Language Effects on Mental Health Stigma

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Abstract

Language is powerful, and the social power of language and labels is something that still needs to be developed in the field of psychology. In two studies, we investigated the effects language had on the stigmatization of mental health problems, specifically depression and suicidal ideation. In study 1 we examined individuals' emotional responses to, perceptions of, and biases towards those labeled with possesive-based or noun-based labels of depression. We hypothesized the noun-based label would be seen more negatively than either an individual labeled with the possessively-phrased label or an individual with no label and that an individual associated with the possessively-phrased label would be seen more negatively than an individual associated with no label. Results indicated that a label of depression appeared to benefit the labeled individual.. In study 2, we investigated the effects of joking about suicide on individuals' perceptions and helping behaviors toward someone who admitted to having suicidal ideation. We hypothesized participants who hear someone joking about suicide will have more negative perceptions of someone who states feeling suicidal and that they would be less likely to report the suicidal ideation. While no significant results were found for study 2, we found trends supporting our hypothesis. Overall, the language that is used to discuss mental health has important implications. Whether this be due to the way we phrase labels or the context we use to talk about mental health, it is beneficial to understand what the impacts our conversations may have.

Language Effects on Mental Health Stigma

Oftentimes, we may be afraid to admit quirks about ourselves because we are worried about what other people might think or say about them. We are worried about what people's perceptions might be. We do not want to be treated poorly for something we enjoy, or even something about us that is outside of our control, like an illness. However, especially when it comes to mental illness, people are often kept isolated in shame and in fear of admitting something is wrong with them, because people may view them as dangerous or contagious. Such stigma is based on the language and stereotypes we use (Goffman, 1963). Indeed, in regards to mental health, over time, our society has consistently used language that perpetuates fear. Even within the medical field, mental health is primarily discussed in a negative framework (Alex, Whitty-Rogers, & Panagopoulos, 2013). The way we use language in terms of mental health may have detrimental effects on prejudice and discrimination toward diagnosed or struggling individuals. Study 1 investigated the effects of label-wording on perceptions of diagnosed individuals. Study 2, investigated the effects of humor about suicide on individual's perceptions and behaviors toward someone struggling with depression and thoughts of suicide.

Statement of Purpose

Throughout the last eight years of my life, I have been involved with an organization, To Write Love On Her Arms (TWLOHA), a non-profit dedicated to presenting hope and finding help for people struggling with mental health problems. Their purpose is to start honest conversations about mental health topics as well as the daily struggles we experience in our lives. Often, topics such as depression, addiction, self-injury, and suicide are not discussed because people do not know how to talk about them or are afraid of how people may perceive them. Part of the vision of the organization is to provide a safe place to seek out information and to be a

reminder that mental illnesses do not discriminate. Each individual has been affected differently by mental illness. For example, one individual may struggle with depression and anxiety, while another struggles with a personality disorder. Even if an individual does not have a mental illness, they are likely to know someone who does; whether they know someone who died by suicide or someone in treatment for an addiction, mental illnesses affect everyone in different ways.

Through working with this organization focused on fighting mental health stigma and studying psychology in college with the goal of becoming a clinician, I became attuned to hearing people make jokes about mental health and use language that may perpetuate prejudicial views of those with mental illness. Further, as part of my training to found and lead a University Chapter of TWLOHA, as well as in an internship I had at TWLOHA's national headquarters, I was educated on a variety of mental health issues and the way stigma affects each of these. For example, in my internship, we were asked why we may be hesitant to ask someone if they are considering killing themselves. This question caused me to think about how language plays a vital role in keeping people isolated in their stories and struggles, and about how we could use language to our advantage to help people share their stories in ways that are therapeutic and encouraging. We discussed how powerful language is, whether in the media or in our daily lives, in shaping our views of people who are struggling. We emphasized the power of relationships and how, through our relationships, we can be a voice of hope and communicate that people belong in this world. We looked at the way myths and lies about our social roles become the foundation for stigma, and how this stigma keeps people in isolation and causes them to feel hopelessness (Moore, 2013).

From this basis of training and personal interest, I hope to apply this research in ways that are beneficial to society and by helping people take topics like suicide and depression seriously, as well as by encouraging those who are struggling to seek treatment despite stigma. Language has powerful effects. I believe researchers, clinicians, and regular people can all help fight this stigma associated with mental health. A good starting point is with the language we use every day.

Study 1: Effects of Label Phrasing on Stigma

Goffman (1963) was one of the first researchers to explore the concept of stigma. According to Goffman, stigma is “an attribute that is deeply discrediting” (p. 3). Additionally, Goffman believed that a person associated with a stigma was seen as less of a human, causing others to discriminate against that individual. Goffman suggested that it is the language of the attribute that creates stigma. To clarify, communities place value on certain attributes and label others as “unusual.” Designating a label to an individual points out one’s differences and communicates that this individual is not “normal” and that something is wrong with them.

More recent definitions of stigma include multiple components in the process of stigmatization. Jones et al. (1984) proposed that stigma depends on six different dimensions: concealability (how obvious the characteristic is to others), course (permanency of the characteristic), disruptiveness (how it effects interpersonal relationships), aesthetics (reaction of disgust), origin (how condition arose), and peril (dangerousness). The severity of each of these components would determine the extent to which one is stigmatized. Additionally, Link and Phelan (2001) added the concept of discrimination to stigma. They stated stigma is present “when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation” (p. 367). More specifically, they argued that in order for stigma to be present,

people must identify and label different characteristics in others. These characteristics are then seen as undesirable in that specific culture, which then causes the stigmatized individual to experience status loss and discrimination. Lastly, stigma is fully experienced through the loss of power by those who are undesirably labeled.

