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Post-Secondary Students' Perceptions of Mental Health Messages Conveyed by Video Storytelling and Informational Approaches

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Abstract

This study's aim was to examine how Western students perceive mental health messages conveyed by video storytelling and informational approaches. In focus group discussions, participants' perceptions of help seeking behaviors were unchanged by either approach. However, discussions suggested that messages enhanced understanding and awareness, which potentially reduced stigma. Participants who watched the storytelling videos asserted that they were open and receptive to the messages and expressed perceptual changes. Four facilitators appeared to contribute to effective mental health messages: *diversity; explicit instructions; shift toward understanding societal and biological causes of mental health conditions;* and *a combination of storytelling and information.* Future mental health messages could incorporate the message facilitators to improve effectiveness in reducing stigma and promoting positive attitudes toward mental health issues.

Keywords

Mental health, stigma, post-secondary students, video storytelling, informational message

Summary for Lay Audience

This study's aim was to examine how Western students perceive mental health messages conveyed by video stories and informational pamphlets. Results indicated that participants' perceptions of help seeking behaviors were unchanged by either message. However, discussions suggested that messages enhanced understanding and awareness, which potentially reduced stigma. Participants who watched the videos asserted that they were open and receptive to the messages and expressed perceptual changes. Four areas that could contribute to effective mental health messages were: *diversity; explicit instructions; shift toward understanding societal and biological causes of mental health conditions;* and *a combination of storytelling and information.* Future mental health messages could incorporate these suggestions to improve effectiveness in reducing stigma and promoting positive attitudes toward mental health issues.

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Chapter 1 – Introduction

1.1 The Study Rationale

The purpose of this study is to explore how Western students perceive mental health messages conveyed by two different approaches: video storytelling and informational messages. The videos that contain post-secondary students' mental health stories are adopted from the project "I am not OK" done by Niagara News, a campus news organization of Niagara College (Dayboll, 2016). The informational messages are available on the Canadian Mental Health Association Ontario's website.. In understanding the post-secondary students' perceptions of the messages, this study also aims to illustrate which message features would appeal to this population.

This study results from a literature review which suggests that informational approach has been extensively applied to health communication field (Lueck, 2018; Champlin & Nisbett, 2018). In addition, video storytelling could be promising when it comes to inspiring and promoting positive health behavior change (Green, 2006; Kim, Bigman, Leader, Lerman, & Cappella, 2012; Moyer-Gusé, Chung, & Jain, 2011). However, research specific to qualitatively exploring post-secondary students' perceptions of these two different modes of mental health information delivery is lacking. Therefore, this study aims to shed light on this area. Moreover, thanks to the qualitative nature of this study, preliminary suggestions on how mental health messages should be designed to communicate to post-secondary students will also be provided.

This thesis begins with a literature review of relevant topics. First of all, the topic of the prevalence of mental health issues among post-secondary students will be presented. The prevalence is believed to result from the stigma associated with mental health issues

and lack of mental health knowledge of post-secondary students. Therefore, the relationships between mental health knowledge, mental health literacy, stigma, and help seeking behaviors will be discussed. Next, the literature review will examine various public health campaigns that have been developed as a possible solution to increasing mental health literacy and reducing stigma associated with mental health issues. Different approaches to communicating mental health issues will be highlighted, especially the two that will be employed in this study: video storytelling and informational messages. The last section of the literature review will focus on explaining what is considered an effective mental health message in each approach. The method is then explained, followed by the presentation of findings, discussion, recommendations, limitations, and suggestions for future research.

1.2 Literature Review

1.2.1 The Prevalence of Mental Health Issues among Post-Secondary Students

According to the website of the World Health Organization (WHO, n.d.), mental health is "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (para. 2). It is determined by a combination of multiple social, psychological and biological factors. As pointed out by Galderisi, Heinz, Kastrup, Beezhold, and Sartorius (2015), although this definition moves away from the tendency of conceptualizing mental health as a lack of mental illnesses, the focus on positive feelings and positive functioning as important factors of mental health might be problematic. As such, Galderisi et al. (2015) proposed a revised definition:

> Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute to varying degrees, to the state of internal equilibrium (pp. 231-232).

The notion of "dynamic state of internal equilibrium" (p. 231) emphasizes the fact that different life stages require necessary changes to achieve the desired mental equilibrium. Since post-secondary students enter a new phase of their life in which they have to deal for the first time with many issues such as living away from home, different academic environment, new friendships and relationships, Galderisi et al.'s (2015) definition of mental health is relevant to the population of this thesis. Contrary to mental health, mental illness refers to "an illness that affects that way people think, feel, behave, or interact with others" (Canadian Mental Health Association British Columbia, n.d., para. 3). Since this thesis does not focus on treatment, instead of "mental illness," it uses phrases such as "mental health issues," or "mental health conditions." As Cheung (2018) advised, "we have to keep critically examining our word choices when we talk about mental illness. Our only hope of stopping the euphemism treadmill is to stop the stigma that powers it" (p. 7).

When it comes to types of mental health issues, the 2011 United Kingdom's national clinical guidelines identified depression as one of the two most common (British Psychological Society, Royal College of Psychiatrists, National Institute for Health and

Clinical Excellence, & National Collaborating Centre for Mental Health, 2011). Globally, there are more than 300 million people who are suffering from depression (WHO, 2018). According to a survey done by the American College Health Association (2018) on 88,178 post-secondary students in 140 institutions in the United States, 41.9 per cent of respondents indicated they had felt so depressed within the past year that it was difficult for them to function, and 63.4 per cent of them were overwhelmingly anxious.

In Canada, every year, 20 per cent of the citizens have at least one mental health or addiction issue (Smetanin, Briante, Stiff, Ahmad, & Khan, 2011), and approximately 8 per cent of Canadian adults experience a major depression at some time in their lives (Canadian Mental Health Association, n.d.). Among all populations, youth are more likely to experience mental health issues and/or substance use than any other age groups (Pearson, Janz, & Ali, 2013). Carver et al. (2015) in a report prepared for the Mental Health Commission of Canada (MHCC) defined youth aged between 16 to 25 as emerging adults. This notion emphasizes the importance of this developmental period, during which 75 per cent of mental health issues appear. In addition, according to the 2016 National College Health Assessment—a survey of 41 Canadian post-secondary institutions and 43,780 students—37.9 per cent of the respondents were depressed; 51.4 per cent were anxious; 11.5 per cent considered suicide; and 1.8 per cent attempted suicide within the last 12 months (American College Health Association, 2016). The same study revealed that statistics regarding Ontario post-secondary students were higher than the national ones: 46 per cent of the post-secondary student respondents were depressed; 65 per cent were anxious; 14 per cent considered suicide; and 2.2 per cent attempted suicide within the last 12 months (Council of Ontario Universities, 2017). As

compared to the 2013 survey results, these numbers were much more alarming. In 2013, nationally, 33.3 per cent of the post-secondary student respondents were depressed, 45.2 per cent were anxious, 8.9 per cent considered suicide; and 1 per cent attempted suicide within the last 12 months (American College Health Association, 2013).

Since there has been a dramatic increase in the prevalence of mental health issues among post-secondary students, particularly in Canada, more attention should be drawn to this area so that appropriate actions can be developed for the betterment of Canadian post-secondary students' mental health. As such, the next section will provide an in-depth discussion of potential factors that contribute to the prevalence of mental health issues among post-secondary students and how these factors interact with one another.

1.2.2 The Relationships between Mental Health Knowledge, Mental Health Literacy, Mental Health Stigma and Help Seeking Behaviors

A possible explanation for the prevalence of mental health issues among post-secondary students is the existing stigma associated with those issues, which is a barrier to help seeking behaviors. In addition, stigma is believed to result from the post-secondary students' lack of knowledge about mental health issues. In order to gain an understanding of these assumptions, this section examines the possible relationships among mental health knowledge and literacy, stigma, and help seeking behaviors that have been discussed in the literature.

1.2.2.1 Mental Health Stigma

Before the discussions of the possible relationships between stigma and other variables, it is critical to deconstruct the notion of stigma. According to the CMHA Ontario (n.d.-c), stigma is defined as a "negative stereotype," (para. 1) which would

result in discriminatory behaviors. In the literature, Goffman (1963) was considered to first develop the theory of stigma. Goffman (1963) defined stigma as an "attribute that is deeply discrediting" that reduces a person "from a whole and usual person to a tainted and discredited one" (p. 3). Stigmatized individuals, by being surrounded by people without a stigmatizing attribute, could experience self-hate, self-isolation, depression or hostility (Carnevale, 2007), which in turn could lead to negative health outcomes. Chaudoir, Earnshaw, and Andel (2013) proposed the Stigma Mechanisms in Health Disparities Framework to understand how stigma causes mental and physical health inequalities between stigmatized and non-stigmatized individuals. According to Chaudoir et al. (2013), the stigma mechanisms can be conceptualized to take place at "individual, interpersonal, and sociocultural levels" (p. 76).

There are numerous ways to categorize stigma based on its types and dimensions. Goffman (1963) drew a clear distinction between the *discredited* and the *discreditable* (p. 4). The *discredited* refer to people who are stigmatized based on a visible trait such as race, gender, or disability; whereas the *discreditable* are individuals whose stigma is hidden such as mental health issues, HIV infection, or sexual orientation. As for different natures of stigma, Goffman (1963) suggested three distinct categories. Tribal stigmas refer to traits that are passed from generations to generations such as race, ethnicity, or religion. Abominations of the body are physical attributes that contribute to a lower social identity such as obesity or physical disabilities. Blemishes of character concern tainted behavioral or personality characteristics such as alcoholism or pedophilia (as cited in Blodorn & Major, 2016). In the area of mental health issues, stigma is often presented as a variable that consists of two opposite constructs: implicit and explicit stigma (Peris,

Teachman, & Nosek, 2008; Kopera et al., 2015; O'Dricoll, Heary, Hennessy, & McKeague, 2012), or self-stigma and public stigma (Corrigan & Watson, 2002; Pescosolido & Martin, 2015; Oexle et al., 2018; Nearchou et al., 2018). This thesis, however, divides the discussion of stigma into two sections: stigma toward mental health conditions and stigma toward help seeking. These two different types of stigma are thought to interact with each other and collectively influence help seeking behaviors.

Stigma toward Mental Health Conditions

First of all, since stigma toward mental health conditions is a multifaceted process that Henderson and Gronholm (2018) called a "wicked problem," it is necessary to conceptualize and operationalize its constructs. In an effort to do so, Link and Phelan's (2001) article, as a development to Goffman's (1963) work, situated stigma toward mental health conditions as a convergence point of four interconnected components. Firstly, distinguishing and labeling differences refers to the process of selecting human differences that matter socially. Secondly, associating differences with negative attributes involves connecting labeled people with a set of unfavorable traits that constitute the stereotype. Thirdly, separating "us" from "them" occurs when the labeled people are put in separately distinct categories. Fourthly, status loss and discrimination happen when the labeled people are devalued, rejected, and excluded.

Furthermore, Silke, Swords, and Heary (2016) developed an empirical model of adolescents' stigma toward mental health conditions. A total of 332 adolescents completed a survey that measured their stigmatizing responses toward a fictional peer with depression. After the advanced statistical analyses, the authors proposed a model of stigma that comprised seven factors: Dangerousness, Warmth and Competency,

Responsibility, Negative Attributes, Prejudice, Classroom Discrimination, and Friendship Discrimination. These seven factors were asserted to represent the three theoretical constructs of stigma: Stereotypes, Prejudice, and Discrimination.

Taking another approach, Griffiths, Carron-Arthur, Parsons, and Reid (2014) identified different types of stigma toward mental health conditions. Personal stigma was defined as "personal attitudes to people with a mental disorder," whereas social distance referred to "the willingness of a person to make contact socially with a person with a mental illness" (p. 163). In addition, perceived stigma concerned the participants' beliefs about the attitudes of other people toward those with mental health issues. Lastly, self- or internalized stigma was related to the participants' beliefs or anticipated beliefs about their own or possible mental health issues.

