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The Relationship Between the Stigmatization of Mental Illness, Communication Apprehension and the Willingness to Communicate

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Mental Health Communication:

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By

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This thesis has been examined and approved by the following members of the student's committee.

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Acknowledgement and Dedication

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I would like to dedicate my thesis to all individuals who are currently struggling with a mental illness, those who have taken their own lives, and for those who provide support to people who have a mental illness. To my dear friends who are no longer with us, I hope to make you proud and continue to fight for continued mental health research. Living with a mental illness and supporting someone with a mental illness is difficult and is a different journey for all. My work in mental health research is inspired by my own mental health journey and struggles. Lastly, for those who have doubted their lives and positive impact in this world, please remember that you matter, you are loved, and it does get easier.

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Abstract

This project explores how mental health stigmatization influences communication apprehension and the willingness to communicate about mental illness. A total of 153 people completed an online survey regarding three variables. Perceived stigma and communication apprehension when communicating about *their own* mental health were found to be positively correlated. Perceived stigma and communication apprehension when communicating about *someone else's* mental health was also found to be positively correlated. Communicating about *one's own* mental illness lead to higher levels of communication apprehension compared to communicating about *someone else's* mental illness. Communication apprehension when talking about *one's own* mental health and willingness to communicate was found to be negatively correlated. Communication apprehension when talking about *someone else's* mental health and willingness to communicate was also found to be negatively correlated. My study found significant relationships between the three variables. When talking about one's own mental health, perceived stigma increases communication apprehension, which decreases the willingness to communicate. Thus, communication apprehension mediates the relationship between perceived stigma and willingness to communicate. Theoretical implications were explored using Communication Privacy Management theory, Stigma Management Communication theory, and Anxiety/Uncertainty Management theory. Practical implications included increasing social support, mental health literacy, and positive media influence.

Chapter 1: Introduction

It was my sophomore year of college. I couldn't get out of bed and I was struggling to make grades, keep friends, and perform normal daily tasks such as showering, eating, or even leaving my house. I was sad, but not just sad, depressed. I didn't reach out and I absolutely would not talk about it. I was ashamed and embarrassed. Honestly, I didn't want to burden my friends or family and I figured they would never understand. Time started to pass, week by week, and I continued to deteriorate. Later that semester, I was admitted into the psychiatric ward for suicidal ideation. Like many young adults, I didn't take care of my mental health until it was too late, nor was I comfortable seeking support from loved ones. According to the Centers for Disease Control and Prevention (CDC), suicide is "the second leading cause of death among people aged 15-34" (2018, para. 4). In the hospital, I learned how to talk about these tough topics and how to better care of myself. However, the most important piece of information that I received was that it is okay to not be okay. My story illustrates the communicative conundrum of mental illness: Despite the prevalence of mental illnesses, the stigmas surrounding them make them invisible because it is difficult to disclose or talk about these conditions. The only way to prevent mental illnesses from being silent killers is to make talking about mental health more common and accepted.

Statement of Problem

Did reading my personal story make you uncomfortable? Even though research indicates that "more than half of all people will be diagnosed with a mental illness or disorder at some point in their lifetime," in-depth conversations about mental health are

often rare because of social stigma (CDC, 2018, para. 6). The CDC (2018) defines *mental illness* as "conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder, or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day" (para. 1). Social stigma limits individuals who are stigmatized by reducing their perceived status. Individuals with a mental illness are frequently perceived as being highly stigmatized because they are often stereotyped or characterized in popular media as being "dangerous, evil, weak, or purposefully uncooperative, beliefs that often lead to the avoidance and disparagement of the mentally ill in the United States" (Lippert et al., 2020, p. 14). Given the prevalence of these social constructions of mental illness, it is unsurprising they foster uncertainty surrounding how to interact with individuals who experience a mental illness. Moreover, it stands to reason that uncertainty and perceived stigma may further prevent others from reaching out or providing the necessary support that individuals with a mental illness may desperately need. Although Americans have become more aware of mental illnesses in recent decades, efforts to support afflicted individuals have not yet been successful. For instance, the suicide rate has increased by 33% in the past twenty years (Hedegaard et al., 2018).

Previous studies conclude that the inclusion of interpersonal communication and personal experiences through narrative can be beneficial in decreasing mental illness stigmatizations (Elkington et al., 2012; Kellas et al., 2015; McGinty et al., 2018; Wong et al., 2018). However, stigmatizing beliefs about mental illness may hinder the important and necessary conversations for treating serious mental health issues and promoting

positive mental health. Communication provides a gateway for disclosing mental health struggles, as well as providing support for someone who may be at risk, and assistance in seeking professional help. The problem is that individuals are not communicating about their own or others' mental illnesses. My study is important in finding the level of perceived stigma in my sample and identifying the impact that those stigmas have on communication apprehension and an individual's willingness to communicate regarding mental illness. If we can better understand the level at which individuals perceive mental illness and the stigma surrounding it, then we can hopefully find a solution to decrease those stigmatizing perceptions.

Purpose of Study

In this study, I explore the relationship amongst the perceived stigmatization of mental illness, communication apprehension, and the willingness to communicate. The purpose of my study was to distinguish whether or not one's perceived stigma about mental illness affected one's communication apprehension about mental illness and if there was a relationship between communication apprehension and the willingness to communicate about mental illness.

Preview of the Study

In Chapter Two, I review the literature relevant to the stigmatization of mental illness, communication apprehension, and the willingness to communicate about mental illness. Chapter Three explains and elaborates on the methodology I have chosen for this study. More specifically, Chapter Three discusses the approach chosen, participants and procedures, the scales that will be implemented, as well as data analysis and

contributions. Results are provided in Chapter Four. Lastly, Chapter Five contains a discussion of my results and their implications, as well as limitations, and areas for possible future research.

Chapter 2: Review of Literature

Stigmatization of Mental Illness

History

Before we dive into the stigmatization of mental illness, we must first define stigma. *Stigma* is of Greek origin and initially referred to a permanent mark imprinted onto the skin of people who were thought of as morally polluted (Elkington et al., 2012; Frye, 2012). Anyone with said markings was to be avoided because their personal attributes were considered shameful and discrediting (Elkington, et al., 2012; Frye, 2012; Goffman, 1963). Although stigma was originally conceptualized as a physical mark of deviance, it has evolved beyond that to include any physical or social attribute (e.g., illness, race, gender, etc.) that is perceived to separate oneself from being normal or socially acceptable (Goffman, 1963).

Goffman (1963) explains that there are three different kinds of stigmas: "abominations of the body," "blemishes of the individual character," and "tribal stigmas" (p. 4). The first type of stigma refers to physical attributes such as being physically unattractive or abnormal. This type of stigma can be visibly seen and identified. The second type of stigma relates to an individual's character, values, and morals. Goffman (1963) argues this stigma is frequently attached to individuals whose behaviors deviate from socially constructed norms, such as those with a "mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior" (p. 4). Unlike abominations of the body, blemishes of individual character are often invisible. If the individual does not disclose the stigmatized behavior,

society may never know. However, the individual may experience stigmatization if the characteristic is disclosed. The third type of stigma, "race, nation, and religion," may be visible and/or invisible (Goffman, 1963, p. 4). For example, unless the individual is practicing their religious beliefs in a space where it can be viewed, it may be unclear or unknown to others. Goffman (1963) also explains that all individuals have a social identity developed from our "personal attributes," that may or may not be deemed acceptable based on our "normative expectations" (p. 2). Those who do not meet the expected social norms may encounter judgement or may be labeled as different from others. They may be viewed as having lower potential or seen as incompetent, weak, or lazy based on their stigmatized and, therefore, discreditable behaviors. For instance, in professional settings, an individual with a known stigma may have all the qualifications and skills necessary to excel in a certain job, position, or relationship but may not be given a chance based on the decision maker's bias, lack of education, or even the fear that the stigmatized person cannot handle the responsibility. Gray (2002) states that individuals who are stigmatized "may come to accept others' low expectations of them and give up trying. Hopelessness and lack of prospects are a factor in the high suicide rate of people with severe mental health difficulties" (p. 74). Individuals may come to believe they are not worthy or capable of being anything more than what they are labeled. Goffman states, "he is thus reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3).

Stigmas are very prominent in health context because social norms often dictate which bodies are considered "normal" or "deviant." Some health issues are often seen as

controllable, whereas some are seen as uncontrollable. For instance, some illnesses, diseases, or conditions are seen as acceptable and not shameful, such as a common cold, stomach flu, or a sprained ankle. These conditions are most often viewed as uncontrollable, particularly when the affected individual is not perceived as having agency for becoming ill or injured. However, other conditions, such as sexually transmitted infections (STIs), addiction, or mental illness are stigmatized at a much greater level because they are viewed as being connected to an individual's agency and character. For example, individuals who are diagnosed with an STI are stigmatized for being promiscuous or easy. Individuals battling addiction may be stigmatized as weak or too lazy to face their problems. Lastly, those with a mental illness are often characterized as being dangerous, unpredictable, and weak. These illness are labeled more as controllable. The person with the illness is stigmatized because they are perceived as having control over actions or circumstances affecting their well-being, which then discredits their character deeming them as a lesser human being (Gray, 2002).

During ancient times, individuals who suffered a mental illness were treated no better than slaves or criminals, facing harsh punishments such as torture, isolation, and even death (Rössler, 2016). In the Middle Ages, individuals with a mental illness were said "to be possessed by the devil" and suffered excruciating punishments such as being "burned at the stake or thrown in penitentiaries and madhouses where they were chained to the walls or their beds" (Rössler, 2016, p. 1250).