In this study, we focused on the effects labeling had in the stigmatization process. The language we use has important implications. Even simple labels can have impacting effects on people's perceptions and further dehumanize or stigmatize the individual behind the label. For example, *rape survivor* has different implications than *rape victim*. A *rape survivor* is perceived to be more likely to better cope with the trauma than a woman labeled as a *rape victim*, or *woman who has been raped* (Hockett, McGraw, & Saucier, 2014). In reference to mental health labels, "politically correct" labels, such as *person with schizophrenia* rather than *schizophrenic,* are being used in attempts to reduce the amount of stigmatization experienced by individuals with mental health diagnoses or concerns. However, even politically correct labels like *person with severe mental illness* or *person with schizophrenia* may have negative implications, especially when compared to the label of *consumer of mental health services* (Penn & Nowlin-Drummond, 2001). In their assessment of such labels, Penn and Nowlin-Drummond suggested these differences may be due in part to the more generic nature of *consumer of mental health services*, whereas *severe mental illness* may already be perceived as a diagnosis of schizophrenia. Overall, the research is split between the pros and cons of both generic and specific mental health labels.

Supporting the benefit of more generic labels, when labeled with a generic mental health label (i.e. mental illness, mental health problem, mental disease, mental disorder) in relation to a specific mental health diagnosis like depression, individuals are perceived more positively.

Individuals with the specific label of depression are seen as less friendly and less pleasant when compared to individuals with a generic label (Szeto, Luong, & Dobson, 2013). Szeto et al.'s research concluded there were no significant differences in individuals' perceptions between each of the generic mental health labels: participants regarded the generic labels, *mental illness, mental health problem, mental disease,* and *mental disorder* as more likely to be due to biological factors than psychosocial factors compared to individuals' perceptions of the specific label of *depression,* which was not seen as being due to biological factors. Thus, generic labels may allow others to consider the labeled individual and believe they are less at fault for their condition (c.f., Haslam, 2006; Kvaale, Gottdiener, & Haslam, 2013; Lebowitz, 2014). Individuals attached to generic mental health labels were viewed more optimistically and as being likely to overcome their diagnosis (Szeto et al, 2013; Penn & Nowlin-Drummond, 2001). Generally speaking, using generic mental health labels appears to inspire more positive perceptions of those with mental health diagnoses.

Despite these benefits, using a generic label may also disregard an individual's identity and imply what one person is experiencing with one diagnosis is no different than what another person with a completely different diagnosis is experiencing. Specific labels are useful to distinguish between different diagnoses. Another benefit explored by Wadley and Haley (2001) is that a specific label may increase the levels of support an individual receives from others. In cases of family support, they found that having a specific label influenced a loved one's emotional responses to their labeled family member. In their research, daughters were asked about their perceptions when their parent was diagnosed either with *Alzheimer's disease* or *major depression*. When compared to a no label condition, participants presented with a specific label had higher levels of sympathy for their parent when a specific label was present. They were

also more willing to help their family member in the *Alzheimer's disease* condition. In this case, having that label was beneficial for the parent to receive help from the child.

While stigma may be present with specific mental health labels, Rosenfield (1997) speculated that an additional benefit specific labels provide is that individuals labeled with a diagnosis are more likely to receive treatment. Rosenfield concluded that receiving services for a diagnosis increases one's quality of life, regardless of whether stigma is present. In Rosenfield's sample, at least half of the participants felt they were stigmatized. The more stigma that was present, the lower individuals rated their quality of life. However, despite the presence of stigma, those receiving services rated an increased quality of life compared to those not receiving services. This important benefit of a label allows for individuals to seek services to aid them in coping with mental illness. These services attempt to provide them with the skills they need to counteract the side effects of their diagnosis (Rosenfield, 1997).

People's stigmatization of those with mental illness may come from the label itself or may be based on schemas and the behaviors that have been portrayed by other individuals with mental health diagnoses (Gove, 1970). Martinez, Piff, Mendoza-Denton, and Hinshaw (2011) investigated whether or not a simple label is enough to stigmatize the individual. When no behavioral information was present, a label of a *chronic mental illness* dehumanized the individual associated with the label and they were seen as more dangerous compared to someone diagnosed with a label of a chronic physical illness. However, when non-stereotypical, normative behavioral information (such as non-violent behaviors) was present and the specific diagnosis of *bipolar disorder* was used, the diagnosis was tied to higher degrees of perceived humanity compared to the physical illness. Thus, this research suggested that individuals utilize their own schemas and stereotypes to judge individuals labeled with no behavioral information present

with a generic mental health label. Yet, when a specific label was utilized individuals perceived them more positively.

As that research suggested, behaviors may provide a framework for how mental health labels are interpreted. However, mental health labels may also create certain expectations for the way a person will behave. For example, parents and teachers who were told their child had a learning disability believed these children would be significantly less likely to complete college compared to peers who displayed the same behaviors but are not labeled (Shrifer, 2013). This finding suggests specific labels may create a frame of reference for what people expect based on stereotypes, which in turn can perpetuate stigma and limit the extent to which people perceive labeled individuals will succeed further in life.

In addition to the label itself, the way a person phrases the label can also impact individuals' perceptions. Reynaert and Gelman (2007) proposed that in our culture, mental illness is commonly referred to with noun-based (e.g. *He is a schizophrenic*) and adjective-based (e.g. *He is schizophrenic*) labels. However, Reynaert and Gelman found that possessively-phrased labels (e.g. *He has schizophrenia*) were generally seen as less permanent than adjective or noun-based labels, regardless of whether the labels referred to physical or mental conditions. Additionally, other research by Howell and Woolgar (2013) found that people who have lower rates of compassion and higher rates of essentialism, or the belief that people have set characteristics that make them who they are, tend to prefer noun-based labels. Such research provides a framework for the idea that noun-based phrases may reinforce stereotypes about mental health diagnoses – specifically, the stereotype that diagnosed individuals will never change or recover from their mental illness.