As this thesis does not take into account the longitudinal aspect, it is not able to apply the mental processes proposed by Link and Phelan (2001). In addition, the seven factors introduced by Silke et al. (2016) are more relevant to studies examining the participants' stigma toward mental health conditions of people they know. Therefore, out of these three approaches, Griffiths et al.'s (2014) is the most appropriate for this thesis.

Stigma toward Help Seeking

When it comes to help seeking, there are two types of stigma: public stigma (or external stigma) and self-stigma (or internal stigma). Public stigma toward help seeking refers to "the perception held by society that an individual who seeks counselling services is undesirable or socially unacceptable" (Vogel, Wade, & Haake, 2006, as cited in Topkaya, Vogel, & Brenner, 2017, p. 214), whereas self-stigma toward help seeking refers to "the perception held by the individual that he or she is undesirable or socially

unacceptable because of seeking counselling services" (Vogel, Wade, & Hackler, 2007, as cited in Topkaya et al., 2017, p. 214). Vogel, Bitman, Hammer, and Wade (2013) discovered the stigma internalization process in which public stigma could be internalized as self-stigma over time. Similar to stigma toward mental health conditions, public stigma toward help seeking leads to discrimination that impedes somebody's access to employment, education, healthcare, or housing. On the other hand, personal stigma toward help seeking prevents people from achieving their goals (Ciftci, Jones, & Corrigan, 2013). As a result, research has shown that greater public stigma and self-stigma toward help seeking are associated with more negative attitudes toward and decreased intentions of seeking help (Komiya, Good, & Sherrod, 2000; Bathje & Pryor, 2011; Blais & Renshaw, 2013; Hackler, Vogel, & Wade, 2010; Shea & Yeh, 2008). More directly related to post-secondary student populations, past studies have demonstrated that students from diverse races and ethnicities with higher levels of self-stigma toward help seeking are less likely to seek help (Nam et al., 2013; Vogel, Wade, & Hackler, 2007).

1.2.2.2 The Relationship between Mental Health Knowledge and Literacy and Mental Health Stigma

The literature has shown that there is a strong relationship between understanding and awareness of mental health issues and stigma. Simmons, Jones and Bradley (2017) explored the relationship between increasing knowledge of mental health and change in stigma. Through their experiments involving 39 students from a university in the West Midlands in the United Kingdom, the authors were able to prove that providing information about mental health issues could help to reduce stigma. In contrast, a lack of

understanding of an issue in general is more likely to bring about negative attitudes, which consist of stigma (Griffith, Hart, & Brickel, 2010).

Scholars have also developed the concept of mental health literacy to more accurately define understanding and awareness of mental health issues. Jorm et al. (1997) coined the term "mental health literacy" to describe "the knowledge and beliefs about mental disorders that aid in a person's recognition, management, or prevention of mental illness" (as cited in Crowe, Mullen, & Littlewood, 2018, p. 268). The concept has evolved to include "maintaining positive mental health, understanding disorders and treatments, *decreasing stigma related to mental illness*, and enhancing one's knowledge of resources for mental illnesses so that one can manage a mental illness successfully" (Kutcher, Wei, & Coniglio, 2016, as cited in Crowe et al., 2018, p. 268). As seen in Kutcher et al.'s (2016) conceptualization of mental health literacy, there is a close link between this variable and stigma. In their study of 1,027 staff members from public services in Sweden, Svensson and Hansson (2016) demonstrated that a higher degree of mental health literacy was negatively related to stigma and social distance toward people with depression. Interestingly, Crowe et al. (2018) were also able to confirm that self-stigma toward mental health conditions and self-stigma toward help seeking were both negatively associated with mental health literacy. In other words, self-stigma is a crucial predictor of mental health literacy; reducing self-stigma could contribute to people's improved mental health literacy.

When it comes to mental health literacy, students were reported to be the least informed population (Mahto et al., 2009), and their level of mental health literacy was negatively associated with their level of stigma (Chandra & Minkovitz, 2007). As such,

Mahto et al. (2009) recommended educating students about mental health since this population would have a significant influence on future generations (Sawyer, Hubbard, & Rice-Spearman, 2006).

1.2.2.3 The Relationship between Mental Health Stigma and Help Seeking Behaviors

The relationship between mental health stigma and help seeking behaviors has been emphasized by post-secondary students. In an interview with the press, Ariana Chasses—a second-year fine arts student at St. Lawrence College in Brockville, Ontario, and the vice-president of the student council—asserted that she could not seek help from the available resources on campus due to the stigma around mental health issues (The Canadian Press, 2017). Scholars in mental health research have also examined the relationship between these two variables by carrying out empirical research. For example, Golberstein, Elsenberg, and Gollust (2008) conducted a survey on 2,782 undergraduate and graduate students who completed the Healthy Minds Study. These students were from a large, Midwestern, public university in the United States. After the data analysis, the authors concluded that perceived public stigma was not associated with help seeking behaviors. Perceived public stigma was only negatively correlated with the likelihood of perceiving a need for mental health services among 18- to 22-year-old students. As such, the authors posited that among post-secondary students, perceived public stigma was not an important factor when considering utilizing mental health services. This study did not measure the mental health knowledge of the participants; however, the authors speculated that there was no significant relationship between perceived public stigma and mental health service utilization seemingly because their participants had increased awareness

and understanding of mental health issues. The relationships among mental health knowledge, stigma, and help seeking behaviors are emphasized once again.

To expand on Golberstein et al.'s (2008) work, Wu et al. (2017) added personal stigma when doing research with 8,285 American college students who had finished the Healthy Minds Study. Besides exploring the relationship between two distinct types of stigma (public and personal) and mental health service utilization, the authors also attempted to describe the demographic predictors of stigma and mental health service utilization. Subsequently, the study demonstrated different results from those of Golberstein et al. (2008). As discussed above, Golberstein et al. (2008) could not establish a significant relationship between perceived public stigma and help seeking behaviors. In contrast, Wu et al. (2017), by incorporating self-stigma in the research design, could confirm the association between stigma and help seeking behaviors. For example, students with low self, low public stigma reported greater mental health service use, and participants in the high self, high public stigma group were least likely to utilize mental health services. When taking demographic factors into consideration, Wu et al. (2017) postulated that Asian male college students were more likely to belong to the high self, high public stigma category; thus, they tended to less utilize mental health services than other groups of students.

Clement et al. (2015) carried out a systematic review of 144 quantitative and qualitative studies with 90,189 participants. The review identified that internalized stigma was most negatively associated with help seeking behaviors. As such, the authors recommended anti-stigma interventions focus on addressing stereotypes (especially the

notions of weakness and craziness), social judgement and rejection, as well as shame and embarrassment.

To sum up, the literature is able to establish the significant relationships among mental health knowledge and literacy, stigma, and help seeking behaviors. Although different types of stigma exert their effects differently across studies, the presence of their effects is uncontested, as seen from the literature. Therefore, addressing these existing types of stigma among post-secondary students will encourage more help seeking behaviors in the future. One way to potentially destigmatize mental health issues and help seeking behaviors is through public campaigns pertaining to mental health. The next section will examine how these campaigns have been developed around the world to tackle this issue.

1.2.3 Public Health Campaigns Developed to Address Mental Health Issues among Post-Secondary Students

Canada and other countries around the world have developed numerous campaigns at various levels to grapple with mental health issues. This section outlines those campaigns specifically aimed at youth/post-secondary students and discusses their results. Given the focus of this thesis, this section will be divided into three subsections: informational approach, storytelling or narrative approach, and other approaches.

1.2.3.1 Informational Approach

In Canada, the program Transitions: Student Reality Check was launched in Halifax in 2007 and disseminated to 8,000 post-secondary students in five institutions (Potvin-Boucher, Szumilas, Sheikh, & Kutcher, 2010). It was a 30-page pocket-sized booklet that consisted of various topics related to mental health such as peer pressure, time

management, and alcohol and drug use. The program's goal was to increase awareness of mental well-being, improve help seeking behaviors, and decrease stigmatizing attitudes toward mental health issues. In their study, Potvin-Boucher et al. (2010) revealed that 95 per cent of the participants found the materials relatable and enjoyed reading them, and 40 per cent of them indeed had discussions about those topics with their friends. However, as the authors acknowledged, this was only a preliminary assessment as it did not address the level of help seeking behaviors as set out in the program's goals. As a follow up to the previous study, Kutcher, Wei, and Morgan (2016) assessed the second edition of Transitions, which was available in book, e-book and iPhone app formats. Surveys of 82 students from a large university in Canada revealed favorable findings. Students who had read this resource package had increased knowledge about and reduced stigma toward mental health issues. In addition, they also reported increased help seeking efficacy. Therefore, the second edition of Transitions served as a potentially useful and valuable mental health resource guide for other post-secondary students.

1.2.3.2 Storytelling or Narrative Approach

The campaigns described below employed more than one approach; however, live or video storytelling was one of the main components that defined the campaigns. In Canada, the Mental Health Commission of Canada was formed in 2007 with the aim of devising the very first national mental health strategy, and promoting mental health knowledge exchange (MHCC, n.d.). Since its inception, the commission has been undertaking pioneering initiatives in a variety of areas such as caregiving, diversity, e-mental health, etc. Out of these major initiatives, children and youth are one of their central focuses. As part of this portfolio, in November 2014, the commission officially

launched a program called HEADSTRONG. The program's objective was to change youth's attitudes and behaviors around mental health issues (MHCC, 2016). By holding national and regional summits, the program hosted thousands of students, school staff, and speakers with lived experience, who shared their stories of recovery. By employing this type of contact-based education, the program hoped to effect change in the students. As expected, the post-summit results confirmed that the program had been successful in positively changing how youth participants thought about mental health issues. In particular, the percentage of students who reported non-stigmatizing responses went up from 47 per cent pre-summit to 66.6 per cent post-summit (MHCC, 2016). However, the post-summit reports did not qualitatively evaluate why and how these programs worked. For example, students were not asked which specific aspects of the program were appealing to them. Doing so would have given the MHCC more insights into how to improve their future initiatives. Moreover, such programs are not sustainable. As indicated by the MHCC, the initial funding is no longer available; new partnership opportunities are being explored for continued funding of the program. In addition, to be eligible to participate in the summits, these 4,450 students were recruited by boards of education, community organizations, school boards, etc. (MHCC, 2016). Thus, these students were not representative of Canadian youth or post-secondary students; their non-stigmatizing attitudes and behaviors could be drastically different from ordinary students. Furthermore, the program expected these students to become change agents who could advocate the anti-stigma messages when they would return to their schools. However, there were no follow-up programs that supported these students to fulfill this expectation.

In addition, no assessments were carried out to determine if this mission was successfully accomplished.

At the provincial level, the campaign In One Voice, launched from January to March 2012, was developed as part of a multi-component, multi-year strategy to increase mental health literacy among youth in British Columbia (Livingston, Tugwell, Korf-Uzan, Cianfrone, & Coniglio, 2013). The campaign's two main goals were to increase traffic on the website mindcheck.ca as an avenue for enhancing mental health knowledge and to reinforce positive attitudes toward mental health issues. The campaign introduced a two-minute public service announcement in which a famous hockey player discussed his suffering from depression. Viewers were also invited to make and submit their own videos as a form of support for their friends and family members who lived with mental health issues. The campaign was also promoted in other traditional media platforms such as a television show called the Hockey Night in Canada and social media sites such as Facebook, Twitter, and YouTube. In their study, Livingston et al. (2013) assessed the effectiveness of the campaign based on its two goals. Two samples of 806 participants aged 13 to 25 did an online survey immediately before or two months after the campaign's launch. The results indicated that participants who had been exposed to the campaign were more likely to discuss and seek mental health information. However, personal stigma, social distance, and attitudes toward mental health issues were not significantly different between the two groups. As such, the authors concluded that a brief social media campaign like In One Voice could increase mental health literacy; nevertheless, it would have minimal effects on personal and public stigma. One year after the intervention, Livingston, Cianfrone, Korf-Uzan, and Coniglio (2014) carried out the

same study to extend the evaluation of the campaign. The results demonstrated that there was a small but significant reduction in personal stigma and social distance among young people. The authors speculated that the results were due to the nature of social media. Since the campaign utilized social media as its main channel of communication, exposure could be accumulated over time, which in turn could result in attitudinal improvements. However, the authors also highlighted that they were not able to separate the effects of this campaign from others that were happening during that one-year period.