The Enlightenment, often known as the Age of Reason, ushered in changes to public perceptions of those with mental illnesses. The Enlightenment was an era of

intellectual reasoning in the 18th century that provided a sense of empiricism. As scientific understanding of mental illnesses expanded, individuals who were afflicted with these conditions "were regarded less as being possessed, evil or practicing as witches, but suffering from some mysterious disease process" (Carron & Saad, 2012, para. 5). As a result of the 1845 Lunacy Act in Great Britain, individuals with mental illness were freed from the penitentiaries and other institutions. Organizations were created to help those who suffered as the result of being institutionalized (Carron & Saad, 2012).

In the United States, the Enlightenment also sparked the development of new kinds of institutions aimed at treating mental illness, known as asylums. Such spaces were intended to provide more humane and better treatment for patients. Yet, the language used to describe these institutions indicate the lingered social stigmatization of individuals with mental illness. For example, institutions were often referred to as insane asylums, lunatic asylums, or mental asylums; some were even referred to as madhouses (Ozarin, 2006).

Some asylums provided new forms of treatment that replaced cruel and harsh regiments (e.g., painful long-term restraints and complete isolation) with more compassionate and humane approaches, such as experiencing the "healing values of fresh air, exercise, civilized interaction and conversation with the other patients" (Carron & Saad, 2012, para. 7). However, some asylums did not, favoring harsher therapies meant to control patients. From the early 1900's until the 1960's, hydrotherapy, surgery, insulin coma therapy, Metrazol therapy, shock therapy, electroconvulsive shock therapy,

lobotomies, and sedation medications were some of the early psychiatric “treatments” offered to individuals experiencing mental illness (Fabian, 2017). Treatments seemed to be a looser term for experiments. Some asylums “also relied heavily on mechanical restraints, using strait jackets, manacles, waistcoats, and leather wristlets, sometimes for hours or days at a time” (Fabian, 2017, para. 7).

Today’s treatment regiments have improved tremendously, thanks to advances in technology and psychiatric understandings of mental illness. The improved alternatives include short-term psychiatric or mental health hospitals, 24-hour crisis services, and outpatient services and therapy. Rather than being locked patients away, patients are more commonly integrated into society and provided services through community mental health systems that allow them to be treated and remain part of society. Even though institutions and treatments have improved, the stereotypes associated with individuals with mental illness and psychiatric hospitals have not.

Psychiatric hospitals, often called psych-wards, still bring forth stereotypical images of restrained patients, electric shock chairs, padded rooms, and lobotomies. However, such images are inaccurate. Psychiatric hospitals provide a safe and supportive environment for an individual who is struggling with their mental health and helps them to find the proper treatment. These hospitals provide numerous outlets for growth and healing, such as both individual and group therapy, mindfulness and relaxation exercises, goal setting, as well as meetings with a psychiatrist to assess mental state and provide a course of treatment. Despite these positive changes, the stigma surrounding around

mental illness continues to linger. Both the remembrance of historical beliefs and the media play a large role in continuing said stigmas.

The media has a significant impact on how we view certain topics and how we shape our opinions of those with stigmatized behaviors. “The media, including newspapers, movies, television, disperses various stigmatizing images and slogans about severe mental illness throughout our community” (Corrigan, 1998, p. 212). Moreover, the media continues to reinforce the stigmatization of mental illness through how it is presented in popular culture. According to Stuart (2006), “Studies consistently show that both entertainment and news media provide overwhelmingly dramatic and distorted images of mental illness that emphasise dangerousness, criminality and unpredictability. They also model negative reactions to the mentally ill, including fear, rejection, derision and ridicule” (p. 99). People find mental illness intriguing and mysterious, which makes it interesting and engaging to watch or read about. However, depictions of mental illness are not always accurate and tend to escalate the severity character’s illnesses and behaviors. When people watch different media portrayals of mental illness, their beliefs and opinions may be skewed and tainted to believe stereotypes of the mentally ill (e.g., dangerous, unpredictable, or even scary). For instance, a study by Quintero Johnson and Riles (2018) measured whether or not college students’ perceived stigma based on media depictions directly influenced their attitudes and behaviors towards someone with a mental illness. Their findings identified that there was in fact a direct correlation between students’ stereotypical depictions of mental illness within characters in the media and the reflection of those beliefs onto those who are diagnosed with a mental illness. Similarly,

Aguiniga et al. (2016) found that "students who received their primary mental health education from television and film were more likely to believe they were seeing realistic portrayals of mental illness and view portrayed stereotypes of mental illness as acceptable" (p. 428). As the aforementioned studies indicate, negative representations of mental illness perpetuate negative and potentially dangerous stereotypes that further marginalize individuals with a mental illness. Now that I have defined stigma and have explored the history of stigmatization in regard to mental illness, I will define perceived stigma and expand on its consequences and limitations for communicating about mental illness.

Perceived Stigma

Perceived stigma, also known as public stigma, is a form of stigmatization that is projected by others towards individuals who have a mental illness. "The public stigma is the perception held by others that the mentally ill individual is socially undesirable" (Latalova et al., 2014, p. 1399). Society holds numerous stigmatizing beliefs towards individuals with a mental illness. Two of the greatest misconceptions are that individuals who suffer with a mental illness are dangerous and unpredictable (Hensley, 2006; Latalova et al., 2014). Given the prevalence of such misconceptions, individuals may become apprehensive about communicating or involving themselves with someone who has a mental illness.

Having a mental illness can be very difficult to cope with, especially when an individual perceives they are being treated differently and unfairly because of their condition. Individuals with a mental illness often face rejection, blame, and exclusion

based on societal stigmatizations (Zieger et al., 2016). There is evidence that people who suffer from a mental illness are discriminated against in many different areas of their lives, including employment, housing, medical care, access to services, and interpersonal relationships (Fox et al., 2018; Zieger et al., 2016). A case point: Corrigan (1998) notes that landlords have refused to rent to, and employers have refused to hire individuals with a disclosed mental illness. Moses (2010) found that even teachers tend to distance themselves from students who have a mental illness because they fear they may be threatening or challenging, leading to a decreased interest in their education. According to Stuart (2008), "Mental illness was one of the most deeply discrediting and socially damaging of all stigmas, such that people with mental illnesses start out with rights and relationships but end up with little of" (p. 185).

As explained earlier, experiencing perceived stigma can be damaging for an individual's identity. It can also be hurtful to encounter enacted stigma, or deliberate discrimination related to a stigmatized characteristic. Discriminatory actions may include (but are not limited to) name-calling for belittlement, restricting resources such as job security or housing, or withdrawing from someone's life because they are facing discreditable characteristics or behaviors. Encountering this type of discrimination can lead to experiencing felt stigma, which "refers to the shame and expectation of discrimination that prevents people from talking about their experiences and stops them from seeking help" (Gray, 2002, p. 72). The difference between enacted stigma and felt stigma is that individuals may face different enacted discriminating actions, but once they feel discredited and shameful, they then believe the stigmatization as well. Felt stigma is

often referred to as self-stigmatization, and often has profound impacts on an individual's identity (Gray, 2002).

Self-Stigmatization

Self-stigmatization occurs when an individual internalizes real or perceived social stigma, creating feelings of burden, hopelessness, shame, self-doubt, and intensifying distress (Heflinger & Hinshaw, 2010; Oexle et al., 2017; Wong et al., 2018). The process starts when an individual with a mental illness is categorized by a specific characteristic. For example, an individual with schizophrenia may be stigmatized by others as being dangerous. The individual may then internalize the stigmatizing belief, believing that they truly are dangerous. "Once a person internalizes negative stereotypes, they may have negative emotional reactions. Low self-esteem and poor self-efficacy are primary examples of these negative emotional reactions" (Corrigan & Rao, 2012, p. 465). Sometimes self-stigmatization can be a defense mechanism. Because an individual knows the stigmas associated with individuals with a mental illness, it allows them to attempt to avoid enacted stigma. To avoid enacted stigma, individuals who live with a mental illness may conceal their condition and avoid disclosure as a coping mechanism; therefore, bottling it all up (Oexle et al., 2017). Behaviors of enacted stigma may include distancing oneself from an individual with a mental illness, belittling them, treating them differently, or blatant disapproval. Oexle et al. concludes that perceived stigma increases both secrecy and hopelessness, leading to a higher level of suicide ideation. "Social rejection causes diminished self-efficacy, which leads to social withdrawal" (Gray, 2002, p. 74). Because of self-stigmatization, individuals who suffer with a mental illness may not feel

comfortable reaching out for help or discussing their condition with anyone. Individuals who have a mental illness may be nervous or avoidant of conversations involving mental illness, and on the other end, society may also face communication apprehension about mental illness, due to perceived stigma. Both self-stigmatization and perceived stigma can sabotage chances and instances where a conversation could have been started, but didn't, due to the stigmatization of mental illness.

Like other stigmatized identities, mental illness can be difficult to talk about due to increased anxiety and uncertainty and a decrease in comfort with the subject for many individuals. Communicating about mental illness has not been well-studied, which means there is limited understanding of how much uncertainty and anxiety exists around the subject. Learning more about how to minimize these feelings is crucial for increasing mental health literacy and decreasing stigmatizing beliefs surrounding mental illness. Due to negative societal beliefs about mental illness, engaging in conversations about mental health can be affected by communication apprehension. In this next section communication apprehension will be defined and explored using established concepts and past research.