In sum, labels can be very useful. However, the language used to describe mental health diagnoses may affect others' perceptions of the labeled individual in negative ways, too. As reviewed here, past research on label phrasing has given insight into the effects simple phrasing can have. Based on Reynaert and Gelman's (2007) research, in which possessively-phrased labels were seen as less permanent than noun-based or adjective-based labels, we propose using a possessively-phrased label may decrease stigma by allowing individuals' perceptions to extend beyond the illness itself. As American Psychological Association (2010) guidelines state, we should use "non-handicapping language" (p. 76) and person-first language to reduce bias and also focus on the strengths of the individual, rather than focusing on a label. In the current study, we were interested in extending past research on mental health labels and stigma, particularly regarding the way a specific label is phrased and the perceptions individuals have based on the label. Thus, the objective of Study 1 was to examine how perceptions, stereotypes and stigmas vary with different mental health labels. We examined differences in individuals' perceptions of and biases towards people labeled with either a possessively-phrased mental health label (i.e. with depression) or a noun-based mental health label (i.e. depressed). We hypothesized that individuals associated with the noun-based label would be seen more negatively than either an individual labeled with the possessively-phrased label or an individual with no label. Additionally, we expected that an individual associated with the possesively-phrased label would be seen more negatively than an individual associated with no label.

Study 1 Methods

Participants

Participants (*N* = 106) consisted primarily of a pool of introduction to psychology students at a small midwestern University. These participants were offered research credit for

their class in exchange for participation; other alternatives were also available to students who did not participate. Additionally, participants were solicited via the researcher's social media site (Facebook) and participated voluntarily with no compensation other than the opportunity to gain insight into their own attitudes related to mental health. Approximately 26.23% of participants were recruited via social media, while the remainder were participating for class credit. The average age of participants was 20.93 years, *SD* = 4.53, and they ranged from 17 to 44 years old. The majority of participants were white (74.1%) and female (56.8%). All participants were informed the survey was interested in assessing how self-descriptions influence others' perceptions. All participants provided informed consent to participate. All materials and procedures were approved by the university's Institutional Review Board and were consistent with the APA ethical principles.

Materials

Vignettes. After providing informed consent, each participant was presented with one of three randomly assigned vignettes (Appendix A). The vignettes consisted of an individual, Sam, describing his struggles throughout his first year of college. In addition to typical college problems, Sam also disclosed he was either *depressed, had depression,* or did not disclose any information about his mental health. An example of one of the vignettes is below:

> *Hi, my name is Sam. I am a sophomore in college. I'm struggling with some things—in particular, I am depressed, though some days are good and I like the college experience overall. One of my favorite classes I have taken so far was an art class—it gave me a way to express how I am depressed. Even though I am depressed, I enjoy watching TV and reading books.*

Measures. After reading the vignette, participants were directed to several measures used to assess their perceptions and stigma toward Sam. First, a social distance scale (Appendix B) adapted from Whatley (1959) and Norman, Sorrentino, Windell, and Manchanda (2008) was used to evaluate how likely a participant would be willing to interact with Sam in a variety of social situations. The social distance scale had high reliability with Cronbach's alpha = .931. A semantic differential scale (Olmsted & Durham, 1976) was used to assess stereotypes and negative characteristics participants may have associated with Sam (Appendix C). In our analyses, we further broke down this scale into 3 subscales – dull and distant (Cronbach's alpha = .376), productivity (Cronbach's alpha = .695), and hypersensitivity (Cronbach's alpha = .525). Personal and perceived stigma scales (Griffiths, Christensen, Jorm, Evans, & Groves, 2004) were used to assess the extent to which participants personally stigmatized Sam's problem and the extent to which they perceived most other people would stigmatize Sam's problem (Appendix D). Both of these scales had high levels of reliability, with Cronbach's alphas = .771 and .739 respectively. To assess the extent participants thought less of Sam because of his problem, we included a devaluation-discrimination scale (Link, 1987; Appendix E). This scale also had a high reliability with Cronbach's alpha = .879. Additionally, an adapted attributional scale (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003) was used to assess participants' feelings of how personally responsible Sam was, as well as their levels of anger, pity, fear, and helping intentions towards Sam (Appendix F). This measure had high reliability with Cronbach's alpha = .772. All measures used a 1-7 Likert scale. Finally, we asked open-ended questions about whether participants knew someone with depression and what they knew about depression to test if familiarity with depression altered individual's thoughts and perceptions of Sam (Appendix G).

Study 1 Results and Discussion

We first examined intercorrelations among variables (see Table 1). Then, to help control for Type I errors, we conducted a multivariate analysis of variance (MANOVA) with participants' intercorrelated emotional response, personal and perceived stigma, personal responsibility, pity, anger, fear, social distance, and devaluation and discrimination scale averages as our dependent variables to assess the effects of the condition. Results showed a small effect (partial $\eta^2 = .17$) of condition on the dependent measures, multivariate $F(22, 188) = 1.75$, $p = .025$; *Pillai's Trace* = .34, indicating that perceptions of the student differed by condition, supporting our overall expectations – though not in the expected directions. Follow-up univariate analyses of variance (ANOVAs) demonstrated the effect of condition on the hypersensitivity scale was significant, $F(2, 103) = 9.58$, $p < .001$, and the effect of condition on the personal responsibility scale was marginally significant, $F(2, 103) = 3.35$, $p = .049$. For hypersensitivity, estimated marginal means indicated that the unlabeled student ($M = 3.72$, $SE = 0.18$) was perceived as more hypersensitive than either the "depressed" student ($M = 2.86$, $SE = 0.20$) or the student "with depression" ($M = 2.70$, $SE = 0.16$). For personal responsibility, estimated marginal means indicated that the unlabeled student ($M = 3.33$, $SE = 0.22$) was perceived as more personally responsible than the student "with depression" ($M = 2.66$, $SE = 0.20$). Figure 1 shows mean differences between conditions for hypersensitivity and personal responsibility.

To summarize, no differences were found between the two labels of depression. However, when compared to the student with no label, the student labeled as "depressed" or as "having depression" was seen as less hypersensitive. The unlabeled student was seen as more responsible for his experiences than the student who described himself as "having depression."