1.2.3.3 Other Approaches

In their paper, Wright, McGorry, Harris, Jorm, and Pennell (2006) described the development and evaluation of a youth mental health community awareness campaign implemented in Victoria, Australia from 2001 to 2003. The campaign's aim was to educate youth aged 12 to 25 about the benefits of early recognition of mental health issues and help seeking behaviors. Its key message was "get on top of it before it gets on top of you." Wright et al. (2006) also identified other supplemental messages: youth are susceptible to mental health issues; symptoms should be taken seriously; and seeking help early is critical to successful treatments. The choice of communication channels was also thoroughly deliberated during the process of developing the campaign. In their paper, Wright et al. (2006) outlined in detail their seven modules of communication with their rationales. For example, a website, specifically designed for the campaign and called GetOnTop, provided youth with more detailed information about the symptoms and resources for help seekers. In addition, mental health advisors were also available on GetOnTop mental health helpline to offer more personalized information and coaching. In other words, the authors relied on a wide range of communication channels to reach

their target population and convey their messages. Afterwards, the authors conducted a series of post-implementation evaluation tests, which consisted of a cross-sectional quasi-experimental telephone survey of mental health literacy before and after 14 months of the campaign. The results indicated that the campaign, besides other impacts, had increased awareness of suicide risk and reduced perceived barriers to help seeking.

In Los Angeles, California, the United States, the campaign Why We Rise was launched from May to June 2018 to empower youth aged 14 to 24 by increasing awareness of help seeking (Canady, 2018). In addition to being featured on social media, the campaign also organized a "We Rise" event with art exhibitions, musical performances and panel discussions on mental health issues. In her article, Canady (2018) reported that a post-campaign survey of 1,000 Los Angeles youth found that 20 per cent of the respondents were aware of either the campaign or the event. Moreover, those exposed to the campaign not only reported their increased awareness of the challenges people living with mental health issues face, but also felt that they had been empowered to promote access to mental health services.

Han, Nicholas, Aimer, and Gray (2015) described a campaign called "Handle the Jandal"[1]. The campaign was developed by youth leaders to build youth-led support networks focused on helping Pacific Island youth in South Auckland, New Zealand to improve resilience skills for dealing with pressure. From May to October 2013, youth leader teams organized eight events involving 200 youth participants and their parents in workshops, meetings and discussions revolving around the topic of dealing with pressure.

[1] Which means 'pressure' in New Zealand

To assess the effectiveness of the campaign, Han et al. (2015) conducted pre- and post-campaign surveys, focus groups, and interviews. The results revealed that the youth participants had described an increased sense of urgency and improvements to their mental health. As such, the authors concluded that community organizing campaigns such as “Handle the Jandal” would have a potential to improve mental health of vulnerable populations such as youth.

As seen from this section, most of the campaigns targeted youth in general, with no consensus on the age range. As such, more public health campaigns at various levels should be launched to address the mental health issues of post-secondary students. In addition, the campaigns discussed mostly used quantitative methods to assess their effectiveness. Qualitative approaches would complement those results by providing insights into how the participants would perceive the campaigns or the messages. Lastly, these campaigns tended to employ more than one approach to communicating their messages. However, the post-campaign assessments were likely to evaluate the campaign as a whole. Examining each approach separately would give more information about which element worked better than the others and why. As such, this thesis is particularly interested in appraising two specific approaches to communicating mental health issues: video storytelling and informational messages.

1.2.4 Different Approaches to Communicating Mental Health Issues

There have been numerous approaches to communicating mental health issues to youth/post-secondary students such as employing visual and conceptual metaphors (Lazard, Bamgbade, Sontag, & Brown, 2016), implementing a social marketing strategy (Andreasen, 2004), or integrating a mental health curriculum with English language arts

(Weisman, Kia-Keating, Lippincott, Taylor, & Zheng, 2016). However, informational messages and video storytelling seem to be more effective (Clement et al., 2012; Owen, 2007), and easier to use (Lueck, 2018; Champlin & Nisbett, 2018) than other approaches. There have, however, been no attempts that qualitatively examine the two approaches in one study to understand the participants' perceptions of these different types of messages. As such, this thesis aims to shed light on that area by eliciting the post-secondary student participants' perceptions of each approach. This section is divided into two subsections: informational approach, and video storytelling or narrative approach. The literature of each approach is discussed so that a better understanding of its effectiveness will be gained.

1.2.4.1 Informational Approach

The informational approach has been examined by communication scholars to determine its potential to reduce mental health stigma among post-secondary students. In her study, Lueck (2018) aimed to discover whether different mental health informational messages would have an influence on determinants of help seeking. According to the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), a person's behavioral intention is determined by his or her attitudes toward the behavior and the subjective norm. The subjective norm is defined as the perceptions of whether a particular behavior is approved or disapproved by other people. In addition, the theory also posits that behavioral intention is the direct antecedent of behavior (Ajzen, 1985). Based on the theory of reasoned action, Lueck (2018) utilized gain- and loss-framing in her design of the two tested mental health informational messages to understand the college students' perceptions and intentions of seeking help. The gain-frame

informational message focused on the benefits of seeking help, whereas the loss-frame one emphasized the costs of failing to seek help. Both messages included five components: a headline, statements about mental health behavior outcomes, information about depression, a call to action (a link to the post-secondary institution's mental health center), and a visual featuring seven students. What was different between the two informational messages was the affective tone of the visuals, the headline, and the health behavior outcome statements to emphasize the gain-frame or the loss-frame. The findings of this study revealed that gain- and loss-framing in informational messages did not exert an influence on determinants of help seeking.

Also assessing the effectiveness of informational messages versus other approaches, Champlin and Nisbett (2018) divided 380 student participants into six groups. Group one viewed an online informational message containing information about the post-secondary institution's mental health and wellness services. Group two was exposed to the same informational message supplemented by a first-time experience banner with a tagline "Trying something new makes a better you." In addition to the informational message and the banner, the other four groups were each shown a campaign involving a student story and photo about a first-time experience of (1) moving from home, (2) skydiving, (3) acting in a play, or (4) exercising with a personal trainer. Statistical analyses revealed that as compared to the information-only message, framing help seeking as a first-time experience was viewed with increased appeal, support, and engagement by the participants. In other words, this study indicated that the information-only approach was less effective when it came to appeal, support, and engagement.

1.2.4.2 Video Storytelling or Narrative Approach

Narrative, or sometimes referred to in the literature as storytelling or social contact, is defined as "any cohesive and coherent story with an identifiable beginning, middle, and end that provides information about scene, characters, and conflict; raises unanswered questions or unresolved conflict; and provides resolution" (Hinyard & Kreuter, 2006, p. 2). Narrative has been increasingly used by health communication scholars in a variety of topics such as smoking (Kim et al., 2012), cancer (Green, 2006), and safe sex (Moyer-Gusé et al., 2011). Schank and Berman (2002) classified five specific types of stories used in various communication contexts: *official stories*; *invented stories*; *first-hand experiential stories; second-hand stories*, and *culturally common stories.* Narrative communication comprises the use of any of these types of stories to send a message across to another party.

Narratives can only provide a central medium for expressing and shaping health behaviors when they are culturally grounded. Larkey and Hecht (2010) proposed a model of culture-centric narratives in health promotion to guide the development and testing of the narrative characteristics in a broad range of health interventions. The model proposed that the salient narrative characteristics in a story, including both personally engaging elements and culturally embedded aspects, are expected to influence responses that are mediators of attitudinal and behavioral change. These responses consist of identification and engagement with the characters. Identification with the characters is an important predictor of the behavioral intentions as it increases self-efficacy and reduces counterarguments. Therefore, the model of culture-centric narratives in health promotion suggests that narratives have two layers: one as a medium with characteristics that shape

individual attitudes and beliefs, and the other as an expression of culture embedded in the telling of stories in group contexts.

Social contact, or first-person narratives, was confirmed to be more effective than other forms of intervention when it came to reducing mental health-related stigma and discrimination (Higgins et al., 2011; Clement et al., 2013; Yamaguchi et al., 2013; Mansouri et al., 2009; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). More specifically related to the population of this thesis, Thornicroft et al. (2016), in their narrative review of eight systematic reviews and 8,143 quantitative studies, found that for students, social contact-based interventions usually achieved short-term attitudinal improvements, but not long-term ones.

In addition, video was proven to be an effective, inexpensive, and easy tool used for anti-stigma efforts, especially among youth (Clement et al., 2012). In their article, Janoušková et al. (2017) systematically reviewed 23 studies to examine the effectiveness of video interventions in reducing stigma among 3,900 students aged 13 to 25. The findings revealed that video was more effective than other forms. For example, when compared with educational sessions, video interventions had a more favorable influence on general attitudes and social distance (Clement et al., 2012), and knowledge about mental health issues (Owen, 2007). Moreover, video storytelling was as powerful as a live storyteller when it came to destigmatization. For instance, Reinke, Corrigan, Leonhard, Lundin, and Kubiak (2004) confirmed in their study that both videos and live contacts brought about significant changes in stigmatizing attitudes

Thus, the literature on these two approaches suggests that video storytelling seems to be more effective than informational messages when it comes to reducing stigma and

increasing positive attitudes toward mental health issues. However, video storytelling and informational messages were not included in one study. As such, this thesis aims to include the two approaches in one qualitative study to assess the post-secondary students' perceptions of these two different types of mental health messages. In addition, this thesis also hopes to elicit what the post-secondary students would consider an effective mental health message in each approach. In other words, this thesis wishes to understand the post-secondary students' perceptions of the texts. Hence, following the discussion of these two approaches to communicating mental health messages, the next section will detail what is known in the literature about an effective mental health message in each approach.

1.2.5 Effective Mental Health Messages

Before delving into each approach, what constitutes an effective mental health message in general should be outlined. Michaels, Kosyluk, and Butler (2015), from their literature review of health communication studies, identified four factors that would contribute to the effectiveness of a mental health message. Firstly, an effective mental health message should attract and hold the attention of the recipients by exhibiting the speaker's expertise (Kreuter & McClure, 2004), using a conversational style (Vahabi, 2007), and offering counterarguments to gain message acceptance (Moyer-Gusé, 2008). Secondly, in order to draft an effective mental health message, we should thoughtfully consider the presented information by citing statistics and including personal experience (de Wit, Das, & Vet, 2008; Slater & Rouner, 1996; Strack & Deutsch, 2004). Thirdly, a mental health message is effective when it engages emotions by evoking positive attitudes such as increased empathy or bringing out fear, hope, or anxiety (Cameron &

Chan, 2008; Dal Cin, Zanna, & Fong, 2004; Hawkins, Kreuter, Resincow, Fishbein, & Dijkstra, 2008; McQueen, Kreuter, Kalesan, & Alcaraz, 2011). Lastly, an effective mental health message should contain relevant information to the intended audience by embodying, for instance, culturally appropriate contexts (Banks-Wallace, 2002; McQueen et al., 2011).