Communication Apprehension

McCroskey (1977) defines *communication apprehension* as "an anxiety syndrome associated with either real or anticipated communication with another person or persons" (p. 78). McCroskey's first conceptualization of communication apprehension only concerned trait-like, personality-type variables effecting oral speech (McCroskey, 1984). Trait-like communication can be caused by either heredity or the environment, more

specifically we are either born with that trait or it can be a learned behavior (McCroskey, 1984). For instance, if a child is more sheltered and has less opportunity in different communication channels, they may be predisposed to be shyer. McCroskey (1997) later modified the communication apprehension to include all modes of communication and situational factors. He states, "to view all human behavior as emanating from either trait-like, personality orientation of the individual or from state-like constraints of a situation ignores the powerful interaction of these two sources" (p. 84). Individuals who are all faced with the same situation, will not all react in the same manner. We cannot "predict a universal behavior from all individuals" (McCroskey, 1997, p. 84). The idea of predicting universal behaviors can also be applied to stereotyped individuals with a mental illness. We cannot predict that all individuals with a mental illness will behave in the same manner as another mentally ill individual, even if they have the same diagnosed illness. This type of situation may provide more apprehension when communicating with someone who has a mental illness, because their behaviors or actions may look different than someone else who is affected with the same illness or a different mental illness all together. There are many factors that influence effectiveness in communicating with an individual who experiences a mental illness. For example, apprehension can vary based on an individual's background and life experiences, family upbringing, and education. Individuals who grew up around individuals with a mental illness or were educated on the subject may have lower levels of communication apprehension when compared with someone who is familiar with mediated depictions of mental illness. Stigmatizing beliefs

can decrease or grow through many different channels of communicative messages whether that be learned experiences or portrayals in the media.

Moreover, communication apprehension is not a permanent trait. McCroskey (1997) explains that true traits are characteristics we cannot change once we are our adult form, such as eye color or height. This differs from trait-like personality variables, which can change during adulthood (McCroskey, 1997). For instance, the cerebrum, which controls thinking, learning, emotions will not be fully developed until age 25. Our frontal lobe, which contributes to our ability to reason and initiate communication, holds our emotional control and memory, and also controls our impulses and social behaviors does not fully develop until our mid 30's. Throughout individuals' adolescent and young adulthood, different behaviors can be learned and practiced. For example, an individual may decide to go to college which provides many opportunities to learn different organizational skills and will provide room for growth in their communication skills. If the individual was very shy and introverted, college may provide room for growth in both their personal and professional lives. For instance, an introductory communication course allows students to enhance their skills in various situations. In contrast, an individual with the same shy and introverted demeanor who decides not to pursue higher education may have less opportunities to grow these specific skills. This individual may learn behaviors such as time management and responsibility by starting a career early on without a college degree. How a child is raised in their pre-pubescence years does not account for their personality traits as they grow through learned experiences. Human beings do not react or behave in the same manner in the same situations. Levels of apprehension can be

changed over time based on exposure or a changed level of knowledge. Communication apprehension can also either increase or decrease depending on different situations and circumstances. For example, after watching a movie about an individual with a mental illness, one may either be intrigued and drawn to talk about mental illness or completely opposed or turned off by the subject.

McCroskey's (1997) concept of *generalized-context communication apprehension* recognizes that "people can be highly apprehensive about communicating in one type of context while having less or even no apprehension about communicating in another type of context" (p. 85). Although some individuals may be apprehensive about speaking face to face with someone, others may be less likely to talk on the phone, or perhaps they may be opposed to talking to people who differ from them. McCroskey states that for some people, "more apprehension may be stimulated by unfamiliar individuals or groups" (p. 86). Different situations provide a different level of communication apprehension depending on the individual and their background, experiences, or even their mental health. For instance, an individual diagnosed with an anxiety disorder may have a higher level of apprehension in certain situations. Some situations that may increase communication apprehensions are "novelty, formality, subordinate status, conspicuousness, unfamiliarity, dissimilarity, and degree of attention from others" (McCroskey, 1997, p. 93). McCroskey gives the example of a student asking a teacher for help. The student may face a small amount of apprehension when approaching the teacher for help on an assignment but may face a large amount of apprehension if the teacher says to meet her after class to discuss the problem. The student has a longer wait

period to stew on all the possible outcomes of the conversation. Another example may be a significant other sending the text message: “we need to talk.” There is no clarification as to what the conversation will be about and whether there is a threat to the relationship, which can increase apprehension.

McCroskey (1997) explains *pathological communication apprehension* as every individual being affected by communication apprehension to a different degree. Pathological apprehension considers the normal level of fear human beings face in a life-threatening or scary situation (McCroskey, 1997). Only a small minority of people do not feel fear, it is extremely rare. “At the conceptual level, we view abnormal behavior to be which is nonadaptive, nonresponsive, or nonfunctional in the environment which it is engaged” (McCroskey, 1997, p. 89). In order to be functional in society, individuals need to be aware and mindful of their environment. If an individual is severely afraid of many different situations, the level of communication apprehension would be seen as abnormal. For example, all students need to fulfill a public speaking requirement at specific universities. Most students are able to present their speech with normal levels of apprehension. Some of these apprehensive behaviors might be including filler words, sweating, or fidgeting. An abnormal amount of communication apprehension could lead to passing out, vomiting, or avoiding the speech all together. Different situations provide higher or lower levels of apprehension based on the individuals experiences and concept of life-threatening situations. Watson et al., (1989) found that communication apprehension can have a negative impact on individuals because it decreases communication and affects overall life experiences.

Situational communication apprehension "represents the reactions of an individual to communicating with a given individual or group of individuals at a given time" (McCroskey, 1984, p. 18). This type of communication apprehension changes based on situation. An individual may feel more apprehension when communicating with a certain individual or group of individuals in one situation in comparison to a different situation. For example, an individual may feel less apprehension when having a friendly interaction with a police officer while waiting in line at a restaurant but may feel more apprehension when being pulled over by a police officer while driving. In a mental health context, an individual may feel less apprehension when having a casual conversation with a friend that has a disclosed mental illness but may feel more apprehension if the friend needs to talk about their mental illness. Different conversations and different situation can spark different levels of communication apprehension. Prior history can also impact situational communication apprehension (McCroskey, 1984). If an individual has a negative experience in a specific situation, they will most likely feel more apprehension when faced with that same situation. For instance, if an individual is called into their boss' office and their work is negatively criticized, they may have more apprehension the next time they are called in, regardless of how positive or negative the situation may be.

McCroskey & Beatty (1986), outline three behavioral responses when faced with high levels of communication apprehension: "avoidance, communication withdrawal, and communication disruption (p. 287). When faced with high levels of communications individuals have a choice on how they will respond; they may choose to engage in the confrontation or avoid it all together, which is not always possible. If avoidance is not an

option, the individual may withdraw from communication by simply staying silent, or only engaging enough to get through the interaction. The third behavioral response is communication disruption, where an individual "may not be fluent in verbal presentation or exhibit unnatural or inappropriate verbal or nonverbal behaviors (McCroskey & Beatty, 1986, p. 287).

McCroskey (1984) explains *person-group communication apprehension* as the level of anxiety or the behavioral reactions when communicating with specific individuals or groups of people. "People viewing CA from this vantage point recognize that some individuals and groups may cause a person to be highly apprehensive while other individuals or groups can produce the reverse reaction (McCroskey, 1984, p. 17). For instance, some individuals may feel more apprehension when talking to a stigmatized group of people, such as those who experience mental illness, whereas others may not have that same level of apprehension. This type of communication apprehension is not characterized as trait-like or personality based, but rather a reaction to the situational constraints when communicating with a certain group of people (McCroskey, 1984). Similarity can also play an important role in levels of communication apprehension. Some individuals may be more at ease when talking to peers or individuals who are similar to them, whereas others may feel more apprehensive and pressured because they fear judgement or comparison.

To date, there has been some research on communication apprehension related to stigmatized identities. For example, Rudnick (2012) explores communication apprehension within a LGBTQ+ cultural context. Rudnick found that due to stigmatizing

beliefs, LGBTQ+ instructors are faced with a difficult decision when considering disclosure of their sexual orientation in the classroom. These individuals may face different obstacles such as a decrease in trust, competence, credibility, and other valued skills and dynamics within the classroom. Not only do LGBTQ+ individuals face discrimination and stigma in the classroom, but also in our society. According to the CDC (2016), promoting or engaging in a LGTBQ+ lifestyle "can lead to rejection by friends and family, discriminatory acts and violence, and laws and policies with negative consequences" (para. 3). Disclosing one's sexual identity or sexual orientation can be terrifying because there is a possibility for enacted stigma. To be clear, I am not equating an LGBTQ+ identity to a mental illness identity. However, what these identities have in common is that other people have a tough time accepting and understanding individuals who may be different from them. Rudnick explains that LGBTQ+ professors may have a difficult time disclosing and expressing themselves in the classroom due to fear of stigmatization. The same concept can be applied to individuals who have a mental illness. Individuals with a mental illness may also face apprehension when thinking of disclosing their illness due to stigmatizing beliefs.

This representation shows the communication apprehension individuals with a mental illness may face. McCroskey's (1997) concept of not being able to "predict a universal behavior from all individuals" can help build an understanding of why individuals may be more apprehensive to disclosing (p. 84). Not being able to predict the outcome and conversation after disclosing a stigmatized identity can increase communication apprehension.