While these results did not support our hypothesis, as no differences were found between the two labels of depression, this outcome provides information about the effects of labeling people with mental health diagnoses. The student labeled with depression appeared to be given more leniencies in how he was perceived. This may be one benefit of accurately labeling individuals: when students admit they are struggling and have depression, they are seen as less responsible for that struggle. This information may suggest college students are beginning to understand the effects of having depression and the barriers depression can place on college students' experiences. However, because this finding was not theoretically expected, it should be interpreted with caution.

One limitation of this study is that it examined just the self-disclosed label of depression. Participants may have had difficulty believing the individual was depressed simply by the self-label and therefore had different perceptions than what was represented in our results. Due to the colloquial use of the terms "depressed" and "depression" it may be beneficial to utilize the label of "major depression" to indicate the mental illness. Future research should investigate how perceptions of different specific mental health diagnoses vary with label-phrasing, such as using obsessive compulsive or bipolar disorders. Additionally, with a larger, more representative sample size, we could allow for greater generalizability. An additional possible limitation is that participants, most of whom were college students, may have found it easy to identify with a struggling college student therefore rating them more sympathetically. Balancing school, work, and social obligations can often be exhausting and difficult to accomplish for many students, such that adding a diagnosis of depression may have created the impression that the labeled individual has even greater obstacles than the non-labeled student. Future research should consider changing the scenario in which the labeled individuals are portrayed such as placing the

individual outside a college situation or outside situations that may be seen as stressful. Doing so may allow participants to focus more on the label rather than the situation in the vignette. Finally, future research should include a social desirability scale to analyze whether or not participants are accurately portraying their personal beliefs about the individual and not just reporting beliefs that are seen to be more socially acceptable.

Although these findings are limited and should be replicated and extended by future research, the results indicated that the way we label a person with mental health concerns significantly influences others' perceptions. Although prior research has suggested being labeled as "depressed" would be associated with more negative perceptions than "with depression," and both labels would be perceived more negatively than having no label (Reynaert & Gelman, 2007; Howell & Woolgar, 2013) the present study saw opposite effects. This outcome may have been due to multiple reasons. For instance, depression is a more common and more understood mental health diagnosis compared other mental illnesses used in past research (e.g. Howell & Woolgar, 2013; Penn & Nowlin-Drummond, 2001; Reynaert & Gelman, 2007), potentially causing our results to differ from past research. The differences we found could indicate people perceived individuals labeled with depression as having a reason to struggle more so than an individual without a label. While these post-hoc explanations should be considered tentatively until they are assessed by future research, these results are consistent with past research that outlines a few of the positive impacts of having a specific mental health label (Wadley & Haley, 2001; Rosenfield, 1997). Our findings extended past research by suggesting that some mental health labels may be beneficial by providing justification for the people attached to the label, whereas those without the label may be seen as at fault for their hard times. Practitioners and educators should be cautious of using different labels and of the way they phrase labels in order to decrease the

stigma associated with mental health. However, rather than advocating for the use of any particular labels, we suggest that the effects of labeling are complex and still need to be further developed in research.

While it is helpful to know appropriate ways to discuss mental health that do not further stigma and stereotypes, this information may not be beneficial if individuals are using it in the wrong context. Alex et al. (2013) argued that our society talks about mental health primarily in a way that dehumanizes and demoralizes patients, such as calling people "crazy." This language, even when used casually in a joking manner, may perpetuate stigma and discrimination against individuals who actually do struggle with their mental well-being. The stigma toward mental illness may play a role in keeping people from seeking treatment or talking to a counselor. Thus, in Study 2, we investigated how using mental health labels in a humorous way impacted people's perceptions of a struggling individual.

Study 2: Effects of Humor on Stigma

Disparaging humor (humor that slanders or belittles) toward different social groups has been seen to reinforce and increase prejudice and discrimination toward the targeted group (e.g. Abrams & Bippus, 2011; Abrams & Bippus, 2014; Ford, Woodsicka, Triplett, Kochersberger, & Holden, 2014). Especially among college campuses and in the media, it can be normal to hear people joking about very serious mental health problems, such as saying "This weather is so bipolar!" when referring to the changes of the temperature. While the effects of disparaging humor have been studied in other contexts such as in relation to racial discrimination and discrimination towards women (e.g. Abrams & Bippus, 2011; Abrams & Bippus, 2014; Ford et al., 2014), these remarks may also play a role in the stigma associated with mental illness. There is very little research looking at the effects humor has on mental health problems. The purpose of

this study was to investigate whether or not mental health disparaging humor plays a role in people's perceptions of someone struggling with mental health and their likelihood to help the individual.

Ford and Ferguson (2004) proposed a prejudiced norm theory to explain the ways disparaging humor can have a negative effect on different groups. They proposed that within individuals, humor can reinforce stereotypes and prejudice. This individual-level norming of prejudice can then help maintain prejudice within a society. However, they note that this tolerance in discrimination is seen only when the individual is already prejudiced against the targeted group, as well as when society views discrimination toward the group ambiguously. To clarify, Ford and Ferguson have proposed there is a limited scope of discrimination and prejudice that is examined as such within social psychology. There are social groups against whom discrimination is viewed as more acceptable, such as murderers or terrorists, whereas there are social groups against whom discrimination is viewed as unacceptable because they are considered to be primarily good, such as firefighters or nurses.

However, there is a narrow range in between these groups that is primarily the focus of discussions about prejudice. This range is called the "normative ambiguity range" and is comprised of social groups that may have been disadvantaged in the past (e.g. women, lesbian, gay, bisexual, transgender, and queer [LGBTQ] individuals, African Americans) but for whom prejudice is now shifting from acceptable to unacceptable (Crandall & Warner, 2005). Discrimination against groups in this ambiguity range is primarily seen as unacceptable by society; however, these prejudicial views are often not agreed upon by all of society. Due to this variation, in circumstances involving humor, people may feel more at ease making disparaging comments or laughing at these comments targeting groups in the normative ambiguity range.