In the area of mental health issues among post-secondary students, various strategies have been used to increase the effectiveness of messages. For example, Lazard et al. (2016) employed visual and conceptual metaphors in their message design. Their research indicated that the use of these metaphors led to greater message engagement and had a potential to reduce stigma among post-secondary students. In addition, Andreasen (2004) discussed how to apply the social marketing approach to communicating mental health issues to youth and adolescents. The author posited that social marketing strategies had positive results on other health areas such as family planning, and nutrition; hence, the concepts could be applied to mental health messages targeted at youth and adolescents. Furthermore, Weisman et al. (2016) proposed a curriculum that integrated mental health education with English language arts for youth. The results indicated that the student participants had significantly increased their mental health knowledge and decreased their stigma after the program. However, as explained above, this thesis focuses on informational messages and video storytelling; therefore, what makes an effective mental health message in these two approaches will be discussed more in detail.

1.2.5.1 Informational Approach

In her study, Lueck (2018) suggested mental health informational messages focus on reinforcing the already positive outcome expectations of help seeking. In other words,

informational messages should highlight potential positive subjective experiences while seeking help. Similarly, Sontag (2017) recommended using positive visual frames that inspire the message recipients and gain text frames that focus on positive outcomes of help seeking. The results from her study confirmed that employing both positive visual frames and gain text frames in an informational mental health message was more likely to motivate the recipients to seek help when they suffer from depression.

1.2.5.2 Video Storytelling or Narrative Approach

Janoušková et al. (2017), in their systematic review, provided some recommendations for an effective use of video storytelling. First of all, the authors suggested including a narrative of a person who experienced a mental health issue, together with expert information. In addition, stories told in the videos were recommended to focus on themes of a potential for recovery and/or a possibility to live a meaningful life, which aligned with Clement, Jarrett, Henderson, and Thornicroft's (2010) findings. In Clement et al.'s (2010) consensus development study, a panel of 32 experts attending an international conference on mental health stigma strongly agreed that recovery-oriented messages should be included in population-level campaigns to reduce stigma. Moreover, Janoušková et al. (2017) concluded that videos should be supplemented with information regarding psychosocial and biological explanations of mental health issues. Furthermore, severely negative aspects such as suicide should be used with caution, and the fact that early help seeking behaviors are critical to recovery should be clearly highlighted in the videos (Janoušková et al., 2017).

1.3 The Research Questions

Although mental health issues influence almost every Canadian, this thesis chooses post-secondary students as the target audience due to the prevalence of mental health issues among this population as discussed in the literature review. Moreover, this population will have a significant influence on future generations (Sawyer, Hubbard, & Rice-Spearman, 2006).

Furthermore, it is evident from past studies that informational messages and video storytelling have been extensively used to communicate health issues. When it comes to mental health issues among post-secondary students, video storytelling particularly serves as a potential communication tool to encourage help seeking behaviors. However, no attempts have been made to qualitatively study how the message recipients perceive these two approaches. Therefore, the present study, by examining the participants' perceptions of video storytelling and informational messages, aims to contribute to the body of literature pertaining to mental health.

Lastly, there have been studies that identify aspects of an effective mental health message. Nevertheless, little has been done to analyze what is deemed effective in a mental health message conveyed by video storytelling and informational approaches, especially from the post-secondary students' perspectives. Hence, this study hopes to make practical recommendations on that area.

Informed by the relevant literature, the following research questions are proposed to guide this study:

RQ1: What aspects in a mental health message are deemed effective by the participants?

RQ2: What are the participants' perceptions and reception of mental health messages conveyed by two approaches: video storytelling and informational messages?

Chapter 2 – Methods

2.1 Study Design and Justifications

This study employed a qualitative approach to answering the research questions. Focus group participants were presented with one of two messages about mental health: a set of two storytelling videos or an informational message. Participants then discussed what was deemed effective to them in a mental health message, as well as their perceptions and reception of the messages. This study did not employ an experimental design; indeed, the focus group discussions were meant to elicit the participants' perceptions of the messages being shown to them. The recruited participants were randomly divided into two groups. Group one was asked to watch the storytelling videos, and group two was asked to read the information message. They then stayed in their respective focus group to discuss the messages[2]. The results of these discussions were analyzed and organized into themes to answer the research questions.

Cyr (2016) described the advantages of using focus groups in social sciences research, which closely align with the purpose of this study. First of all, the interaction unit of analysis is suitable for exploratory research as the interactions among participants in focus groups often generate new insights (Cyr, 2016). In addition, it is possible to specify a set of guidelines for focus groups that novice researchers could follow, such as explicating the main purpose of the focus groups, identifying the primary unit of analysis,

[2] At the end of the focus group discussions, the participants also completed a survey. However, due to the small number of participants, the results were not significant. Please refer to Appendix C for the survey details.

and specifying the list of questions asked in the focus groups (Cyr, 2016). Due to these reasons, focus groups were used as the qualitative data collection method in this study.

2.2 Message Choices and Justifications

2.2.1 Informational Message

The informational message (please refer to Appendix A) was taken from the CMHA Ontario's (n.d.-d) website. The two-page informational message, in the form of a PDF file, contains details about mental health issues: different types of mental health issues, what one can do about it, how one can help a loved one, and how one can make a difference in his or her community.

This informational message was chosen because it directly comes from an official governmental website that is accessible to the public. In addition, this informational message contains recovery-oriented visual frames and gain text frames that focus on positive subjective experience while seeking help or helping a loved one to seek help. These features are in line with Lueck's (2018) and Sontag's (2017) suggestions discussed in the literature review.

2.2.2 Storytelling Videos

The videos that contain post-secondary students' personal stories related to mental health were adopted from the project "I am not OK" done by Niagara News, a campus news organization of Niagara College (Dayboll, 2016). Each of the stories was about four to six minutes long. In the videos, the post-secondary students narrated their own stories without the presence of an interviewer. Specifically, Alexa Knapp's and Garrett Suderman's stories were used in the study (Please refer to Appendix A). Alexa was a 19-year-old second-year student in Broadcasting, Television and Film who had social

anxiety disorder. Garrett was a 20-year-old first-year student in Child and Youth Care who had suffered from chronic depression for almost 11 years and generalized anxiety disorder for almost six years.

This project and the two students' stories were selected due to a variety of reasons. Firstly, these stories were told by college students, who are the target population of this study. In addition, the college students were from Niagara College, which is a college in Ontario, Canada; therefore, the target population would find the stories more relatable. Furthermore, the stories fulfilled the definition of narratives by Hinyard and Kreuter (2006). They were first-hand experiential stories that had a beginning, middle, and end, raised conflicts, and provided suggested resolutions. Lastly, the videos focused on how the storytellers combated and recovered from different mental health issues, which, as discussed in the literature review, aligns with what Janoušková et al. (2017) suggested.

2.3 Design of Focus Group Guide

Following Cyr's (2016) guidelines and the research questions, the focus group guide (please refer to Appendix B) was developed. The focus group guide consisted of two parts: how to gather data from focus groups, and the questions to direct the focus group discussions. In the first part, details about the facilitator's roles, logistics, as well as how to run a focus group session were discussed. It was emphasized that the facilitator should let the participants know that they do not need to self-censor themselves; they are welcome to build on each other's thoughts and ideas. In addition, the facilitator should try to keep the conversations on track by actively drawing input from everyone. If the participants' answers are vague, the facilitator is required to ask follow-up probes to elicit concrete examples. In terms of the questions, they were general enough to cover the

participants' thoughts about the messages being shown to them, as well as their perceptions and reception.

2.4 Pre-test of Research Instrument

Before the actual data collection, a pre-test was conducted to get feedback on the focus group questions and to help inform the researcher about any misinterpretations, misunderstandings or confusions from the respondents' side. According to Hurst et al. (2015), a pretest "involves administering the interview to a group of individuals that have similar characteristics to the target study population, and in a manner that replicates how the data collection session will be introduced and what type of study materials will be administered (consent forms, demographic questionnaires, interviews, etc.) as part of the process" (p. 56). The pre-test was carried out with five Western students who were recruited by using the same methods discussed in the section below. Some alterations, such as the rewording of some questions, were made to the research instrument as a result of the feedback received in the pretest.

2.5 Sampling, sample, and data collection procedure

Purposive sampling was used in this study. The target participants were students from Western University whose age was below 26 and who had not been diagnosed with and/or treated for a mental health condition. A mental health condition was defined as any one of a wide range of mental and emotional problems that could affect one's ability to perform daily functions including, but not limited to, depression, stress, feelings of isolation, and anxiety (CMHA Ontario, n.d.-d). The upper age threshold was set at 26 to be in line with the definition of emerging adults used by the MHCC (Carver et al., 2015).

In addition, since this thesis did not focus on treatments, students diagnosed with and/or treated for a mental health condition were excluded from the study.

Before the study was conducted, the proposal had been approved by the Western University Non-Medical Research Ethics Board (NMREB); thus, basic ethical precautions were taken to care for the participants' interests. (Please refer to Appendix D for the NMREB Approval Letter)

Participant recruitment was carried out by three methods. Firstly, a recruitment advertisement was approved by the Faculty of Information and Media Studies (FIMS) and uploaded to its website's 'Participate in Research' section. Secondly, recruitment posters were put up in all 11 Western faculties, including Faculty of Arts and Humanities, Richard Ivey School of Business, Faculty of Education, Faculty of Engineering, Faculty of Health Sciences, FIMS, Faculty of Law, Schulich School of Medicine & Dentistry, Don Wright Faculty of Music, Faculty of Science, and Faculty of Social Science. Lastly, the recruitment messages were posted on all student groups in Western community on Facebook.

The recruitment message included the introduction of the study objectives and the researcher's email. Interested participants emailed the researcher and indicated their availability. They were then randomized into one of the two groups as described in the Study Design section above. Once there were enough participants for one focus group (three to four participants), the researcher sent the details (time and location) to the participants. Before the actual study, each participant was asked to complete the screening form to make sure they were eligible for the study. The researcher then went through the letter of information and consent, which the participants needed to sign. Each

focus group lasted about 30 minutes and was recorded for transcription purposes. At the end of the study, the researcher had a short debriefing session with the participants to explain the purpose of the study. In appreciation for their time, each participant received a $5 gift card.

Within four months from September 10, 2018 to December 7, 2018, four focus groups with a total of 14 respondents were conducted.

Chapter 3 – Data Analyses and Findings

This chapter demonstrates the findings that were derived from the analyses of data obtained from the post-secondary students involved in this study. To thoroughly assess the participants' perceptions and reception of mental health messages conveyed by different approaches, this chapter is broken down into two sections. The first section presents thematic analysis, the method used to analyze data collected from the focus groups. The second section describes the themes that emerged from the analyses.

3.1 Thematic Analysis

According to Braun and Clarke (2006), thematic analysis is "a method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (p. 79). Thematic analysis allows for flexibility and accessibility by novice qualitative researchers. More importantly, Braun and Clarke (2006) highlighted that thematic analysis is useful in that it can "summarize key features of a large body of data, and/or offer a 'thick description' of the data set; highlight similarities and differences across the data set; generate unanticipated insights; allow for social as well as psychological interpretations of data; and produce qualitative analyses suited to informing policy development" (p. 97). Thanks to these advantages of thematic analysis that closely align with the purpose of this research, thematic analysis was adopted in this thesis. However, like any other methods of data analysis, thematic analysis is fraught with pitfalls, which often result from poor executions by the researchers; therefore, in order to avoid these disadvantages and ensure validity and rigor, this thesis strictly followed the six-phase step-by-step guide of doing thematic analysis that was proposed by Braun and Clarke (2006) and will be outlined in detail.

In the first phase “Familiarizing yourself with the data,” the researcher is supposed to transcribe the data, read and reread them, and write down initial thoughts. Although thematic analysis does not require a transcript that is as detailed as other qualitative analysis methods such as conversation analysis, discourse analysis, or narrative analysis, Braun and Clarke (2006) emphasized that a thematic analysis transcript should be rigorous and thorough. In other words, it should contain “a ‘verbatim’ account of all verbal (and sometimes nonverbal – eg, coughs) utterances (Braun & Clarke, 2006, p. 88).