The second type of stigma that Goffman (1963) refers to includes individuals who have an invisible disability or a stigmatized characteristic that is unknown unless disclosed. People would be unable to stigmatize an individual who is part of the LGBTQ+ community, or an individual with a mental illness unless their "discrediting" characteristics were disclosed. One cannot look at an LGBTQ+ individual and just know that they identify with that group, that characteristic is invisible and unknown.

Research conducted by Magsamen-Conrad et al., (2016) similarly focused on how apprehension with stigmatized identities specifically in the context of disability. Magsamen-Conrad et al. surveyed college students and found that self-esteem and lack of contact with individuals with a disability were two enablers of negative attitudes and stigmatizing beliefs towards people with lived differences. Magsamen-Conrad et al., states, "Withdraw-oriented communication patterns would influence individuals' contact experience(s) with others, especially those with disabilities" (p. 331). Individuals who did not have a disability avoided individuals who did have a disability because they were unsure of that person's behaviors due to lack of contact and understanding. The same scenario can be applied to individuals with a mental illness. People who do not have a mental illness may avoid individuals who do have a mental illness based off of behavioral uncertainty. Stigmatizations of mental illness provide an illusion of what mental illness may look, sound, or feel like.

I discuss these two studies for a specific reason: Rudnick's research article pertains to an individual's decision whether to disclose potentially stigmatizing personal information, whereas Magsamen-Conrad proposes how non-disabled individuals

communicate with someone who lives with a visibly stigmatized identity. With these two studies in mind, we can infer that individuals who are different from "the normal" can provoke stigmatizing beliefs and insight into different levels of communication apprehension.

There are two different angles of communication that I focus on in this study. First, I am interested in how individuals feel about disclosing their own mental health struggles. Additionally, I explore how individuals discuss someone else's mental health struggles. I chose to look at both perspectives to determine which type of communication presents a higher level of communication apprehension. Individuals who are determining whether or not to disclose their own mental illness may feel communication apprehension due to perceived stigma. Many factors could play a role in this decision. For instance, an individual's traits, predisposition, or experiences with perceived stigma or previous conversations about mental illness could greatly impact one's communication apprehension (McCroskey, 1997). If the individual has the predisposed idea that mental illness should be kept as private information due to negative perceptions of others than they may be less likely to disclose. Similarly, past experiences either disclosing or listening to others discuss mental illness in a negative light could induce more anxiety when thinking of disclosure. Moreover, individuals who do not have a mental illness may also be apprehensive when communicating with someone with a mental illness. McCroskey's (1984) definition of *person-group communication apprehension* induces the thought that individual's may be more apprehensive when communicating with specific individuals or groups of people who have a stigmatized identity. Individuals who

do not have a mental illness may frame their beliefs and possible outcomes of the conversation solely on societies' ideas and stigmatizations of mental illness, hindering their level of comfortability when engaging in that type of conversation. With these two scenarios in mind, I propose my first set of hypotheses:

H1a: Individuals communicating about their own mental illness will have an increased level of communication apprehension.

H1b: Individuals communicating about someone else's mental illness will have an increased level of communication apprehension.

H1c: Individuals communicating about their own mental illness will have a higher level of communication apprehension than individuals communicating about someone else's mental illness.

I propose that individuals will have a high level of communication apprehension when discussing their own mental illness due to self-stigmatizing beliefs. I also believe that due to perceived stigmatizing beliefs, individuals will have a high level of communication apprehension when communicating to someone about their mental illness. Talking to someone about their mental health can be nerve wracking, especially if one party believes the person may be unpredictable or dangerous as a result of their condition. However, I predict that communication apprehension will be higher when discussing one's own mental illness. For instance, the National Alliance on Mental Illness (2021) states that only "43.8% of U.S. adults with a mental illness received treatment in 2019" and only "65.5% with a serious mental illness received treatment in 2019" (para. 7). That is still roughly 50% of individuals who are suffering with a mental illness who have yet to be

treated. Almost 50% of individuals with a mental illness have decided not to disclose their illness or have refused treatment due to communication apprehension regarding mental illness. Individuals contemplating conversations about mental health, whether disclosing or providing support, have three different behavioral responses: “avoidance, communication withdrawal, and communication disruption” (McCroskey & Beatty, 1986, p. 287). All three behavioral responses depend on an individual’s willingness to communicate about mental health. In this next section willingness to communicate will be defined and elaborated based on previous scholarly literature and previous studies.

Willingness to Communicate

McCroskey and Richmond (1998) define *willingness to communicate* as “an individual's predisposition to initiate communication with others” (p. 120). The key word in this definition is “initiate.” Initiating a conversation is more difficult than simply replying to someone or answering a question, because it is already known that the individual wants to communicate. When an individual decides to initiate a conversation, they are putting themselves out there for an endless possibility of responses. Interpersonal perception allows individuals to form impressions, evaluations, and essentially judgements of the people around them. Starting a conversation with someone can be terrifying, because unless stated, the other person’s perception is unknown. This uncertainty leaves an individual who initiates a conversation to decide whether the risk of engaging in conversation is worth any potential drawbacks. McCroskey & Richmond (1987) explains that the degree of talking is different for every human being, whether they are starting the conversation or simply replying if they are spoken to. They also state

that some individuals talk more or less depending on who the conversation is with and can be dependent on what the context of the conversation regards (McCroskey & Richmond, 1987). Previous research indicates that certain individuals have a tendency to communicate more frequently than others regardless of the situation (McCroskey & Richmond, 1987). These individuals have a stronger willingness to communicate personality variable.

Burgoon (1976) provides an oppositional view explaining unwillingness to communicate where "anomia, alienation, introversion, self-esteem and communication apprehension" are her main variables when accounting for someone's level of unwillingness to communicate (p. 60). People who have anomia are generally socially awkward as they have not learned or adapted to society's communication norms, values, or standards (Burgoon, 1976). Anomics are often "alienated from society" leaving them feeling more insecure and checked out from conversations, which results in a negative view of communication (p. 60). Burgoon (1976) states that introversion also can play a role in someone's unwillingness to communicate. Introverts tend to be more shy, timid, and less likely to engage in conversation, communication apprehension may impact someone's level of introversion. Similarly, McCroskey & Richmond (1987) address that shyness could be a factor in someone's willingness to communicate as a shy person is generally more guarded and desires less talking. People with poor self-esteem are also said to be more unwilling to communicate because they fear rejection or criticism of their opinions or thoughts. Poor self-esteem when communicating often stems from a past negative experience when communicating with others (Burgoon, 1976). The last

variables Burgoon (1976) mentions are communication apprehension and reticence. A reticent person is generally withdrawn from communication as they avoid social conversation or communication with their superiors. Reticent individuals avoid confrontation by choosing not to express their ideas, problems, or opinions out of fear that they may be challenged or questioned (Burgoon, 1976). “Moreover, the reticent or communication apprehensive person is insecure, feels inadequate in communication, is easily embarrassed, shy, withdrawn and prone to agree with others” causing a “predisposition of unwillingness to communicate” (Burgoon, 1976, p. 62). Burgoon’s construct helps to explain an individual’s predisposition to avoid or devalue communication.

McCroskey and Richmond (1998) conducted multiple studies over the past few decades to investigate what contributes to a person’s willingness to communicate. They found that an individual’s traits can play a large role in willingness level; however, situational factors may also apply. Willingness to communicate and communication apprehension studies first started in regard to only public speaking but have later included all types of communication channels including communication in small groups or even everyday conversations. McCroskey (1997) states:

> Whether a person is willing to communicate with another person in a given situation is affected by situational constraints of that encounter. Many situational variables can have an impact. How the person feels that day, what communication the person has had with others recently, who the other person is, what that person looks like, what might be gained or lost through communicating and what other

> demands on the person's time are present can all have a major impact, as can a wide variety of other elements not specified here (p. 77).

Therefore, studies designed to measure someone's willingness to communicate must include different situational factors across different audiences such as strangers, acquaintances, friends, doctors, etc. Stating that an individual will be less willing to hold a conversation strictly based on personality-based trait-like predispositions would be equating that an individual will react in the same manner across multiple communication situations. McCroskey and Richmond (1998) found it mandatory when creating their WTC scale to include an individual's level of willingness to communicate with all receivers throughout different communication contexts or situations. Where Burgoon (1976) listed the different personality traits as factors in the level of someone's unwillingness to communicate, McCroskey and Richmond (1998) refer to these traits as antecedents. While these personality-based traits could impact someone's willingness to communicate, it cannot be proven that they cause someone's tendency to communicate without factoring in situational elements. McCroskey and Richmond (1998) also include communication skills and cultural divergence as antecedents of willingness to communicate. People with poor communication skills are more likely to be reticent and withdrawn from conversation because they are aware of their deficiency and fear making a mistake or embarrassing themselves. Communication expectations and norms are different across different cultures. To be culturally divergent, one must be able to adapt to different cultural communication norms. Individuals who "do not know how to communicate effectively" with someone from a different culture "tend to be less willing

to communicate at all for fear of failure and possible negative consequences" (McCroskey & Richmond, 1998, p. 140). In general, some may find it difficult to communicate with someone who is different than them. There is a sense of unknown and uncertainty which may decrease someone's willingness to communicate. More specifically, it could be more difficult to communicate with someone who may be stigmatized based on their differences. Individuals who are stigmatized may also find it harder to communicate with someone who does not have that stigmatized differentiating trait or illness, such as a mental illness.

