixon (dixon@purdue.edu), or Purdue IRB (irb@purdue.edu).

- I am over 18 and consent to participate (1)
- I do not consent. I do not wish to participate (2)

Please fill out this short demographic survey.
Age

- Sex**
 Male Female Other

- Education Level**
- Some High School (1)
 - High School Diploma (2)

- Some College (3)
- Associate's Degree (4)
- Bachelor's Degree (5)
- Graduate Degree (6)
- Post Graduate (7)

I perceive myself to be in the

- Lower Economic Class (1)
- Middle Economic Class (2)
- Upper Economic Class (3)

The area I grew up in was:

- Rural (1)
- Urban (2)

Marital Status

- Single (1)
- In a relationship (2)
- Married (3)
- Divorced (4)
- Widowed (5)

Ethnicity

- Caucasian/ White (1)
- African American/ Black (2)
- Hispanic/Latino (3)
- Asian (4)
- Other (5)

Are you a military veteran?

- Yes (1)
- No (2)

Are you currently a student athlete?

- Yes (1)
- No (2)

Imagine you are experiencing feelings such as: helplessness, loss of self-esteem, fatigue, persistent sadness, loss of enjoyment in activities previously enjoyed, sudden weight loss/gain, being overwhelmed, socially unaccepted, unsupported, and/or loss of concentration. What do you think you would do?

Indicate your level of agreement with each statement below (Strongly Disagree – Strongly Agree).

Q8 I would ignore it until the feelings went away.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q9 I would keep the information to myself.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q10 I would talk to a close friend about my feelings.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q47 I would wait six months before seeking help.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q12 I would seek counseling.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q48 I would go to my family doctor for medication.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q13 I would talk to my parent(s) about my feelings.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q49 I would talk to my sibling(s) about how I am feeling.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q50 I would discuss my feelings with my significant other (e.g. spouse, boyfriend/girlfriend, etc.).

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q1 I would try to manage it by myself.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q51 I would hide my concerns from my coworkers.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q15 I would describe how I am feeling on social media.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q16 I would seek help from support groups.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q52 I would seek help from ONLINE support groups.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q53 I would act like nothing is wrong.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q17 I would google my symptoms.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q18 I would talk to a professional.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q63 Home remedies (e.g. sleep, alcohol, drugs) work better than professional help.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q64 I am too proud to ask for help.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q65 I would not seek help because professional push medication.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q19 I would seek help from others who have experienced depression.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q20 We are interested in how you feel people with depression or other mental health issues are treated/viewed by other people. Indicate your level of agreement with each statement about how other people may perceive/interact with those who have mental health issues (Strongly Disagree – Strongly Agree)

Q21 People may be viewed as weak if they suffer from mental health issues.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q22 People may be viewed as broken if they admit to suffering from mental health issues.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q23 They would be seen as a "lesser" person.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q24 Friends would treat people with mental health issues as if they are fragile.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q25 People who are depressed may be rejected by their social circles.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q26 Someone with depression is perceived as a person without a sense of humor.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q27 Depression is not real; some people just have too many worries.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q28 People with depression are lazy and do not want to work.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q29 People who think they are depressed need to work harder to overcome it.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q30 Depression is the devil.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q31 People with depression are just too sensitive.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q32 People with depression have to be medication.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q33 People suffering from mental health issues have a character flaw.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q58 Sometimes getting help has more tangible issues that occur. Indicate your level of agreement with the statements about possible fears/obstacles you

would have if you were seeking help for mental health issues.

Q33 People would not take me seriously if I had depression.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q34 If I seek help professionally medication would be involved.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q31 Counseling/therapy is too expensive for me to get help.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q35 I do not have the money to get help for depression.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q36 Depression is an uncomfortable topic for me to talk about.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q56 I would be rejected from my community if people found out about my struggles.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q60 My doctor would not take my concerns seriously.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q61 My social circles will see me differently if I am diagnosed with a mental illness.

- Strongly disagree (1)
- Disagree (2)
- Neither agree nor disagree (3)
- Agree (4)
- Strongly agree (5)

Q55 Have you ever been formally diagnosed with a mental illness?

- Yes (1)
- No (2)

APPENDIX B. FULL T-TEST RESULTS

T-Test

Group Statistics					
Have you ever been formally diagnosed with a mental illness?					
	N	Mean	Std. Deviation	Std. Error	Mean
Attitudes of the Individual	143	34.8951	6.65732	.55671	
Likelihood to Share Concerns	178	32.2416	6.45830	.48407	

Independent Samples Test

Levene's Test for Equality of Variances						t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)						
Attitudes of the Individual	239	.626	3.609	319	.000						
Likelihood to Share Concerns			3.597	300.215	.000						

Group Statistics

Have you ever been formally diagnosed with a mental illness?					
	N	Mean	Std. Deviation	Std. Error	Mean
Likelihood to Share Concerns	143	19.3357	4.79134	.40267	
Attitudes of the Individual	175	19.9314	4.35704	.32936	

Independent Samples Test

T-Test

	Yes	Mean	Std. Deviation	Std. Error	Mean
Attitudes of the Individual	145	8.3172	2.83751	.23564	
Likelihood to Share Concerns	179	9.8883	3.43459	.25671	

Independent Samples Test

Levene's Test for Equality of Variances						t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)						
Attitudes of the Individual	8.756	.003	-4.420	322	.000						
Likelihood to Share Concerns			-4.508	321.868	.000						

Group Statistics

Have you ever been formally diagnosed with a mental illness?					
	N	Mean	Std. Deviation	Std. Error	Mean
Likelihood to Share Concerns	145	20.3448	5.31949	.44176	
Attitudes of the Individual	177	20.2203	4.85612	.36501	

Independent Samples Test

Levene's Test for Equality of Variances						t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)						
Likelihood to Share Concerns	1.168	.281	.219	320	.827						
Attitudes of the Individual			.217	295.173	.828						

1

T-Test

Levene's Test for Equality of Variances						t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)						
Likelihood to Share Concerns	2.139	.145	-1.160	316	.247						
Attitudes of the Individual			-1.149	290.495	.252						

Group Statistics

Have you ever been formally diagnosed with a mental illness?					
	N	Mean	Std. Deviation	Std. Error	Mean
Attitudes of the Individual	144	18.0417	4.31273	.35939	
Likelihood to Share Concerns	178	16.4551	3.92453	.29416	

Independent Samples Test

Levene's Test for Equality of Variances						t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)						
Attitudes of the Individual	.118	.732	3.450	320	.001						
Likelihood to Share Concerns			3.416	292.659	.001						

Group Statistics

Have you ever been formally diagnosed with a mental illness?					
	N	Mean	Std. Deviation	Std. Error	Mean

3

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