In the second phase “Generating initial codes,” the researcher is required to code the data systematically and sort them according to each code. Boyatzis (1998) noted that codes concern “the most basic segment, or element, of the raw data or information that can be accessed in a meaningful way regarding the phenomenon” (as cited in Braun & Clarke, 2006, p. 88). Coding can be accomplished either manually or with the assistance of computer software packages. Each method has its own pros and cons; however, Webb (1999) suggested that novice researchers use the manual approach as it would facilitate the process of gaining insights into the intuitive aspects of analysis. As such, this thesis did not employ any computer software packages when it came to qualitative data analysis. Instead, the researcher used a combination of highlighters, colored pens, and post-it notes in the process of manual coding.

In the third phase “Searching for themes,” the researcher should organize codes into potential themes and collect all data relevant to each potential theme. The researcher is also recommended to start considering the relationships among codes, themes, and different levels of themes.

In the fourth phase “Reviewing themes,” a thematic map should be generated. However, before doing so, the researcher is supposed to check if the themes are related to the coded extracts and the entire data set. A lot of refinement needs to be carried out in this phase. For example, some themes need to be discarded if they do not have enough data to support them. Other themes need to be combined as they overlap or separated into smaller subthemes. As a general rule of thumb for this process, Braun and Clarke (2006) cited Patton’s (1990) dual criteria of internal homogeneity and external heterogeneity (p. 91). In other words, data in one theme should cohere together and support that theme meaningfully, and at the same time themes should be distinct from one another.

In the fifth phase “Defining and naming themes,” as the name suggests, definitions and names for each theme should be clearly articulated. In addition, Braun and Clarke (2006) suggested carrying out an ongoing analysis to improve each theme, and the overall story of the analysis. The most substantial feature of this phase is to tease out the essence of each theme and demonstrate what aspect of the data each theme covers.

The last phase “Producing the report” also presents the final opportunity for analysis. In order to produce a scholarly report of the analysis, when presenting themes, the researcher is supposed to select vivid, compelling examples, and relate them back to the research questions and the literature. It is crucial to convince the readers that the analysis has been conducted in a thoughtful and rigorous way; therefore, the findings are valid. More importantly, the writing should not be a descriptive account of the data; instead, it should make out a strong case regarding the research questions, with the support of evidence manifested in themes and data.

3.2 Findings

This section aims to present findings pertaining to answer the research questions: what makes for effective mental health messages, and what the post-secondary students' perceptions of mental health messages conveyed by different approaches are. This section is organized into three categories that correspond to the research questions: message facilitators, perceptions of mental health conditions and perceptions of help seeking behaviors. Message facilitators could also be understood as the participants' perceptions of the texts. In each section, the themes emerged from the focus group discussions are presented.

3.2.1 Message Facilitators

This section discusses what the participants deemed effective in a mental health message, or their perceptions of the texts.

3.2.1.1 Applicable to Both Approaches

The participants alluded to four factors they considered to be compelling when it came to effective mental health messages. The first factor of effective messages described by the participants was *diversity*, which can firstly manifest itself in inclusion of a variety of mental health issues or stories told by different people.

> Not only should we have a variety of mental health issues, but also a variety of stories of the same issue. Not everybody feels depression or anxiety in the same way, so having multiple people tell their stories of how they deal with it, I think that will be beneficial. (Participant 3, Videos group)
>
> The mental health issue is very broad, so including more perspectives from a variety of people would help. (Participant 5, Videos group)

> It seems pretty inclusive, like they mentioned about like how some people don't really like being diagnosed and then some people do, like it kind of includes all those different feelings that people may have toward their personal mental illness or general mental illness. So it wasn't like, you know, very alienating in essence. And I really like that one big little quote there: "Mental illnesses are just like any other illnesses; everyone deserves care, help, and support." (Participant 13, Information sheet group)

By including a variety of mental health issues, mental health messages could contribute to normalizing and destigmatizing mental health issues, as explained by this participant:

> Potentially it would be beneficial to have people who struggle from like schizophrenia or multiple personalities, or whatever it is called, different things like that. In my experience, I had a professor once who opened up about having schizophrenia, and it was like a very interesting experience to say: "Oh my goodness! This is something you deal with on a daily basis, but you are still functional as if those people aren't able to function." (Participant 4, Videos group)

Diversity can also involve a variety of voices from different backgrounds.

> Also having different races, genders, ages also affects. It's hard to deny but every single person has some sort of stereotypes. (Participant 7, Videos group)
>
> I feel like diversity in mental health is important too. Because it's just so hard to get support if you don't feel represented. In the conversations of being

> held, if you don't see people of color, if you don't see men talking about their experiences of mental health, you will think it's separate, it's not my problem. (Participant 12, Information sheet group)

The second factor discussed by the participants was *explicit instructions*. They felt that *explicit instructions* should be more clearly highlighted. *Explicit instructions* could take the form of what to do when they encounter similar situations:

> For me, while they shared their experiences, I didn't notice anything like, maybe if you experience similar things, you can call this number. For example, if I'm going through something similar, after watching the videos, what's next? (Participant 5, Videos group)
>
> And then something I don't really like I think they should add more resources. They only have the website. I know that in society obviously not everyone has access to the Internet. So leaving a phone number would be good. (Participant 8, Information sheet group)
>
> If they have like a part on accommodation students can contact during their final exams, I think that'll be a little better. So students can have actual support. (Participant 12, Information sheet group)

The participants also expressed the need for *explicit instructions* on how to tell and what to do if your loved one is experiencing a mental health issue.

> The only thing that I don't like is here "How can I help a loved one?" They don't really address like what happens when someone is mentally ill but they are not diagnosed. That could be a challenge because you know sometimes

> you don't even know if your loved one has a mental illness. (Participant 9, Information sheet group)
>
> It's very informative overall. It like gives you good tips to kind of how to move on from this. However, they are not specific like you mentioned. Like that page, it's too general. "Listen to your loved ones." You know like it may be better to ask you to do something more than just listening for a few times. (Participant 12, Information sheet group)

Shift toward understanding societal and biological causes of mental health conditions was also acknowledged by the participants as one of the important factors of an effective message. According to the participants, the mental health messages shown to them placed too much emphasis on individual factors contributing to the development of mental health issues. They thought that shifting the emphasis away from individual factors would make the mental health messages more effective as mental health issues could be caused by societal factors or simply by biological factors.

> I think the stories are pretty interesting. I find it interesting – both the stories that you showed us. Both participants had to… well, they didn't get to explain why they had their mental illness. But I think that's come across a lot. With people that are suffering from mental illness, they may have to say: "Well, I have anxiety," or like the second participant was like: "I was depressed because I was bullied and seen as a weak child, and that's why." But I don't think that needs to be included. Sometimes, you just have a mental illness because it has something to do with like chemical imbalance in your brain, or other things that you can't explain. But it's pretty common in

> the large communities that you have to justify why you're suffering in certain ways. (Participant 1, Videos group)
>
> I feel like it's very individualized. I come from a sociological background, so everything can be a social problem, and can be interpreted in different ways. By making it like here are the symptoms, here are the individual factors, they kind of say depression or mental illness is a root problem, as opposed to mentioning how structures can play a role in shaping or making certain symptoms even worse. (Participant 11, Information sheet group)

Lastly, when expressing their opinions about the mental health messages that they were shown, the majority of the participants from both groups indicated they would prefer a *combination of both information and storytelling*. They asserted that a mixture of both approaches would be advantageous. For example, the participants who watched the storytelling videos suggested more background and factual information should be inserted into the stories told by the fellow post-secondary students. To them, these pieces of background and factual information would enhance their knowledge about and understanding of the mental health issues and the stories told by the post-secondary students, which in turn would make the messages more effective.

> For me I think especially with the first speaker she wasn't sure what is mental health, what isn't mental health. Even when she was describing her symptoms, I myself was confused whether that was mental illness or maybe it was social skills thing. Well it's positive information I think there's still more information in terms of actually explaining what this thing is and what it looks like. (Participant 5, Videos group)

> I think just a little bit more information because I feel like if you want to identify with the person more, you might want to know more about their characteristics. The videos only had their names and then jumped directly to their personal stories. I found that a little bit drastic. Like I want to connect with them and try to empathize with them, I just had a hard time with that. (Participant 6, Videos group)
>
> Both of them, their experiences are different, but for the second participant, it's more about his own process of seeking help, about his medications and his utilizing psychiatric services. In a way that was a bit more developed like it wasn't just a symptom. Maybe for the first person, that could have been included so we would have a more concrete idea of what she is going through. (Participant 6, Videos group)

At the same time, the participants who read the informational message would like to see stories or testimonials to be included.

> I would prefer if some kinds of stories were included. When you're actually hearing testimonials like mental illness does actually happen to real people, like this is actually what they go through and what they experience, so it makes it more real I think. I think it would be beneficial. (Participant 8)
>
> And to have both [information and stories] and not just like one or the other because like some people benefit from like hearing actual testimonials but some people are also like: "I don't want to hear actual testimonials." So then just having like you know a section or two on like actual testimonials so that they can skip that if they would like to. (Participant 9)

> For example, the "What are mental health illnesses?" section, for me, they can provide a link and people can search on their own time, and maybe provide more space for more story sharing or resources. (Participant 12)

In general, the participants detailed four aspects that would contribute to effective mental health messages. They were: *diversity; explicit instructions; shift toward understanding societal and biological causes of mental health conditions;* and *a combination of both storytelling and information.* These aspects could be illustrated in different ways. As such, being aware of and mastering these techniques would allow for effective mental health messages to be drafted and delivered to post-secondary students.

3.2.1.2 Specific to Video Storytelling

In addition to the four facilitators discussed above that could be applicable to both approaches, there were two other message facilitators specific to video storytelling approach. The participants from this group particularly asserted that they would like to see the *inclusion of loved ones' voices*. For example, a participant shared that a mental health message would be more effective if it identified the supports that a person with mental health issues has from their loved ones:

> I feel like the messages would be much more effective if the person is not talking by himself or herself. Maybe if there is a close friend. Because even the girl was saying she always had a second best friend, or whatever. They are only displaying that they were able to cope with the problem, they were able to become successful, or at least on their way to success. But it's hard to see from the videos that you are actually having care from people around

> them. So it might be more effective if, you know, there's someone accompanying them and telling about their experience as well. (Participant 3)

In addition, the participants highlighted that the inclusion of loved ones' voices would benefit and empower caregivers of mental health sufferers. More particularly, this inclusion could also help prepare the message recipients in case their loved ones were in the same situation.

> I don't personally have a mental illness. Seeing like how someone related to them like their friend like not deals with it per se, but like how they support them, how they understand it, I think that would be really helpful. (Participant 2)

> I think like even having separate videos of just like our participants saying: "My friend is having depression, and this is how I've kind of helped them through it." I think that could help for people like us that may not suffer from depression or anxiety or any other mental health illness but know somebody that has. That may be helpful when we interact with them. I think that goes along with the stigma as well. We don't know how to interact with people that are suffering, so we kind of ignore it. We pretend that does not happen because it is awkward. We don't really know how to react. Yeah so if we have more messages of people saying: "This is how I dealt with it," I think that would help. (Participant 7)

The second message facilitator specific to video storytelling was *emotional engagement.* According to the participants, in order for the mental health messages to be

appealing, they should be emotionally engaging by showing the most accurate portrayal of the storytellers. They shared:

> I noticed that when she cried, it directly jumped to when she recovered. Maybe that should be shown a little bit more. Because when she was crying, you know, people when they're vulnerable, they tend to say their truest feelings. So maybe that should be played a little bit more. (Participant 3)
>
> I feel the editing [of their crying scenes] was a little bit choppy for both of them. You could tell they were picking and choosing certain words. It's good to keep the videos short. But I think having a link to the full interview would help. (Participant 1)

3.2.1.3 Specific to Informational Approach

Similar to the other group, participants who read the informational message also shared another message facilitator that they thought could help to improve its effectiveness. As shared by the participants, mental health messages should be *better designed* so that they could respond to the needs of post-secondary students who are busy with schoolwork and inundated with substantial numbers of mental health messages on campus. In other words, post-secondary students are heavily overloaded with mental health information. Mental health messages appealingly designed and specifically tailoring to the post-secondary population could capture their attention better and help to differentiate from other mental health messages that the post-secondary students are already being exposed to.