When an individual with a mental illness is faced with the difficult decision to disclose their illness (or not), their choices are likely to be shaped by perceived disclosure risks, such as enacted mental illness stigma. Individuals may also be less likely to initiate certain kinds of conversations based on situational factors. For instance, individuals who self-stigmatize their mental illness may feel hopeless, shameful, or burdening. Communicating one own's struggles with mental illness can be extremely difficult. "Those contemplating disclosure of mental illness information recognize the possibility for negative consequences including avoidance, rejection, or relational damage" (Venetis et al., 2018, p. 653). With such scrutinizing and negative beliefs, someone suffering may feel less inclined to initiate a conversation or disclose their mental illness. When roles are reversed, individuals who have perceived stigmatizations towards people with a mental illness may feel uncomfortable or nervous due to the stigmatizing beliefs that the mentally ill are dangerous or unpredictable.

There is a large gap in literature when it comes to willingness to communicate about mental illness or even mental health in general. There are only a few areas where health and willingness to communicate have been studied together such as cancer disclosure, organ donation, HIV/AIDS, and patient/provider communication. The most closely related study I found explored the relationship between the willingness to communicate and anxiety associated when talking to an intercultural health professional (Logan et al., 2016). Logan et al. found that with heightened anxiety and lower predictability, came a decrease in the patient's willingness to communicate. The same logic can be used when discussing communicating about one's mental illness. Disclosing a mental illness can be anxiety-inducing and the outcome of the conversation is unpredictable. According to Logan et al., when anxiety and unpredictability was high, the level of one's willingness to communicate decreased. It would be assumed that in a mental health setting, the results would be similar; as communication apprehension increases, the willingness to communicate will decrease. Surveying willingness to communicate about one own's mental illness and willingness to communicate with someone about their mental illness is essential in identifying levels of communication apprehension and its relationship to willingness to communicate in both communication scenarios. My hypotheses are as follows:

> H2a: The higher the level of communication apprehension when talking about one's own mental illness, the lower the degree of willingness to communicate about mental illness.

H2b: The higher the level of communication apprehension when talking about an acquaintance's mental illness, the lower the degree of willingness to communicate about mental illness.

My final hypotheses explore the relationship between all three variables: perceived stigma, communication apprehension, and willingness to communicate. Perceived stigmatization of mental illness could increase communication apprehension, in turn, leading to a decrease in the willingness to communicate about mental illness due to the stigmatizing beliefs that increased said apprehension. Perceived stigmatizations of mental illness could increase levels of communication apprehension due to unknown possibilities and outcomes of the conversation. If an individual who does not have a mental illness believes the negative stereotypes associated with mental illness, such as dangerous or radical behaviors and unknown emotional stability, they may have a higher level of communication apprehension and less desire to engage in communication. Individuals who do have a mental illness may internalize real or perceived stigmatization which could lead to a higher level of anxiety associated with the fear of possible judgement or negative responses. An increase in communication apprehension regarding mental health conversations will likely result in a lower level of willingness to communicate due to the unknown outcome of the conversation. These justifications allowed me to propose my next two hypotheses:

H3a: When perceived stigma increases, communication apprehension will also increase causing a decrease in willingness to communicate about one's own mental illness.

H3b: When perceived stigma increases, communication apprehension will also increase causing a decrease in willingness to communicate about an acquaintance's mental illness.

Chapter Two captured the important topics that help the audience to better understand what mental health stigma is and how it may affect communication apprehension and the willingness to communicate. This next chapter will provide all the necessary information to explain and better understand the methodology that was chosen to gather my results. Furthermore, the study will look specifically at ways in which participants have viewed the perception of mental health stigmatizations, observe and apply their own beliefs and behaviors towards their apprehension when communicating about mental illness, and lastly, participants will assess their willingness to communicate about mental illness within their own life. Participants will categorize their levels of perceived stigma, communication apprehension, and willingness to communicate through modified pre-set scales.

Chapter 3: Methodology

Approach

I chose a quantitative approach because I was interested in identifying the statistical correlation between perceived stigma, communication apprehension and the willingness to communicate about mental illness. I was also interested to see the significance level of my results and identify the impact of my study.

Participants and Procedure

153 people participated in this study. Regarding gender, 19.6% (30) identified as males, 79.7% (122) identified as females, and .7% (1) chose other. The participants were also given four age categories to choose from: 49% (75) chose 18-22 years old, 34% (52) chose 23-26, 7.2% (11) chose 27-30, and 9.8% (15) chose 31-35. The last demographic question asked if participants had ever been diagnosed with a mental illness, 43.8% (67) answered yes, 55.6% (85) answered no, and .7% (1) preferred not to say.

I chose an online survey because it was a contactless way to collect data, therefore protecting the safety and health of both me and my participants amid the COVID-19 pandemic. Additionally, an online survey was a logical option given the sensitivities of talking about mental illness. Questions about mental illness can be difficult or even uncomfortable for individuals to answer, especially if they are in presence of someone else, such as a researcher. An online survey provides a safe and comfortable environment by reducing participant's perceived face threat, potentially increasing people's willingness to participate. I chose to survey young adults (ages 18-35) because in the future they could help to decrease stigmatizing beliefs about mental illnesses. I also chose

this age range because my survey is online and most young adults will have access to the survey through technology. I choose 18 as the minimum age for participation because I believe that they will have a good sense of what a mental illness is and how it may be impacting their life or someone they know. The survey was created using Qualtrics and was administered via Facebook and through the SONA system. I posted the survey through my own personal Facebook account. The SONA system is a research portal used by Minnesota State University, Mankato that enables students to complete different surveys in exchange for extra credit. Both forms of the survey were anonymous.

Instrumentation

The survey includes three different modified scales and three demographic questions. The three demographic questions were: age, gender identity, and mental illness diagnosis (see Appendix A). Respondents completed a 10-item modified version of the Depression Stigma Scale (Griffiths et al., 2004), a 20-item modified version of the Intercultural Communication Apprehension Scale (Neuliep & McCroskey, 1997), and a 20-item modified version of the Willingness to Communicate Scale (McCroskey & Richmond, 1987).

Perceived Stigma of Mental Illness

The 10-item version of the Depression Stigma Scale (Griffiths et al., 2004) measured the degree to which individuals feel perceived mental health stigmatization (see Appendix B). The original version of the scale was designed to measure both personal and perceived stigma of depression. I adapted the scale to measure only perceived stigma, and to all mental illnesses, not just depression. The instrument asked individuals to

identify how the public feels about individuals with a mental illness (e.g., “Most people believe that mental illness is a sign of personal weakness”, “Most people believe that people with mental illness are dangerous”, “Most people would not employ someone they know had been mentally ill”). A five-point Likert scale that ranges from *strongly disagree (1)* to *strongly agree (5)* was used to measure responses. The higher the score on the scale, the higher the level of perceived stigmatization. The average level of perceived stigma was 29.4 (SD = 6.8). Alpha reliability for the scale was .830.

Apprehension when Communicating about Mental Illness

The Intercultural Communication Apprehension Scale was developed by Neuliep and McCroskey in 1997 to determine whether there is apprehension about intercultural communication. According to Neuliep and McCroskey (1997), “Intercultural communication apprehension (ICA) is conceptualized as the fear or anxiety associated with either real or anticipated interaction with people of different groups, especially cultural and ethnic/or racial groups” (p. 145). I adapted the scale to focus on communicating with those who have a mental illness (see Appendix C). I chose this scale because it includes questions that can be applied when communicating with someone who may be perceived as different from the respondent. The scale measured the degree of communication apprehension that the individual feels within different contexts. The statements are broken up into two sections: negatively worded (e.g., “I am tense and unsure when interacting with a person about their mental health”) and positively worded questions (e.g., “I am calm and relaxed when interacting with a person about their mental health”). I also included questions regarding communicating about one’s own mental

health and communicating with someone else about their mental health. Doing so allowed me to measure which scenario induces more communication apprehension. A five-point Likert scale that ranges from *strongly disagree (1)* to *strongly agree (5)* was used to measure responses. The average level of communication apprehension when discussing one's own mental health was 26.4 (SD = 7.6) and the average level of communication apprehension when discussing an acquaintance's mental health was 28.1 (SD = 6.8). Alpha reliability for communication apprehension when about one's own mental illness was .917 and communication apprehension when about someone else's mental illness was .872.

Willingness to Communicate about Mental Illness

The final scale I used was the Willingness to Communicate Scale created by McCroskey and Richmond (1987). The scale was adapted from a very generic and basic scale regarding communication in general (see Appendix D). I adapted the scale to reflect how individuals feel about the willingness to communicate about mental health. The scale was divided into two different sections. The first section was created to measure the willingness to communicate about one's own mental health (e.g., "Talk with a physician about your mental health", "Talk with a stranger about your mental health"). The second section was created to measure the willingness to communicate about someone else's mental health (e.g., "Talk with a physician about someone else's mental health", "Talk with a stranger about someone else's mental health"). Data was collected using a percentage rating of the time an individual would choose to communicate. The percentages were measured using a 0-100% range. *0%* would be considered as *never*,

whereas *100%* would be considered as *always.* The average level of willingness to communicate (WTC) when discussing one's own mental health was 47.7 (SD = 19.2) and the average level of willingness to communicate (WTC) when discussing an acquaintance's mental health was 34.2 (*SD* = 18.3). Alpha reliability for willingness to communicate about one's own mental illness was .897 and willingness to communicate about someone else's mental illness was .899.