This tendency is consistent with other theoretical explanations of prejudice such as Crandall and Eshleman's (2003) justification-suppression model, which suggests that people who hold prejudices will be more likely to express them when they can justify those prejudices. Much of this research has investigated the effects of humor on sexism towards women (Abrams & Bippus, 2011; Abrams & Bippus, 2014) as well as discrimination towards social groups such as Muslims or LGBTQ individuals (Ford et al., 2014). We propose that people who are struggling with mental illness may also be considered as part of this ambiguity range.

In particular, unfortunately, it was only a short time ago that our society had very negative views towards people with mental illness. Now, as research on mental illness continues to grow, people may increasingly be aware of the serious effects of mental illness and understand it is less socially acceptable to discriminate against individuals with mental health problems. For example, we have modified our language to refer to those with cognitive disabilities as "mentally handicapped" or "intellectually disabled" opposed to the word "retarded." In today's society, it would be rare to hear someone describing an individual with a cognitive disability as "retarded." The word "retarded" began to shift meaning in our culture as a word that referred to stupid. The word "retarded" is not typically applied to individuals with cognitive disabilities but when it is used colloquially to mean "stupid" it reflects back on individuals with cognitive disabilities, reinforcing the stereotype that an individual with a cognitive disability is unequal to those without a disability. This idea is similar to the usage of the phrase "That's gay!" to refer to something being abnormal or stupid. Researchers found that due to how common this phrase was only 21% of participants took offense to it (Postic & Prough, 2014). Postic and Prough did find that the more participants knew a person who identified as homosexual, the higher the percentage of viewing the phrase as a slur became. Notably, the overall low percentage of

individuals who identify phrases such as "That's gay/retarded" as being offensive may indicate the social groups represented by such phrases do fall under the normative ambiguity range (Ford et al, 2014). Further research has shown that disparaging jokes have increased individuals' discrimination against social groups identified in the normative ambiguity range previously discussed. Thus, when phrases such as "That's gay" or "That's retarded" are used jokingly in everyday conversation, they may reinforce other's prejudicial views towards those social groups.

In Ford and Ferguson's (2004) prejudiced norm theory, they offered four interrelated propositions. First, individuals must be able to switch into a humorous mindset. Second, this mindset causes them to perceive that they do not need to be critical of comments made (as they are merely intended to be funny). Third, this uncritical humorous mindset may create cognitive dissonance in the individual if they found the joke to be funny but feel that they should not be laughing at the targeted group, which may increase their tolerance of discrimination toward the targeted group. Individuals may then be more likely to adjust their personal viewpoints to become more aligned with the discrimination. Therefore, disparaging humor can increase one's prejudices towards specific groups.

If our language has an effect on our perceptions of the world (e.g. Hockett, 2013; Oduro & Ostin, 2013; Wadley & Haley, 2001), joking about mental health may be a factor in the way society discriminates against those who are struggling. For example, when jokes about suicide are commonplace (e.g., "This class makes me want to kill myself."), it may become difficult to distinguish between when a person is serious opposed to when they are joking. According to American Foundation for Suicide Prevention (2015), expressing a verbal intent to die is a warning sign for a person who is contemplating suicide. The commonplace of joking about self-harm may be a potential reason people are unlikely to respond urgently when they hear someone

expressing their intent to die (Rudd, Goulding, & Carlisle, 2013). The language we hear in everyday conversation may have an effect on the way we hear and perceive honest cues and cries for help.

In this behavioral study, we investigated the effects of joking about suicide on individuals' perceptions and helping behaviors toward a peer who admits they are struggling with suicidal ideation and depression. Consistent with prejudiced norm theory, we hypothesized that those who hear someone joking about suicide will be less likely to perceive another individual who admits they are having a problem with depression and thoughts of suicide as being serious about those feelings. Second, we hypothesized participants who hear a joke about suicide will also be less likely to report the suicidal ideation expressed by their peer to the researcher. Finally, we hypothesized that participants would rate the peer expressing suicidal ideation as more personally responsible for their emotions, and would be less sympathetic and more angry toward the peer when they previously heard someone make a joke about suicide compared to when they did not.

Study 2 Methods

Participants

Participants ($N = 20$) consisted of a pool of introduction to psychology students at a small midwestern university. These participants were offered research credit for their class in exchange for participation; other alternatives were also available to students. The average age of participants was 21.47 years, $SD = 8.03$. The range of ages was 17-54. The majority of participants were white (75%) and female (55%). Participants signed up for a time to meet with the researcher to complete the research through an online scheduling website. Participants were told the study aimed to examine how classroom problems affect individuals' perceptions of their

teaching assistants and peers. Another undergraduate student served as a confederate to simulate a student who was truly struggling with suicidal ideation and depression. This student was an upperclassman and did not know any of the participants in the study. All materials and procedures were approved by the university's Institutional Review Board and were consistent with the APA ethical principles.

Procedures and Materials

Only one participant and one confederate was used in each trial. When each participant arrived, the researcher introduced herself as a teaching assistant (T.A.) for an introductory psychology course, reminded both the participant and the confederate of the purpose of this research, and gave a brief overview of participation. After obtaining informed consent, the researcher handed out the first survey (Appendix H), which participants were told was used to assess their attitudes towards different psychology concepts. Embedded within filler questions asking about opinions towards psychology concepts and classroom behaviors was the true measure of interest, comprised of the same two adapted social distance scales used in Study 1 (Norman et al., 2008; Whatley, 1959) to evaluate participants' willingness to interact with a person with depression in a variety of social settings. This measure had high reliability with Cronbach's alpha = .951. Participants were given large envelopes to place all materials in and were told that their responses were confidential and would not be tied back to them in any way.

After the first measure was completed, the researcher told each participant and the confederate about a particular class problem they were having as a T.A., after which participants would complete a variety of measures pertaining to how they perceived the T.A. and her problem. Participants were randomly assigned to one of the two conditions. In the joke condition, the T.A. joked about wanting to kill herself due to all the troubles she was having with

her class. In the control condition, the T.A. simply stated that these problems were frustrating. Below is the script of the joke condition.