> I feel like on campus, we are just being bombarded with information about mental health, mental illness and self care. Like there's a lot of information

> on campus. And like on social media, there are just so many posters and talks about it. I feel like this will just be one of those posters that they pick up and may not take to heart. You know what I mean? Because there is just so much material on it. I mean it's really good. There's a lot of information because there's a lot of stigma toward mental health issues. However, I feel like there's just a lot. They will just like: "OK, thank you!" and then move on, that kind of thing. So infographics are really good to go because they provide statistics, and graphics, and short texts. (Participant 12)
>
> I find also like to emphasize, like that "Do you need help?" section could be a little bit more bolded so it can start getting people's attention maybe. Just because a lot of it kind of looks the same, so maybe if someone is really struggling, they can find it early. (Participant 8)
>
> I think there's a lot of information, but I can't see a lot of students reading it. Like I know myself personally, I remember during orientation week, they gave us like 30 different of those pamphlets, and I think I threw out 29 of them. I have no background in design, but I would probably make it very simple, like lots of pictures over texts. (Participant 14)

3.2.2 Perceptions of Mental Health Conditions

3.2.2.1 Understanding and Awareness

Sharing from the participants revealed that both approaches had advanced their understanding and awareness of the issue. In addition, they perceived that these messages would similarly promote other people's understanding and awareness of mental health issues. In other words, the participants felt that these messages were effective in raising

awareness and providing information. For example, a participant anticipated that these mental health messages, by giving insiders' perspectives, would further people's understanding of mental health issues in society.

> I think these messages could help other people in society understand, like giving insiders' perspectives, to further understand what they are going through. I think if we keep everything locked in and we don't share our personal experiences from your suffering, how are other people going to understand what we are going through? So mental health is vastly misunderstood in our society because we are not talking about it. More messages like these are going to spread more awareness and making more people in society aware of what we're feeling and what we're going through. (Participant 1, Videos group)

These messages also broadened the participants' specific knowledge about mental health issues. As illustrated below, a few participants praised these mental health messages for their informativeness.

> For me I think awareness. I know there's mental health but I don't really know all the names of the illnesses. So I think I learned about that. (Participant 5, Videos group)

> I think it was pretty informative, like they gave information on all types, like some of them people may or may not be aware of. People mainly are interested in like, or they know, depression and suicide obviously, but maybe not like schizophrenia. (Participant 8, Information sheet group)

> It's very informative overall. I like how it breaks down the different types because people tend to lump everything in with mental illness, which is a very broad term. (Participant 13, Information sheet group)
>
> I think a lot of people get the regular stress or sadness instead of the mental illness. So I think this leaflet kind of helps illustrate anxiety disorder or depression is a continuous thing that interferes with your life, and it's just not temporary. And I think my friends would really appreciate this pamphlet. (Participant 9, Information sheet group)

3.2.2.2 Openness and Receptiveness

In the participants' opinions, video storytelling seemed to be effective in enhancing openness and receptiveness to mental health messages, and ultimately toward mental health issues. This perceived effectiveness was attributed to the sense of connectedness and relatability that the stories told by the fellow post-secondary students could bring.

> They would be relieved to see that someone can relate to them and that like you know there's actually someone out there who has the similar stories to them. And so they are not always being judged. (Participant 2)
>
> It's interesting that the guy, Garrett, I think that what his name is, was saying how many, when he started posting on social media, he got negative comments saying: "This is personal. Don't put it online!" But I think there are a lot of people that are suffering would be able to connect with some of the stuff that he says and think: "Oh I'm going through that too. At least I know somebody else is struggling." They can even maybe like identify the ways that he's coping with, the ways he's suffering, and maybe if I try these coping

> mechanisms, maybe that will help me too. But because we have the stigma of mental health, for example, you are not supposed to share your personal feelings about it, we don't have that information out there. And people just suffer on their own. (Participant 4)
>
> I think they would be very open to it. They can have somebody that's relatable. They know that they're not alone, that it's normal, or that it's the point where you should get help. (Participant 4)
>
> I think it makes them more relatable. So we can see how these people are suffering, and how they are struggling, and we can relate to, like we've all developed anxiety and depression at smaller levels, so to see how they're suffering from these issues on a daily basis, I think it kind of puts our own lives into perspectives. (Participant 3)
>
> Yeah it's definitely more relatable, especially the more and more you hear about these messages, you'll hear different experiences. You will almost always find something that you either experienced the similar things, or you know, it doesn't have to be as intense or severe. For example, I was talking about my being bullied. Obviously, I recovered because it wasn't as bad. But like being able to understand his feelings and you can imagine how much worse. So it definitely helps the more messages you pass around, the more you become aware that people out there are experiencing those kinds of things constantly. (Participant 2)

By contrast, the participants who read the informational message expressed their skepticism about their openness and receptiveness. For instance, one of the participants

clearly distinguished between gaining information and eventually demonstrating openness toward mental health issues.

> Honestly I'm not going to lie. I think like as much as there's still stigma around mental health, I feel like people still don't want to talk about it. For me personally, I know my friends are stressed or might be having slight anxiety, but it's never to the point where we talk about like huge mental illnesses. So I'm not too sure if it's just like my friend group that does that or people just don't want to tell them. I know that sometimes like if I'm stressed, I obviously might tell them but I won't tell them the intensity of it, so I just feel like it's not really talked about as much as it could be. In terms of opening up, I think these mental health messages could give them resources, but I'm not too sure if they would necessarily open up. I find that nowadays it's so hard to maybe open up to your family and your friends. (Participant 8)

3.2.2.3 Perceptual Changes

The participants highlighted that video storytelling could normalize mental health issues. They asserted that the stories told by the fellow post-secondary students helped them to realize that they had neglected and taken for granted certain aspects of mental health issues. As shared by the participant below, this realization was developed gradually and evolved from his or her better understanding of mental health issues conveyed by the stories.

> It's always hard to imagine how much mental illnesses have affected them. By the way they are talking at first, you would think oh they're just like regular people, they're probably well. But they're like… I remember the girl

> almost started crying. They must be very bad memories related. So yeah we often don't understand what's going on with them. And also, for example, the guy said he was very overweight, and he got bullied. Both were related to myself as well. I was thinking: "Oh that happened to me as well. Why did he need all the help?" We tend to ignore the fact that, you know, the level of the incidence can be different, people might be from a different environment. For example, that guy might have a big family, that, you know, may be less caring for him. My parents cared more or put more efforts to help me, so yeah I guess it's easy to ignore those factors. (Participant 3, Videos group)

Similarly, another participant documented a change in perception over the course of watching the storytelling videos. He or she was doubtful about the stories at first, but that changed over time.

> My initial reaction was, I think again especially the first one, kind of skepticism. Like it was, you know, these were just normal feelings. Why haven't you kind of developed the faculties just to deal with them? But I mean I think that kind of gets to the entire essence of I guess what this is about. That might have been my initial reaction but really I realized that we might deal with things differently and really the definition of mental illness is just kind of having into normal I guess mental processes get to the point where they interrupt with your enjoyment of your everyday life and your normal functioning. Yeah when people describe their problems at first it seems like I deal with the same things, but I mean I start to realize that people might have different thresholds. (Participant 6, Videos group)

Another participant expressed a shift in his or her perceptions of mental health issues before and after watching the storytelling videos.

> I guess in the past, I have had doubts like I am just a normal person, I don't know how I can help. But now I know I can also in a way be like a support system for them. (Participant 2, Videos group)

Similarly, the participants in the informational message group also discussed their change in perceptions. However, it is worth noting that the language used by the participants in this group was not as strong as the storytelling videos group. For example, one participant said that he was only .5 per cent more sympathetic after being exposed to the message.

> I would say from reading a part about how it would affect employment or this paragraph here says: "Some people feel concern, fear, or confusion. Some even avoid those who experience mental illnesses," if you ask me to talk to someone with mental health illness before reading this and after, I probably would be just .5 per cent a little bit more sympathetic. Because now I know in my head the list of problems they are going through, as opposed to a really broad, general idea before that. So that's definitely a good thing. (Participant 14, Information sheet group)

Another participant affirmed that it would take more than just an informational message to change her perceptions completely.

> I think it takes more than this to alter my perceptions drastically. But it kind of brought into perspective some of the challenges they face that you might not think about on a daily basis. (Participant 13, Information sheet group)

3.2.3 Perceptions of Help Seeking Behaviors

Almost all participants from both groups stressed that their perceptions of help seeking behaviors remained unchanged after being exposed to the mental health messages. For example, a participant from the informational message group shared:

> Mine hasn't changed. I don't think I could bring myself to a mental health clinic because I would be afraid even just being around. What if my friends walk by and see me hang around there and then ask me: "Dude, are you ok?"? Definitely there's something about stigma. You don't want to be known as "that guy," you know what I mean? For example, eating disorder, you won't want to be known as "the guy who has eating disorder." Especially something like schizophrenia, you don't want to be heard: "Yeah yeah he's a crazy dude." It's about seeking help and but also trying to balance the fear of stigma. (Participant 14)

Some participants asserted that they had been advocates of mental health help seeking before participating in the study. One member of a group that watched the storytelling videos said:

> I don't think my attitudes changed because I was pro-seeking mental health before. But I think the videos did help me put things into perspective. (Participant 1)

Another participant, who read the informational message, expressed a similar perspective:

> For me, it stays the same too. You know, I always think people should seek help if they can. But again I recognize that it's very hard for people to do that. (Participant 10)

In some cases, participants indicated that they had received, prior to participating in the study, sufficient information about mental health issues, and as a result had come in to the study with a positive attitude toward help seeking behaviors. One participant in the informational message group, for example, had received mental health information as part of her university training:

> I think personally it's kind of the same for me because like I'm majoring in psychology now so I kind of hear about all these things and read about stuff that I'm learning about, so it does not really change my perspectives, to be honest. (Participant 8)

Finally, one participant suggested that the effectiveness of mental health messages might depend on the situation or attitude of the recipient:

> I would also say to an extent these leaflets would help people to seek help. I know personally if I ever read something, it just depends on which stage I am. Like if I really need help, I think reading these would be beneficial. But I feel like if it's just something that is not a huge problem for me at the moment, I maybe just read it, and forget about it until I read it again. (Participant 8)

This participant essentially suggested that mental health messages would be more effective if delivered 'just in time' to an audience with a current mental health issue.

Chapter 4 – Discussion

4.1 Significance of this Study

First of all, as demonstrated in the literature review, there has been an increase in the prevalence of mental health issues among post-secondary students. Although mental health issues affect everyone in the society, this thesis chose to study post-secondary students as this population will have a considerable impact on future generations. Moreover, this population face unique challenges that could have adverse effects on their mental health such as moving away from home, different academic environment, new friendships and relationships. Thus, this research on post-secondary students contributed to the growing body of knowledge about this young population.

Furthermore, it is evident from previous studies that informational messages and video storytelling have been extensively used to communicate health issues. When it comes to mental health issues among post-secondary students, video storytelling particularly serves as a potential communication tool to encourage help seeking behaviors. However, no attempts have been made to qualitatively study how the message recipients, especially post-secondary students, perceive these two approaches. Therefore, the present study, by examining the participants' perceptions of video storytelling and informational messages, contributed to the body of literature pertaining to mental health.