Data Analysis

Data was collected from the online surveys and then imported into SPSS for analysis. Hypotheses were tested using correlation tests, a t-test, and a mediation test (Hayes, 2018). Tests were chosen based on variable type. Correlation tests were used to analyze the effects of one variable to another and the significance of the relationship. The t-test was used to compare two variables. The mediation tests were used to identify if communication apprehension mediated perceived stigma and willingness to communicate (Hayes, 2018). Hypothesis H1a, H1b, H2a, and H2b were calculated using a correlation test. Hypothesis H1c was analyzed by using a t-test and H3 was calculated by using a mediation test (Hayes, 2018).

Chapter 4: Results

Correlation Analysis

Analysis of H1a, H1b, and H1c

Hypothesis 1a states that individuals communicating about *their own* mental illness will have an increased level of communication apprehension. Hypothesis 1b states that individuals communicating about *someone else's* mental illness will have an increased level of communication apprehension. To conduct the analysis, two Pearson product-moment correlations were conducted. According to Laerd Statistics (2020), a correlation determines whether changes in one variable are associated with changes in another, and how. A positive covariance indicates that as one variable deviates from the mean the other variable deviates in the same direction. A negative covariance indicates that as one variable deviates from the mean (e.g., increases), the other variable deviates from the mean in the opposite direction (e.g., decreases).

Perceived stigma and communication apprehension when communicating about *one's own* mental health were found to be positively correlated, (r = .25, n=153, p < .01). This relationship was considered a weak because the correlation was less than 0.29. The test also concludes that the correlation coefficient was significantly different from zero at a 95% confidence interval, meaning the correlation coefficient is not significant. Perceived stigma and communication apprehension when communicating about *someone else's* mental health was also found to be positively correlated with a weak relationship, (r =.09, n=153, p =.3). This relationship has a low significance level.

Hypothesis 1c states that communicating about *one's own* mental illness will lead to higher levels of communication apprehension compared to communicating about *someone else's* mental illness. A paired samples *t*-test was conducted, which shows whether one group experienced a change in some variable of interest. Communication apprehension about *one's own* mental illness leads to a higher level of communication apprehension than communicating about *someone else's* mental illness, (t_{152} =-7.06, $p <$ 0.001). The eta-squared value is .25, which indicates a large effect size. The hypothesis was accepted: Communicating about *one's own* mental illness leads to higher levels of communication apprehension compared to communicating about *someone else's* mental illness. There was a significant average difference between the two variables. On average, apprehension when communicating about one's own mental illness scored 3.78 points higher than apprehension when communicating about someone else's mental illness (95% CI [-2.72, -4.84]).

Analysis of H2a and H2b

Hypothesis H2a states that the higher the level of communication apprehension when talking about *one's own* mental illness, the lower the amount of willingness to communicate about mental illness. Hypothesis H2b states that the higher the level of communication apprehension when talking about *an acquaintance's* mental illness, the lower the amount of willingness to communicate about mental illness. My hypotheses were again tested using Pearson product-moment correlations. Communication apprehension when talking about *the participant's own* mental health and willingness to communicate was found to be negatively correlated, (r = -.47, n = 153 $p < .01$). The

correlation between the two variables is considered moderately strong. Communication apprehension when talking about *someone else's* mental and willingness to communicate was also found to be negatively correlated, (r = -.25, n = 153, p <0.05), which indicates a weak relationship, but a high level of significance.

Analysis of H3a and H3b

Hypothesis H3a states: when perceived stigma increases, communication apprehension will also increase causing a decrease in willingness to communicate about one's own mental illness. In the case of self, perceived stigma increases communication apprehension, which decreases the willingness to communicate, (F(2,149) = 34.75, p < .0001, R^2 = .32). Thus, communication apprehension mediates the relationship between perceived stigma and willingness to communicate at a highly significant level. The direct effect of perceived stigma on willingness to communicate is not significant, (F(1, 148) = 1.10, p < 3.0, R^2 = .01).

Hypothesis H3b states: when perceived stigma increases, communication apprehension will also increase causing a decrease in willingness to communicate about an acquaintance's mental illness. In the case of an acquaintance, communication apprehension does not mediate the relationship between perceived stigma and willingness to communicate (F(2, 147) = 3.83, p < .03, R^2 = .05). However, there is a direct effect of stigma on willingness to communicate, (F(1, 150) = 9.67, p < .01, R^2 = .06). Perceived stigma reduces the willingness to communicate.

Chapter 5: Discussion

The aim of this study was to explore the relationships between perceived stigma, communication apprehension, and the willingness to communicate about mental health. I investigated these issues both in the context of talking about one's own mental illness, as well as the willingness to communicate about an acquaintance's mental illness. The results of the study revealed that perceived stigma has a greater effect on individuals' willingness to talk about their own mental illness when compared to talking about an acquaintance's mental illness. Communication apprehension when talking about one's own mental illness also revealed greater levels of apprehension than talking about an acquaintance's mental illness. Ultimately, communicating about one's own mental health has a higher significance level and impact when all hypotheses were tested. In this chapter, I discuss both the theoretical and practical implications of my research, as well as limitations, and areas for future research.

Implications

Theoretical Implications

First, my findings support previous research on stigma and communication apprehension. This is particularly the case when considering participants' preference for talking about other people's mental health instead of their own. Communication Privacy Management (CPM) theory notes that the disclosure of a stigmatized identity involves calculating the potential risks and benefits of sharing private information with another person (Kennedy-Lightsey et al., 2012). Once shared, the other individual becomes a co-

owner of this information. There is always an inherent risk that the other person will fail to keep the information private.

Previous studies, such as Rudnick (2012), Lippert et al. (2020), and Magsamen-Conrad (2016), have articulated the implications that individuals must weigh when calculating the risks (e.g., others' decreased perceptions of trust, competence, and credibility, and other valued skills) of sharing stigmatized identity. As this body of research indicates, such disclosures are potentially threatening to desired personal and professional identities. Within my study, 68.7% of participants had higher levels of communication apprehension when discussing their own mental illness because they feared others' judgement. My findings indicate that concern about potential stigma increases communication apprehension and reduces the willingness to disclose a mental illness, as participant weigh factors like potential rejection, judgement, or privacy boundary violations. Individuals must decide if the risk of disclosure is worth potential rewards from sharing such private information. For instance, Rudnick (2012) found that professors who disclosed their LGBTQ+ identity in the classroom found a sense of release and freedom when sharing this information. Additionally, students who were struggling with their own gender and sexual identities also benefited from this disclosure. Individuals with a mental illness may find similar benefits for disclosing, including receiving comfort or support, as well as assistance with seeking medical help. Increasing an individual's likelihood to communicate about mental health is imperative. According to the National Alliance on Mental Illness (2021), "the average delay between onset of mental illness symptoms and treatment is 11 years (para. 7). That is 11 years of

someone's life that they could be suffering from a mental illness, instead of reaching out for help. My study found that there is a significant relationship between perceived stigma, communication apprehension, and willingness to communicate. If we can reduce perceived stigma about mental illness, hopefully an individual's willingness to communicate about their own mental illness will increase. Decreasing perceived stigma may induce the thought that the reward is greater than the risk.

My findings also highlight that people are more likely to be willing to communicate about others' mental illnesses than their own. Discussing some else's mental health lowers potential stakes of talking about mental health: Individuals no longer need to weigh the risks and benefits of personal disclosure to participate in the conversation. However, for this scenario to happen, at least one person must be willing to disclose their illness. As discussed in the previous paragraph, individuals are almost 50% less likely to discuss their own mental health. My study shows that the capacity for support and dialogue around mental illness exists. But it requires vulnerability and openness to "break the silence" around mental health. A case in point: Lippert et al. (2020) found that when professors were willing to disclose their mental health status, students felt more comfortable disclosing their illness and their needs. They felt more understood and weren't treated differently based on their illness and their needs. This finding makes sense considering Stigma Management Communication (SMC) theory, which argues that individuals with stigmatized characteristics may bond through conversation about these traits (Meisenbach, 2020). In other words, if talking about another's mental illness reduces stigmatization fears and increases personal acceptance, it

could potentially increase a person's future willingness to talk about their own mental health.

Additionally, communication apprehension was shown to mediate an individual's perceived stigma, and in turn, decrease their willingness to communicate. Perceived stigma is the stigmatization believed to be projected towards individuals with a mental illness. For example, people with a mental illness may feel as though others judge them to be lazy, weak, or burdensome. Similarly, individuals who do not have a mental illness may perceive the mentally ill as dangerous, difficult, or overly emotional. These negative perceptions of the other group increases communication apprehension due to the fears associated with unknown outcomes. The perceptions from both groups create a cycle that constrains mental health discussions: These negative beliefs hinder the likeliness of disclosure and shut down conversation that might challenge and foster changes in the perception and treatment of the mentally ill. Conversely, my findings demonstrate how reducing stigma can increase dialogue. Participants who reported lower levels of perceived stigma also had lower levels of communication apprehension about mental illness and a higher level of willingness to communicate. These findings make sense for multiple reasons. First, it reflects how social dialogue regarding mental health has shifted over time. As characteristics become increasingly accepted and viewed as normal, there is likely to be less apprehension and more normalcy surrounding talk about them (Goffman, 1963). Second, SMC suggests that individuals who view a personal characteristic as deviant are less inclined to manage their stigma in a positive or open manner. They are more likely to isolate, engage in self-blame, or conceal their perceived

stigmatized characteristic (see arguments by Meisenbach, 2010; Lippert et al., 2020). Third, people with high levels of perceived stigma related to mental illness may be experiencing *person-group communication apprehension*, or anxiety and/or behavioral reactions related to communicating with specific individuals or groups of people (McCroskey, 1984).