> *"I have a class that does not respect me as a T.A. in any way. They interrupt me and make sarcastic comments when I give them advice on group projects. I also have to do a ton of grading to do each night! It makes me want to kill myself!"*

The measures participants completed for their perceptions of the T.A. included the measures personal and perceived stigma used in Study 1 (Griffiths et al., 2004) to assess the extent to which participants stigmatized the T.A. and her problem (Appendix D). These scales had moderate reliability with Cronbach's alpha = .686 and .631 respectively. The adapted attributional scale (Corrigan et al., 2003) used in Study 1 was again used to assess participants' feelings of the T.A.'s personal responsibility for the problem, as well as perceptions of anger, pity, and fear towards the T.A. (Appendix I). This scale had moderate reliability with Cronbach's alpha = .557. Additionally, we used a Situation Response Scale (Appendix J) adapted from Rudd, Goulding, and Carlisle (2013) to assess participants' perceived seriousness of the class problem, comfort levels with the problem, urgency to respond to the problem, how sure they felt the T.A. would be okay due to the problem, and how likely they were to disclose this information to a mentor or professor. All measures used a 1-7 Likert scale. The measures for the T.A. were intended to conceal the true purpose of the study, but were included in analyses since participants' perceptions of the T.A. may have differed depending on condition (see Table 3).

After completing the measures for the T.A., each participant and the confederate were instructed to fill out a student information sheet (Appendix K), reporting their class year, how many years they had been enrolled in a college program, their major, and a brief description of a

problem they had in their college classes. Each participant was reminded they could share any class problem they had and that their peer (the confederate) also had this same opportunity, so some of the information may be more distressing or more typical of a college setting. The confederate was trained to write down a scripted class problem briefly describing how their struggle with depression and suicidal ideation impacted their class performance (Appendix L). After the participant and confederate provided their responses, they exchanged papers, read each other's responses, and filled out the same set of measures they previously filled out for the T.A. (i.e. personal and perceived stigma, attributional scale, situation response scale). Participants also responded to demographic questions (Appendix M).

Upon completing the measures, the confederate left the room stating they were late for class and had to go. When the participant finished the measures, the researcher asked them if they had any questions or comments about the study. This was meant to allow students to have an opportunity to disclose to the researcher that confederate had written about thoughts of suicide. Following this question, the researcher continued with the debriefing, asking them what they thought the purpose of the study was to probe for suspicion, then revealing the deception and explaining the purpose of the study. The researcher also asked participants how often they heard people joking about suicide and how seriously they take these jokes when they hear them. Participants were thanked for their participation, asked to not discuss this study in their classes, and provided with a list of campus, local, and national mental health resources to utilize in the event they or someone they know struggled with depression or suicide.

Study 2 Results and Discussion

We first examined intercorrelations among variables (Table 2). To help control for Type I errors, we ran a multivariate analysis of covariance (MANCOVA) with participants' average

scores for social distance, personal stigma, perceived stigma, perceptions of personal responsibility, pity, anger, comfort, and seriousness for both the T.A. and the confederate as dependent variables to assess the effects of condition. No significant results were found, multivariate $F(2, 14) = 1.853$, $p = .405$. However, as indicated by mean scores, there were meaningful trends in the expected direction (see Table 4). Participants tended to perceive the confederate's problem as less serious when presented with the joke, consistent with our hypothesis. Participants tended to view the confederate as more personally responsible and felt less anger in the joke condition. Participants' levels of personal stigma toward the student in the joke condition were slightly higher compared to when no joke was presented, suggesting this humor reinforces the stereotypes we may believe about suicide, such as the belief that the individual is not really struggling. As expected, participants also tended to believe the general population would have more stigmatizing attitudes about the confederate than they themselves had, regardless of condition. Between conditions, perceived stigma was slightly lower in the joke condition compared to the control condition. These higher levels of perceived stigma and lower levels of personal stigma may be evidence that people struggling with suicidality and depression are in the normative ambiguity range of prejudice. Participants were more likely in the joke condition to believe other people do stigmatize individuals who are feeling suicidal, but then reported they personally do not stigmatize them. They may understand this group of people should not be discriminated against but still believe there is some range of prejudice against them. Participants rated their comfort with the confederate's problem higher when the researcher joked about wanting to kill herself compared to when she did not joke. According to past research (Rudd et al., 2013), it would be expected the participants would be less comfortable with the confederate's suicidal ideation when they believed the confederate was actively suicidal.

Therefore, because they tended to perceive the confederate's problem as less serious in the joke condition compared to the control condition, it would make sense that they were more comfortable with the confederate's problem in the joke condition. This suggests humor may have served as a way to ease some of the discomfort they may have been feeling about the confederate's suicidal ideation.

Inconsistent with our hypothesis, participants perceived the confederate more sympathetically when they heard the researcher joke about suicide compared to when the researcher did not make a joke. This may be congruent with stigmatizing attitudes if the participants believe people who are truly struggling with suicidal ideation are doing it for attention or are faking it, which would be evidenced by higher rates of personal stigma. In this instance, the joke may have reinforced how much the confederate was struggling and that they also may have been using the context of wanting to kill themselves as a way to describe how stressed out they were, not that they truly were considering suicide as an option.

While none of the trends were significant and therefore cannot be generalized to the broader population, the majority of the findings were consistent with our hypotheses. There are also several limitations to this study. First, our sample size was small and therefore limited our generalizability. Additionally, past research states that disparaging humor only has a detrimental effect when individuals are already prejudiced towards the target group (Ford & Ferguson, 2004). The participants in this study had lower (versus higher) levels of prejudice toward people with depression ($M = 3.03$, $SE = 1.41$). Due to these low levels, it is possible the humor did not affect the maintenance of their prejudiced views. Because humor can also serve as a healthy way to react to potential threats or uncomfortable situations (McGraw & Warren, 2010), humor involving suicide or other mental illness may serve as a way for people to reduce the anxiety and

confusion they may be dealing with when confronted with an individual struggling with their mental health. It is possible that participants were able to reflect on the T.A.'s humor to relieve their own anxiety about their struggling peer.