Lastly, very few studies have been done to analyze what is deemed effective in a mental health message conveyed by video storytelling and informational approaches, especially from the post-secondary students' perspectives. In other words, little has been done to understand the post-secondary students' perceptions of the texts. Hence, the results of this study made practical recommendations on that area.

4.2 Theoretical Implications

Although the effectiveness of storytelling approach has been supported in past studies on health communication (Green, 2006; Kim et al., 2012; Moyer-Gusé et al., 2011), this thesis focused on another important aspect: eliciting the post-secondary students' perceptions of mental health messages conveyed by video storytelling and informational approaches. The results of this study demonstrated that although both video storytelling and informational messages could advance the recipients' understanding and awareness of the mental health issues, the participants shared that their openness and receptiveness to the messages was enhanced after watching the storytelling videos. The recipients who were exposed to video stories expressed their perceptual changes in stronger language, which could potentially reduce stigma.

Since this thesis did not employ an experimental and longitudinal design, it could not draw any causal links between the participants' perceptions and actual help seeking behaviors in the future. However, as explained by the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), the post-secondary students' perceptions, or attitudes, are closely associated with their behavioral intentions. As such, this thesis is a crucial first step toward improving the post-secondary students' help seeking behavioral intentions.

In addition, as illustrated in the literature review, mental health knowledge and literacy is negatively related to stigma (Simmons et al., 2017; Kutcher et al., 2016; Svensson et al., 2016; Crowe et al., 2018; Chandra & Minkovitz, 2007), and mental health stigma is negatively associated with help seeking behaviors (Wu et al., 2017; Clement et al., 2015). Therefore, by highlighting that both video storytelling and

informational approaches increased the post-secondary students' understanding and awareness of mental health issues, this thesis initiates the first move toward encouraging more help seeking behaviors among post-secondary students.

4.3 Practical Recommendations

By examining the post-secondary students' perceptions of mental health messages conveyed by two different approaches, this thesis could tease out the message facilitators that the post-secondary student participants deemed effective in communicating to them. In other words, this thesis managed to understand the post-secondary students' perceptions of the texts. This discovery is of practical importance in that it enables communicators to utilize these facilitators in drafting the messages so that they could appeal to the intended audience. These message facilitators also confirmed and added to findings of previous studies (Kosyluk & Butler, 2015; Janoušková et al., 2017). Firstly, mental health messages should be *diverse* in that they should include a variety of mental health issues, as well as stories told by different people from various backgrounds. Secondly, mental health messages should give *explicit instructions* about what to do if the recipient encounters similar situations or how to tell and help if a loved one is experiencing a mental health issue. Thirdly, mental health messages should focus on a *shift toward understanding societal and biological causes of mental health conditions.* In other words, more emphases should be placed on societal or biological factors, instead of individual ones. Lastly, in terms of message form, this study suggests that a balanced combination of both information and video storytelling be used.

In addition to these four general suggestions, there are two other message facilitators specific to the video storytelling approach. Firstly, mental health stories

should include the *voices of loved ones*. Secondly, mental health stories should engender the *emotional engagement* by showing the most accurate portrayal of the storytellers.

As for informational approach, there is also another message facilitator that could be employed. Informational mental health messages should be *better designed* so that they could specifically tailored to the target population.

With these suggested features thoroughly embedded in message design, mental health messages would be able to capture the post-secondary students' attention more, which is the first crucial step toward increasing their knowledge, reducing their stigma, and encouraging help seeking behaviors.

4.4 Limitations of the Present Study and Recommendations for Future Research

Although this thesis made meaningful theoretical and practical contributions to mental health communication to post-secondary students in Canada, it was not without limitations. First of all, the findings of this thesis derived from a small sample size of 14 students in Western University. Future studies should include more participants to validate the results of this study.

Moreover, this thesis set out to examine post-secondary students' perceptions and reception of mental health messages conveyed by two different approaches as this population are more vulnerable and need more attention at this moment when it comes to mental health issues. Other populations might have different perceptions and reception. Future research needs to focus on other populations to assess whether there are differences in how they perceive mental health video storytelling and informational messages.

Furthermore, this thesis lacked a longitudinal component. Given the complexity nature of mental health issues, future studies in this area might consider information retention and retrieval processes so that the phenomenon would be fully understood. For example, future research can conduct a retest after a few months to examine if the participants could still retain and retrieve the information obtained previously.

In addition, the two messages used in this thesis were not parallel. First of all, they were not produced by the same organizational level. The storytelling videos were made by a college news club, whereas the informational message was published by a provincial governmental association. Moreover, the engagement level with the two messages also varied. As the storytelling videos were ten minutes long, the participants may have lost their attention span toward the end. Future studies should examine storytelling videos and informational messages with similar attributes.

Lastly, another potential area that future studies could elaborate on is the design of video storytelling and informational messages. Taking into account this study's suggestions in terms of message facilitators, holistically designed mental health messages could be drafted and tested.

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Appendices
Appendix A: Informational Messages and Storytelling Videos

Informational Messages:

WHAT CAN I DO ABOUT IT?

Experiencing a mental illness can be very distressing. You may wonder if you'll feel like yourself again. You may not know what's happening to you, and you may worry about other people's reactions. It's important to know that it's not your fault and it's not a sign of weakness. It's important to seek help early. Finding help early will get you on the road to recovery faster and may even reduce the risk of problems in the future.

Treatment often includes a few different approaches—for example, counselling, medication and self-care. Support groups can connect people with shared experiences. And there are many self-help strategies to try. Some people may also find extra supports like income and housing. Each person has their own preferences and goals, and recovery plans should reflect that. Contact your local CMHA branch to find help and support in your community.

HOW CAN I HELP A LOVED ONE?

When someone you love experiences a mental illness, you may have conflicting feelings. You may feel worried about their future, and feel relieved that the problem has a name. You may even wonder if you've done anything to cause their illness. These feelings—and many more—are normal.

You can be an important person in your loved one's recovery. Ask what you can do to help. Emotional support is important, but don't forget about practical help with daily tasks, if needed. Remember to take care of yourself and find support, too. Contact your local CMHA branch to find resources in your community.

HOW CAN I MAKE A DIFFERENCE IN MY COMMUNITY?

Mental illness affects everyone. People who experience a mental illness may face challenges in their communities. Capable workers may not find good employment. Housing may come with restrictions or may be limited by inadequate income. Many challenges around living with a mental illness have to do with unfair attitudes and discrimination. You can make a difference by advocating for people who experience mental illnesses. Let leaders and policy-makers know that your community includes everyone, and support organizations that work to give everyone a voice.

DO YOU NEED MORE HELP?

Contact a community organization like the Canadian Mental Health Association to learn more about support and resources in your area.

Founded in 1918, The Canadian Mental Health Association (CMHA) is a national charity that helps maintain and improve mental health for all Canadians. As the nation-wide leader and champion for mental health, CMHA helps people access the community resources they need to build resilience and support recovery from mental illness.

Visit the CMHA website at www.cmha.ca today.

Canadian Mental Health Association
Mental health for all

Development of this brochure generously supported by
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MENTAL ILLNESSES

Canadian Mental Health Association
Mental health for all

www.cmha.ca

What do you think of when you hear that someone is experiencing a mental illness? Some people feel concern, fear, or confusion. Some even avoid those who experience mental illnesses. But mental illnesses are just like any other illness: everyone deserves care, help, and support.

Mental illnesses are just like any other illness: everyone deserves care, help, and support.

WHAT ARE MENTAL ILLNESSES?

Mental illnesses are health problems that affect the way we think about ourselves, relate to others, and interact with the world around us. They affect our thoughts, feelings, and behaviours. Mental illnesses can disrupt a person's life or create challenges, but with the right supports, a person can get back on a path to recovery and wellness.

It's important to understand that there are many different types of mental illness that affect people in different ways. Within each mental illness, people may have very different symptoms and challenges. However, symptoms are just one piece. Access to services, support from loved ones, and the ability to participate in communities play a big part in the way people experience mental illnesses. Culture, background, and personal beliefs also shape the way people understand mental illnesses.

Some people don't see the name of a diagnosis as an important part of their journey, while others prefer the medical terms to describe the illness. No matter how people talk about their experiences, they will likely need to use medical terms if they seek help in the health system. This is just how the system works right now—but it isn't the only way to talk about wellness.

DIFFERENT MENTAL ILLNESSES

Health professionals divide mental illnesses into several different groups based on signs or symptoms. Common groups of mental illnesses include:

Anxiety disorders

Anxiety disorders are all related to anxiety. They may include excessive and uncontrollable worry, strong fears around everyday things or situations, unwanted thoughts, panic attacks, or fears around a past scary situation. Anxiety disorders are the most common mental illnesses, and they can create barriers in people's lives. Panic disorder and phobias are examples of anxiety disorders.

Mood disorders

Mood disorders all affect a person's mood—the way they feel. This can affect every part of a person's life. When someone experiences a mood disorder, they may feel sad, hopeless, tired, or numb for long periods of time. At times, some people experience an unusually 'high' mood and feel powerful and energetic, but this can also create problems. Depression and bipolar disorder are examples of mood disorders.

Eating disorders

Eating disorders really aren't about food. They are complicated illnesses that are often a way to cope with difficult problems or regain a sense of control. Eating disorders may include seriously restricting how much food a person eats, bingeing, or purging food. Anorexia nervosa and bulimia nervosa are examples of eating disorders.

Psychotic disorders

Psychosis is a health problem that affects how people understand what is real and what isn't real. People may sense things that aren't real or strongly believe things that can't be real. Schizophrenia is one example of a psychotic disorder.

Personality disorders

Personality disorders are patterns of thoughts, feelings, and behaviours that may last for a long time and create challenges in a person's life. People who experience personality disorders may have difficulties developing healthy and satisfying relationships with others, managing their emotions well, avoiding harmful behaviour, and working toward important life goals. Personality disorders can affect the way people understand and view themselves and others and cope with problems. Borderline personality disorder is one example of a personality disorder.

Childhood disorders

This is a large group of mental illnesses that start to affect people when they are young, though some people are not diagnosed until they're older. One example of a disorder in this group is attention-deficit/hyperactivity disorder (or ADHD), which affects a person's ability to focus, complete tasks, plan or organize, sit still, or think through actions.

Dementia

'Dementia' refers to a group of symptoms. It can be caused by a disease that mainly affects nerve cells in the brain or can be associated with many other medical conditions. Dementia impacts a person's memory, language abilities, concentration, organization skills, mood, and behaviours. Alzheimer's disease is one type of dementia.

A note on suicide

Suicide, when someone ends their life on purpose, is not a mental illness in itself. Not all people who die by suicide experience a mental illness. However, suicide may be linked to many different mental illnesses. It's important to take any talk or thoughts of suicide seriously and seek help.

Storytelling Videos:

Alexa Knapp: https://www.youtube.com/watch?v=QxyGwZ2U6v0

Garrett Suderman: https://www.youtube.com/watch?v=FTzFWulgE_M

In these videos, Alexa and Garrett narrated their own stories of suffering from and combating mental health issues without the presence of an interviewer. Both Alexa and Garrett were Niagara College's students. Alexa was a 19-year-old second-year student in Broadcasting, Television and Film who had social anxiety disorder. Garrett was a 20-year-old first-year student in Child and Youth Care who had suffered from chronic depression for almost 11 years and generalized anxiety disorder for almost six years. The videos were adopted from the project "I am not OK" done by Niagara News, a campus news organization of Niagara College. Each video was about four to six minutes long.

Appendix B: Focus Group Guide

Gathering Data from Focus Groups

Facilitator

- Take detailed notes
- Word for word transcripts are not necessary but direct quotes can be powerful.