Relating communication apprehension regarding mental illness to person-group apprehension also makes sense when coupled with Anxiety/Uncertainty Management (AUM) theory (Gudykunst, 1998). Although this theory was specifically developed to increase communication effectiveness related to intercultural communication, the discussion of reducing anxiety and uncertainly can be closely related to people's experiences with mental health stigmas. For example, Gudykunst (1998) stated that both uncertainty and anxiety are beneficial when interacting with someone who may be culturally different because it fosters a level of interpersonal focus that helps us to acknowledge differences and the unknown. However, intercultural communication can be negatively affected when there is an imbalance between anxiety or uncertainty levels (Ting-Toomey, 2009). Individuals who experience mental illness are often "othered" in ways that create apprehension similar to intercultural differences. Participants in my study indicated a high level of fears related to the uncertainties of conversational outcomes: 70.7% reported higher levels of communication apprehension due to not knowing what to say to someone with a mental illness. 66% of individuals feared that they may say the wrong thing when discussing someone else's mental illness.

These findings suggest it may be useful to study communication apprehension about stigmatized identities like mental illness similar to how uncertainties and anxieties around intercultural differences have been explored. People who experience mental illness often view themselves as being part of a unique subculture that affects beliefs, norms, and values related to mental health. Fernando (2014) states:

> 'Culture' in mental health discourse is usually limited to matters to do with individuals (so referring to culture of individuals) and the connections they have to people and events around them as well as their heritage and background- in effect, the total reality within which people live their lives" (p. 16).

Some people's lives may revolve around mental health and mental illness. Individuals may be connected to others through their mental illness, such as through support groups. They may experience significant change in their lives and relationships due to their mental illness. Although aspects of mental illness are believed to be hereditary, much of how we come to understand and communicate about it happens though cultural and familial socializations, which in turn impacts personal practices and values. Those who are part of the "mental health community" are likely to be more willing and able to openly discuss mental illness. For instance, a family that welcomes and accepts mental health is likely to have less anxiety around and more able to provide support for a member with mental illness than a family that is unwilling to talk about it. Individuals who have attended a group therapy session for Post-Traumatic Stress Disorder will have a better understanding of symptoms, treatment, and support than those without that experience. Those who do not belong or understand the subculture surrounding mental

illness often rely on their own cultural frame of reference and stereotypical beliefs to control communication uncertainty or anxiety. AUM theory helps us to recognize and better understand individual's anxieties about particular groups and the importance of controlling our anxieties. Specifically, how one views a group to which they do not identify can greatly impact anxiety, uncertainty, willingness to communicate. AUM theory explains that to decrease apprehensions or anxieties, perceived stigma must be decreased, which I will discuss more in my practical implications.

Practical Implications

In this section, I will discuss the practical implications of my study, specifically what it suggests to reduce perceived stigma, increase mental health literacy, and implement mental health programs.

From a practical perspective, AUM theory contends that social support could greatly increase effective management of anxiety and uncertainty (Gudykunst, 1998). The communicative act of providing social support to someone with a mental illness can include (but is not limited to) offering comfort and guidance, listening without judgement, or assisting resources. Yet, the results of my study indicate that perceived stigma remains an intractable barrier to seeking support. 68.7% of respondents linked fear of judgement to higher levels of communication apprehension when discussing their own mental illness. Though communication apprehensions levels were higher when discussing one's own mental health, respondents were also highly apprehensive about discussing others' mental illnesses when perceived levels of stigma were also high. My findings suggest small positive steps can be taken to demonstrate social support and reduce

perceived stigma. In my own experience, people with a mental illness may be more likely to attribute lack of social support to stigma, even when other factors may be at play (e.g., the other person may be busy with their own life, work, family, etc.). My friends know that I struggle with this perception and make it a goal to check in with me and remind me that level of support and communication is not due to my mental illness, rather their busy life schedules. These small acts of caring not only reduce stigma, they also foster an environment where I am comfortable discussing my mental health. It reduces the feeling that sharing about my mental illness is a burden to others and normalizes conversations around feeling (un)wellness.

The need for better social scripts to offer social support around mental illness was also highlighted in my findings. Fear of not knowing what to say was reported throughout my results, particularly among those who do not experience mental health themselves. 66% of respondents agreed that they fear that they may say the wrong thing when discussing someone else's mental illness. 59.5% reported higher levels of communication apprehension due to uncertainty of the outcome. Providing support may also seem daunting if the individual feels responsible for the person with mental illness' well-being. Increasing mental health literacy, or people's understandings of "how to obtain and maintain positive mental health" as well as "enhancing help-seeking efficacy (knowing when and where to seek help…)" is key to improving both social scripts and the ability to use them (Kutcher et al., 2016, p. 155). Mental health literacy can be learned just as culture can be learned through a person's beliefs, norms, and values. One additional

benefit of increasing mental health literacy is that it also helps to combat perceived stigmas as well.

Combatting stigma more than just individual efforts, though. Society could benefit from implementing positive mental health messages through a multitude of channels. First, I believe mental health literacy should start at a young age both in school and at home. Schools provide a health class; however, schools do not have students complete a mental health course. Students should be able to understand what mental health is, what it could look like, how to help and support themselves and others, and learn healthy coping skills. Normalizing mental health communication is crucial for decreasing stigma and communication apprehension regarding mental illness. Second, media outlets should include positive messages regarding mental illness to provide support for those who have an illness and how other individuals who could support someone with a mental illness. Media is everywhere, and society could greatly increase their mental health literacy through more accurate portrayals of mental illness. During the 2021 Olympics, gymnastics “superstar” Simone Biles withdrew from competition due to mental health reasons. Media coverage was saturated with commentary regarding her actions, though opinions varied: Some media outlets reported her decision as disappointing and weak. Others have portrayed the extreme strength and courage it took for her to act. Ultimately, the media is a powerful influencer. If the media provides more positive support on the topic of mental health, I predict that many individuals would likely change their viewpoints and hopefully reduce societal stigmatizations towards mental health. Mental health has not been greatly studied in relation to media or the

specific communication channels that could provide the greatest impact on stigma management. Positive messages and portrayals of support not only influence people's willingness to disclose mental illness but may also increase caregivers' confidence for offering social support (see related arguments by McGinty et al., 2018).

Limitations and Areas for Future Research

To improve future mental health communication scholarship, I must discuss the limitations of this study. First, an estimated 75% of participants were female. Increasing gender diversity, and especially male representation in future research is important. In Western culture, men tend to be at greater risk for self-stigmatization related to mental illness when compared with women (Vogel, Wester, Hammer, & Downing-Matibag, 2014). Western culture's norms surrounding masculinity often pigeonhole men into appearing strong, independent, and competent when handling stress. Therefore, they are more likely to conceal their emotional distress and not reach out for help compared to women (Vogel et al., 2014). The different gendered expectations for emotional expression and support-seeking surrounding mental health do have consequences. According to the American Foundation for Suicide Prevention (2021), "In 2019, men died by suicide 3.63x more often than women" and "the rate of suicide is highest in middle-aged white men" (para. 2). It is possible the links between perceived stigma and communication apprehension, particularly when communicating about one's own mental health, may have been stronger if more respondents identifying as male had participated in the study. I believe future research needs to engage more male participants to further

explore potential gendered variations in their communication apprehension and willingness to communicate.

Second, this study compared communicating about one's own mental health and communicating about someone else's mental health. The comparison was important, as it found that individuals had higher levels of apprehension when communicating about their own mental health. If I focused solely on communicating about one's own mental health, I would have been able to gain a better understanding of which scenarios and/or settings individuals were the most apprehensive toward communicating in. Identifying specific situations that enable or constrain communication related to mental illness is crucial for stigma management. If individuals were more apprehensive in a specific situation, I would be able to pinpoint where that anxiety lies and what messages or practices could be used to decrease those levels of anxiety. This area of research may also benefit from a qualitative approach that allows for open-ended questions, and narratives.

Third, more than half of my participants were between the ages of 18-26 years old. It would be useful to expand the age groups represented in this research, particularly to determine if there are significant generational differences or ages where perceived stigma and communication apprehension are especially salient to the willingness to communicate about mental health. Thinking more broadly about age sparks additional questions for future investigations as well. Again, researchers should consider conducting qualitative investigations into the origins of an individual's stigmatizing beliefs about mental illness (e.g., through cultural norms, social or popular media, past experiences). For instance, children are often socialized into understanding social stigmas. It would be

productive to explore family communication patterns or educational messages encountered in schools related to mental health and the role they play in fostering or combatting mental illness stigmas and cultivating positive mental health. Expanding this research to include adolescents could also trace out existing knowledge and attitudes toward mental illness, as well as what makes participants (un)comfortable when discussing mental health. Such studies could usefully inform school-based programs aimed at addressing mental health stigmas.