When confronted with jokes about suicide, people may view someone who is expressing suicidal ideation as also joking or overreacting. Humor may serve as a way for individuals to feel as if they do not need to do anything to assist a struggling peer. Throughout our study, less than one-third of the participants came forward and told the researcher what the confederate had written as their problem, regardless of condition. While students may have felt uncomfortable bringing this up to the researcher, even after the confederate left the room, or if they believed the researcher was going to read the class problems immediately following the experiment, this finding brings up a huge concern. Participants reported they moderately ($M = 4.11$, $SE = 2.05$) heard people joke about suicide before and tended to take people less seriously ($M = 2.94$, $SE = 1.76$) when they heard these jokes. American Foundation for Suicide Prevention (2015) lists talking about killing themselves as a warning sign someone is thinking about suicide. If this joking language is commonly being used on college campuses and students are not taking these comments seriously, it would make sense that they would not report even *serious* comments to a professor or counselor. It may be difficult for students to differentiate between someone being serious and someone joking about mental health. Students may not want to assume their peer is thinking about a topic as heavy as suicide or may not want to say anything in case they are wrong and offend their friend. However, it does raise concern that there may be students communicating their pain and then having peers view it as an over-exaggeration rather than taking it seriously and encouraging them to seek treatment.

Suicide is the third leading cause of death for individuals between the ages of 15-24 (Centers for Disease Control and Prevention, 2012) and it is a preventable cause of death. Perhaps by taking comments about suicide more seriously, we can create a culture where these comments are questioned and people making the comments will be connected to professional help. Future research should continue to investigate how humor about mental health affects stigma and discrimination. Future research may also want to look at the effect humor has on individuals who are struggling and their willingness and hopefulness regarding seeking help.

General Discussion and Conclusion

Language carries important implications for our daily lives, especially in regards to stigma and discrimination. These implications may be evident by the words we use, the phrasing we use, or the context in which we communicate ideas about individuals. While our hypotheses were not fully supported in either study, we did find some important outcomes. In these two studies, we investigated the effects language had on mental health stigma. We looked at the role label-phrasing (Study 1) and humor (Study 2) played in invoking and maintaining stigma. We found the label of a mental illness does affect people's perceptions such that participants actually saw labeled individuals as less hypersensitive compared to individuals struggling with no label. While we found no significant effects of humor surrounding mental illness, we did find meaningful trends suggesting humor may play a role in reinforcing prejudicial views and increasing stigma, while also easing participants' comfort with the confederate's suicidal ideation.

Stigma has a basis in language. The myths we tend to believe about mental illness are shaped by the language we use. This language can create a framework for people's expectations and stereotypes, limiting what people perceive labeled individuals are able to do (e.g. Hockett, et

al., 2014; Penn & Nowlin-Drummond, 2001; Shrifer, 2013; Szeto et al, 2013). Due to this fact, it is important to take into consideration the way we talk about these topics and the implications our language has. In Study 1, the label of *depression,* served as an insulator from negative perceptions regardless of the way it was phrased. However, despite the label used or the way that label is phrased, the context in which mental health is discussed may also have an effect on individuals' perceptions. When using language about mental illness in humorous contexts, individuals may uphold prejudicial views that reinforce the myths we believe about mental illness such that mental illness is something individuals can control or snap out of easily.

Future research should continue to investigate the effects language has on social power, prejudice, and discrimination. Researchers should further investigate the role language plays in overt discrimination against individuals with mental illness. Link and Phelan (2001) argue that stigma is dependent on power or the loss of power so it would be beneficial to further the research to include the element of discrimination. Research may also want to explore how language affects the individual diagnosed with a mental illness in addition to how it influences other people's perceptions of that individual.

In conclusion, this research adds to past research on the effects language has on stigma and individual perceptions. Having a label of a mental health diagnosis, such as depression, at times may lead to more understanding perceptions by peers on a college campus. Additionally, hearing a joke about suicide might maintain the stigma an individual has towards someone feeling suicidal. It is important to remain mindful of our language and consider how it may affect other people if we want to work on reducing stigma and prejudice against individuals struggling with their mental health.

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Table 1
Correlations among Measures (Study 1)

	Dull and Distant	Hyper-sensitive	Personal Stigma	Perceived Stigma	Personal Responsibility	Pity	Fear	Social Distance	Devaluation Discrimination	Attitudes Toward Seeking Help
Productive	-.252**	-.111	.323**	-.015	.216*	-.240**	.139	-.590**	.468**	-.017
Dull and Distant	1	.151	-.315**	.099	-.324**	.220*	-.259**	.272**	-.350**	-.007
Hyper-sensitive		1	-.052	-.042	.070	-.151	-.054	-.140	.027	-.086
Personal Stigma			1	.006	.638**	-.403**	.574**	-.432**	.705**	.005
Perceived Stigma				1	-.101	.213*	.168	.102	-.131	-.057
Personal Responsibility					1	-.352**	.347**	-.291**	.502**	-.018
Pity						1	-.244**	.244**	-.452**	.155
Anger							.493**	-.313**	.438**	-.120
Fear							1	-.306**	.575**	.075
Social Distance								1	-.549**	-.088
Devaluation Discrimination									1	-.026
Attitudes Toward Seeking Help										1