Logistics

- Consider about 30 to 45 minutes for each focus group
- Plan to ask no more than 5 to 10 questions total

Running a Session

- Let the participants know that they do not need to self-censor themselves. The room is a safe space to provide feedback. They are welcome to build on each other's thoughts and ideas.
- The facilitator should try to keep the conversation on track by actively trying to draw input from everyone. He/she should call upon quieter participants to ensure that there is equal participation.
- Consider recording key points on flip chart paper to help capture discussions
- If participants' responses are general or vague, ask follow-up probes to help draw out concrete examples or ideas. Examples of probes are:
    - Please tell me more about what you just said.
    - Please elaborate on that statement.
    - Could you please clarify what you meant?
    - Are you willing to provide a specific example?

Questions

1. What do you think of the mental health messages that you have just read/watched?
2. How might your friends respond to the mental health messages that you have just read/watched?
3. What do and don't you like about the mental health messages that you have just read/watched?
4. If you were to add, delete, or change anything from the mental health messages that you have just read/watched, what would that be?
5. How does reading/watching the mental health messages affect your perceptions of mental health issues?
6. What are your attitudes toward help seeking behaviors?

Appendix C: Survey Details

Survey Design

The survey was created based on the variables obtained from the literature review. The survey aimed to quantitatively assess the participants' levels of social distance and attitudes toward help seeking behaviors. It consisted of three parts, all of which had multiple questions. The three parts were Social Distance, Attitudes toward Help Seeking, and Other Information.

The survey started with clarifications of the purpose of the study and specific instructions. An operational definition of a "mental illness" was given. A mental illness was defined as "a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities" (Workplace Mental Health Promotion, n.d.).

Social distance. The construct of social distance is usually measured when it comes to stigma. Baumann (2007) defined social distance as "the distance one wants to have between oneself and another person in a social situation" (p. 132). Social distance was assessed by using the Social Distance Scale developed by Link, Cullen, Frank, and Wozniak (1987). Respondents were required to assess how willing they would be in the six situations by using a 4-point Likert scale, with 1 meant "definitely unwilling" and 5 meant "definitely willing." The situations were as follows: (1) Renting a room in your home to a person with a mental illness, (2) Being as a worker on the same job as a person with a mental illness, (3) Having a person with a mental illness as a neighbor, (4) Having your children marry a person with a mental illness, (5) Introducing a person with a mental illness to a person you are friendly with, and (6) Recommending a person with a mental illness for a job working for a friend of yours.

Attitudes toward help seeking. To assess attitudes toward help seeking, the respondents were asked to indicate how strongly they agreed with the statements with regard to their attitudes toward help seeking. These ten statements were adapted from the Attitudes Toward Seeking Professional Psychological Help Scale Short Form (Fischer and Farina, 1995). A 4-point Likert scale was used, with 1 meant "strongly disagree" and 4 meant "strongly agree." The statements were worded as follows: (1) If I believed I was having a mental breakdown, my first inclination would be to get professional attention, (2) The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts, (3) If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy, (4) There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help, (5) I would want to get psychological help if I were worried or upset for a long period of time, (6) I might want to have psychological counseling in the future, (7) A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help, (8) Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me, (9) A person should work out his or her own problems; getting psychological counseling would be a last resort, and (10) Personal and emotional

troubles, like many things, tend to work out by themselves. Items 2, 4, 8, 9, and 10 were reverse worded.

Other information. In the last part of the questionnaire, other information was asked. Major was asked in an open-ended format, whereas information about age group, gender, year in university, marital status, and perceived overall mental health was phrased in closed-ended questions. A question of whether the participant has sought professional psychological help before was also asked.

Survey

Project Title: Effectiveness of mental health messages

In this survey, we will ask a variety of questions about your opinions on mental health messages that you are shown. Please answer each question by ticking an appropriate checkbox, or by writing your answer in an open space.

A mental illness is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities.

A. Social Distance

In this section, you will be asked how willing you are in each of the following situations by choosing the answer that best represents your opinion. Please keep in mind that you do not need to answer any questions that you are uncomfortable with.

1. How would you feel about renting a room in your home to a person with a mental illness?

☐ Definitely Unwilling ☐ Probably Unwilling
☐ Probably Willing ☐ Definitely Willing

2. How would you feel about being as a worker on the same job as a person with a mental illness?

☐ Definitely Unwilling ☐ Probably Unwilling
☐ Probably Willing ☐ Definitely Willing

3. How would you feel about having a person with a mental illness as a neighbor?

☐ Definitely Unwilling ☐ Probably Unwilling
☐ Probably Willing ☐ Definitely Willing

4. How would you feel about having your children marry a person with a mental illness?

☐ Definitely Unwilling ☐ Probably Unwilling
☐ Probably Willing ☐ Definitely Willing

5. How would you feel about introducing a person with a mental illness to a person you are friendly with?

☐ Definitely Unwilling ☐ Probably Unwilling
☐ Probably Willing ☐ Definitely Willing

6. How would you feel about recommending a person with a mental illness for a job working for a friend of yours?

☐ Definitely Unwilling ☐ Probably Unwilling
☐ Probably Willing ☐ Definitely Willing

B. Attitudes toward Help Seeking

In this section, you will be asked how strongly you agree with each of the following statements by choosing the answer that best represents your opinion. Please keep in mind that you do not need to answer any questions that you are uncomfortable with.

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

5. I would want to get psychological help if I were worried or upset for a long period of time.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

6. I might want to have psychological counseling in the future.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

C. <u>Other Information</u>

In this section, you will be asked some demographic information. Please keep in mind that you do not need to answer any questions that you are uncomfortable with.

1. What is your age group? ☐ 18 to 19 ☐ 20 to 24 ☐ 25
2. What is your gender?
   ☐ Male ☐ Female ☐ Other
3. Which year are you in?

☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4

☐ Master's ☐ PhD ☐ Other (Please specify: _____)

4. What is your major? _____
5. What is your marital status?

☐ Single ☐ Married ☐ Other (Please specify: _____)

6. Have you sought professional psychological help before?

☐ Yes ☐ No

7. How would you describe your overall mental health?

☐ Not at all healthy ☐ Somewhat healthy
☐ Moderately healthy ☐ Healthy ☐ Very healthy

Thank you very much for taking the time to complete this survey. Your thoughts will allow for better understanding of the important subject of mental health messages.

Profiles of the participants

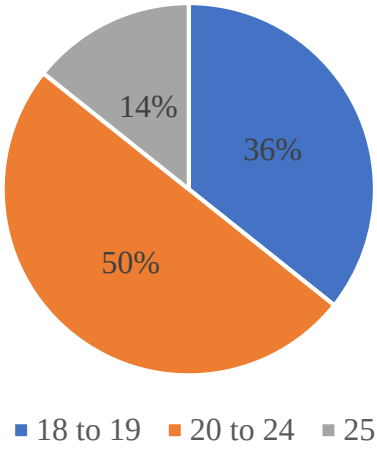

Figure 1. Age group composition

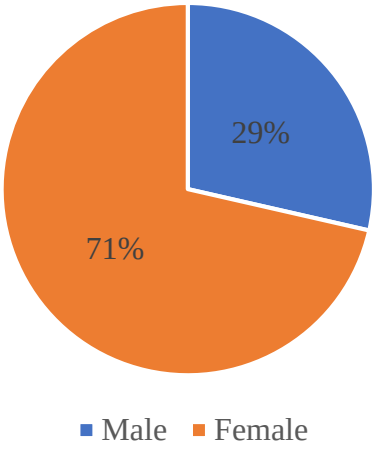

Figure 2. Gender composition

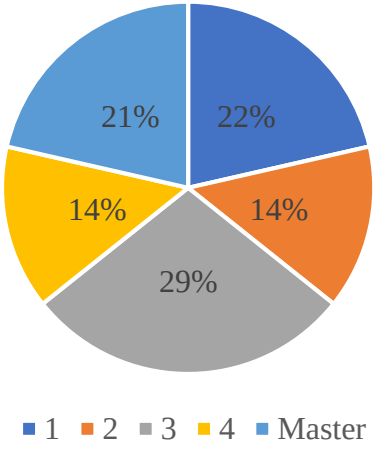

Figure 3. Year of study composition

Descriptive statistics and reliability of research scales

Table 1: Social distance

Individual items and scale	Mean	SD
Social distance (Cronbach's alpha = .794)		
How would you feel about renting a room in your home to a person with a mental illness?	3.14	.77
How would you feel about being as a worker on the same job as a person with a mental illness?	3.86	.363
How would you feel about having a person with a mental illness as a neighbor?	3.93	.267
How would you feel about having your children marry a person with a mental illness?	3.43	.646
How would you feel about introducing a person with a mental illness to a person you are friendly with?	3.71	.469
How would you feel about recommending a person with a mental illness for a job working for a friend of yours?	3.5	.519

Table 2: Attitudes toward help seeking

Individual items and scale	Mean	SD
Attitudes toward help seeking (Cronbach's alpha = .81)		
If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	2.64	.745
The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	3.07	.475
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	2.71	.469
There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	2.93	.475
I would want to get psychological help if I were worried or upset for a long period of time.	3.00	.555
I might want to have psychological counseling in the future.	2.79	.426
A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	2.57	.514

Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	2.71	.469
A person should work out his or her own problems; getting psychological counselling would be a last resort.	2.93	.475
Personal and emotional troubles, like many things, tend to work out by themselves.	2.93	.475

Inferential statistics

Table 3: Independent two-samples t-test of social distance between videos group and information sheet group

Independent two-samples statistics					
Variables		Mean			SD
Videos group		3.52			.49
Information sheet group		3.67			.22
Independent samples test					
	Mean	SD	*t*	df	*p*
Videos group – Information sheet group	-1.43	.2	-.7	12	.5

Table 4: Independent two-samples t-test of attitudes toward help seeking between videos group and information sheet group

Independent two-samples statistics					
Variables		Mean			SD
Videos group		2.79			.28
Information sheet group		2.87			.36
Independent samples test					
	Mean	SD	*t*	df	*p*
Videos group – Information sheet group	-.09	.17	-.5	12	.63

Appendix D: NMREB Approval Letter

Western Research

Date: 27 July 2018

To: Dr. Jacquelyn Burkell

Project ID: 112166

Study Title: Effectiveness of mental health messages in reducing stigma among post-secondary students

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: September 7, 2018

Date Approval Issued: 27/Jul/2018

REB Approval Expiry Date: 27/Jul/2019

Dear Dr. Jacquelyn Burkell

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Debriefing Form_Jul 10_Clean	Debriefing document	10/Jul/2018	2
Focus Group Guide	Focus Group(s) Guide	11/Jun/2018	1
Information Sheet	Other Data Collection Instruments	11/Jun/2018	1
Letter of Information and Consent_Jul 10_Clean	Written Consent/Assent	10/Jul/2018	2
Questionnaire	Paper Survey	19/Jun/2018	1
Recruitment Poster	Recruitment Materials	19/Jun/2018	1
Website Ad	Recruitment Materials	19/Jun/2018	1

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Screening Form	Screening Form/Questionnaire	19/Jun/2018	1

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Curriculum Vitae

Name:	Hugh Huynh
Post-secondary Education and Degrees:	National University of Singapore Singapore 2009-2013 B.Soc.Sci. (Honors) Western University London, Ontario, Canada 2017-2019 M.H.I.S.
Honours and Awards:	ASEAN Undergraduate Scholarship 2009-2013 Western Graduate Research Scholarship 2017-2019
Related Work Experience:	Graduate Teaching Assistant Western University 2017-2019 Teaching Assistant Wilfrid Laurier University 2018

Publication:

Huynh, H. (2019). Review of the book *The rise of addictive technology and the business of keeping us hooked. Mobile Media & Communication, 7*(1), 150-151. https://doi.org/10.1177/2050157918804400.