Conclusion

After reviewing previous literature and applying their knowledge and results to my study, I believe my research was successful in furthering mental health communication research. My study found a relationship between my three variables in relation to both communicating about self and communicating about an acquaintance's mental health. More specifically, the rate of individuals who were anxious and less willing to communicate about their own mental health reported a higher level of perceived stigma. In the future, I believe research should focus on mental health communication messages in the media as well as the benefits and impact of interpersonal communication and narrative in decreasing stigma. Decreasing stigma should help provide a safer environment for individuals with a mental illness when disclosing their illness to another person. My study found an increase in levels of apprehension with a lower level of willingness to communicate in relationship to perceived stigma of mental illness. I believe studies should focus on how individuals interpret and respond to felt stigma of their mental illness and whether or not self-stigmatization was present in their

decision to communicate or not to communicate about their mental health issues. If research can identify or find a correlation between specific messages and triggers of self-stigmatizing beliefs, then we can move forward in finding a solution to decrease levels of mental health stigmatization. Lastly, researching and implementing programs to educate our society on mental health literacy could benefit individuals with a mental illness, as well as individuals who do not have a mental illness. Providing the right resources for caregivers and support systems could greatly impact comfortability and decrease apprehension when communicating about mental health. Ultimately, I believe mental health stigma can be decreased and we can open up more dialogue surrounding mental illness.

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Appendices

Appendix A.

Demographic Questions

What is your age?

- 18-22
- 23-26
- 27-30
- 31-35

What is your gender?

- Male
- Female
- Other
- Prefer not to say

Have you ever been diagnosed with a mental illness?

- Yes
- No
- Prefer not to say

Appendix B.

10-item Perceived Stigma Scale

Five-Point scale ranging from 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree).

1. Most people believe that mental illness is a sign of personal weakness.
2. Most people believe that mental illness is not a real medical illness.
3. Most people believe that people with a mental illness are lazy.
4. Most people believe that individuals with a mental illness should be able to cope with things by themselves.
5. Most people believe that people with mental illness are dangerous.
6. Most people believe that it is best to avoid people with a mental illness.
7. Most people believe that people with mental illness are unpredictable.
8. Most people would not tell anyone if they had a mental illness.
9. Most people would not employ someone with a mental illness.
10. Most people would not vote for a politician with any disclosed mental illness.

Appendix C.

22-item Mental Health Communication Apprehension Scale

Five-Point scale ranging from 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree).

1. I am tense and unsure when interacting with a person about their mental illness.
2. I am tense and unsure when interacting with an acquaintance about my mental health.
3. While participating in a conversation with a person with a mental illness, I get nervous.
4. Communicating with an acquaintance about my mental health makes me feel uncomfortable.
5. Communicating with a person about their mental illness makes me feel uncomfortable.
6. I have anxiety about speaking to a person about their mental illness because I fear I may make it worse.
7. I am anxious when talking about mental health because I am unsure of the outcome.
8. Starting a conversation about mental health makes me uneasy.
9. I am afraid I will say the wrong thing when discussing someone else's mental illness.
10. I am afraid to talk about my mental health because I fear that I will be judged.

11. I am calm and relaxed when interacting with a person about their mental health.
12. I am calm and relaxed when interacting with an acquaintance about my mental health.
13. I do not get nervous while participating in a conversation with a person with a mental illness.
14. I am comfortable communicating with an acquaintance about my mental health.
15. I am comfortable communicating with a person about their mental illness.
16. I am not worried about speaking to a person about their mental illness because I know that I will not make it worse.

17. I am comfortable when talking to an acquaintance about mental health even though I may be unsure of the outcome.
18. I am comfortable starting a conversation about mental health.
19. I am comfortable talking to someone about their mental health, because I know what to say.
20. I am comfortable talking about my mental health because I know that I will not be judged.

Appendix D. –(if you have had mental health issues, or think of someone else)

20-item Mental Health Willingness to Communication Scale

Rate the percentage of the time you would choose to communicate. 0=Never, 100=Always

1. Talk with a physician about your mental health related issues.
2. Talk with a stranger about your mental health related issues.
3. Talk with an acquaintance about your mental health related issues.
4. Talk with a trusted friend about your mental health related issues.
5. Talk with a parent/guardian about your mental health related issues.
6. Talk with a family member (other than a parent) about your mental health related issues.
7. Talk about your mental health related issues with a group of people.
8. Talk online about your mental health related issues (i.e., blog, facebook posts, etc.).
9. Go out of your way to talk to someone about your mental health related issues
10. Ask for advice on how you can get help for a mental health related issue.

11. Talk with a physician about an acquaintance's mental health related issues.
12. Talk with a stranger about an acquaintance's mental health related issues.
13. Talk with an acquaintance about another acquaintance's mental health related issues.
14. Talk with a trusted friend about an acquaintance's mental health related issues.
15. Talk with a parent/guardian about an acquaintance's mental health related issues.
16. Talk with a family member (other than a parent) about an acquaintance's mental health related issues.
17. Talk about an acquaintance's mental health related issues with a group of people.

18. Talk online about an acquaintance's mental health related issues (i.e. blog, facebook posts, etc.).
19. Go out of your way to talk to an acquaintance about their mental health related issues.
20. Ask for advice on how to help an acquaintance with a mental health related issues.

Appendix E.

IRB Approval Letter

November 14, 2020

Dear Anne Kerber, M.A., Ph.D.:

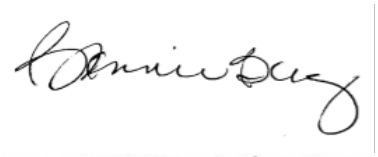
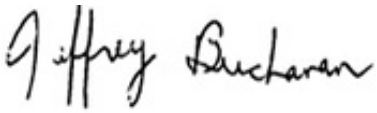
Re: IRB Proposal entitled "[1636042-6] Mental Health Communication: The Correlation between the Stigmatization of Mental Illness, Communication Apprehension and the Willingness to Communicate" Review Level: Level [I]

Your IRB Proposal has been approved as of November 14, 2020. On behalf of the Minnesota State University, Mankato IRB, we wish you success with your study. Remember that you must seek approval for any changes in your study, its design, funding source, consent process, or any part of the study that may affect participants in the study (see https://research.mnsu.edu/institutional-review-board/proposals/ process/proposal-revision/). Should any of the participants in your study suffer a research-related injury or other harmful outcomes, you are required to report them immediately to the Associate Vice-President for Research and Dean of Extended Campus at 507-389-1242.

When you complete your data collection or should you discontinue your study, you must submit a Closure request (see https://research.mnsu.edu/institutional-review-board/proposals/process/proposal-closure/). All documents related to this research must be stored for a minimum of three years following the date on your Closure request. Please include your IRBNet ID number with any correspondence with the IRB.

Cordially,

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Minnesota State University, Mankato IRB's records.


Bonnie Berg, Ph.D.	Jeffrey Buchanan, Ph.D.	Mary Hadley, FACN, Ph.D.
IRB Co-Chair	IRB Director	IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Minnesota State University, Mankato IRB's records.

Appendix F.

Consent Form (SONA)

Survey on Mental Health Communication

You are invited to participate in research conducted by Madeleine Winkler under the guidance of Dr. Anne Kerber from the Department of Communication Studies at Minnesota State University, Mankato on mental health communication. This anonymous survey should take roughly 10 minutes to complete. The purpose of this survey is to better understand the stigmatization of mental illness and you will be asked to answer questions about that topic. If you have any questions, please contact Madeleine at madeleine.winkler@mnsu.edu or Dr. Kerber at anne.kerber@mnsu.edu .

Participation is voluntary. You have the option not to respond to any of the questions. You may stop taking the survey at any time by closing your web browser. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits. If you have any questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board, at (507) 389-1242.

Responses will be anonymous. However, whenever one works with online technology there is always the risk of compromising privacy, confidentiality, and/or anonymity. For example, you should use a private space and a secure Internet connection to complete the survey. Know that completing the survey in a public place may not be secure, as others could potentially view or gain access to your responses. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

The risks of participating are no more than are experienced in daily life but may include stress and discomfort with talking about mental health. If you are uncomfortable or stressed, you can simply exit the survey at any time.

There are no direct benefits for participating, however students can receive one point for completing the survey through the SONA system. Society might benefit from the increased understanding of mental health communication.

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

You may discontinue participation at any time before the data collection is complete without penalty or loss of benefits by exiting out of the browser without saving or submitting.

Please print a copy of this page for your future reference. If you cannot print the consent form, take a screen shot, paste it to a word document and print that.

Minnesota State University, Mankato IRBNet Id# 1636042

Date of Minnesota State University, Mankato IRB approval: 11/14/2020

Do you agree to participate?

Yes O

No O

Appendix G.

Consent Form (Facebook)

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There are no direct benefits for participating, however society might benefit from the increased understanding of mental health communication.

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

You may discontinue participation at any time before the data collection is complete without penalty or loss of benefits by exiting out of the browser without saving or submitting.

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Minnesota State University, Mankato IRBNet Id# 1636042

Date of Minnesota State University, Mankato IRB approval: 11/14/2020

Do you agree to participate?

Yes O

No O

Appendix H.

Recruitment Email (This message will be attached to the letter to SONA Survey)

Who: Madeleine Winkler and Dr. Anne Kerber (Minnesota State University, Mankato) are looking for participants to be part of a research on study mental health communication

What: Participation in the study involves taking part in an anonymous 15-minute online survey.

Eligibility: Individuals must at least 18 years of age to participate in the study.

Risks/Benefits: Risks of participating are no more than experienced in daily life, but may include stress and discomfort with talking about mental health. There are no direct benefits for participating but you will receive one point for completing the survey through the SONA system. Society might benefit by the increased understanding of mental health communication/

For more information, contact:
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Faculty Advisor: Dr. Anne Kerber, anne.kerber@mnsu.edu, 507-389-1407
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