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

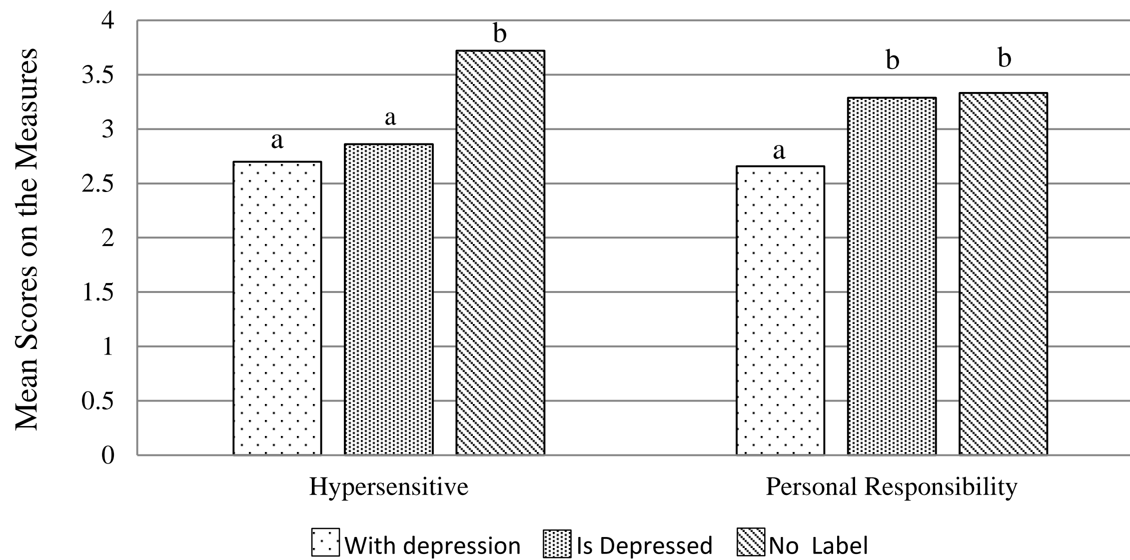

Figure 1: Averages by condition on hypersensitivity and personal responsibility.

Note. Different letters indicate significant differences.

Table 2

Correlations among Measures (Study 2)

	TA Personal Stigma	TA Perceived Stigma	TA Personal Respon-sibility	TA Pity	TA Anger	TA Serious	Student Personal Stigma	Student Perceived Stigma	Confed. Personal Respon-sibility	Confed. Pity	Confed. Anger	Student Comfort -able	Confed. Serious
Social Distance	.137	-.097	.253	-.073	-.035	.066	.331	-.320	.375	.060	.017	-.463*	.133
TA Personal Stigma	1	.692**	.416	-.505*	.332	-.517*	.578**	.487*	.574**	-.439	.185	.142	-.230
TA Perceived Stigma		1	.404	-.374	.222	-.401	.455*	.611**	.187	-.401	.048	.434	-.178
TA Personal Responsibility			1	-.592**	.030	-.077	.043	.042	-.053	-.322	-.420	.127	-.216
TA Pity				1	.031	.588**	-.275	-.309	-.160	.568**	.078	.082	.387
TA Anger					1	-.018	.347	.199	.002	-.117	.498*	.201	-.045
TA Comfortable						-.243	-.049	.041	.102	-.285	-.162	.055	.005
TA Serious						1	-.341	-.375	-.428	.478*	-.140	-.184	.559*
Student Personal							1	.283	.466*	-.378	.500*	-.091	-.302
Student Perceived								1	.274	-.178	.442	.056	.046
Confed. Personal Responsibility									1	-.212	.303	-.179	-.165
Confed. Pity										1	.013	-.226	.731**
Confed. Anger											1	-.153	.010
Student Comfortable												1	-.387
Confed. Serious													1

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Table 3
Mean Scores of Perceptions toward Teaching Assistant

	Joke Condition		Control Condition	
Measure	*M*	*SD*	*M*	*SD*
Personal Stigma	2.67	0.81	2.32	0.80
Perceived Stigma	3.84	1.18	3.30	0.91
Personal Responsibility	3.89	0.73	4.78	1.01
Pity	5.52	1.29	4.89	1.25
Anger	3.19	2.10	2.56	1.51
Seriousness	4.14	1.34	4.44	0.89
Comfort with problem	5.56	1.51	5.22	1.48

Table 4
Mean Scores of Perceptions toward Confederate

	Joke Condition		Control Condition	
Measure	*M*	*SD*	*M*	*SD*
Personal Stigma	3.49	1.24	2.94	0.84
Perceived Stigma	4.25	1.25	4.78	1.01
Personal Responsibility	4.30	1.33	4.15	0.93
Pity	4.78	2.10	4.15	0.97
Anger	3.30	1.85	3.33	1.84
Seriousness	4.58	1.61	5.56	0.75
Comfort with problem	3.56	1.59	2.56	1.51

Appendix A

Vignettes

Vignette 1

Hi, my name is Sam. I am a sophomore in college. I'm struggling with some things—in particular, I am depressed, though some days are good and I like the college experience overall. One of my favorite classes I have taken so far was an art class—it gave me a way to express how I am depressed. Even though I am depressed, I enjoy watching TV and reading books.

Vignette 2

Hi, my name is Sam. I am a sophomore in college. I'm struggling with some things—in particular, I have depression, though some days are good and I like the college experience overall. One of my favorite classes I have taken so far was an art class—it gave me a way to express the depression I have. Even though I have depression, I enjoy watching TV and reading books.

Vignette 3

Hi, my name is Sam. I am a sophomore in college. I'm struggling with some things, though some days are good and I like the college experience overall. One of my favorite classes I have taken so far was an art class—it gave me a way to express myself. I enjoy watching TV and reading books.

Appendix B

Social Distance Measure

Please rate your feelings toward Sam on the following scale:

1(I certainly would) 2 3 4 (neutral) 5 6 7 (I certainly would not)

1. I would speak to this person if I saw the person on campus.
2. I would have lunch with this person.
3. I would be in a study group with this person.
4. I would go to a party at this person’s house.
5. I would invite this person to my home
6. I would take a job where I would be working with this person.
7. I would move into the same apartment complex as this person.
8. I would become friends with this person.
9. I would rent a room from this person.
10. I would recommend this person for a job.
11. I would support having someone in my family marry this person.
12. I would trust this person to look after my child.

Appendix C

Semantic Differential Scale

Please rate the extent to which you think each characteristic applies to Sam using the following scale:

1 (Not at all) 2 3 4 (Neutral) 5 6 7 (Absolutely)

Valuable	1	2	3	4	5	6	7
Clean	1	2	3	4	5	6	7
Insincere	1	2	3	4	5	6	7
Safe	1	2	3	4	5	6	7
Cold	1	2	3	4	5	6	7
Wise	1	2	3	4	5	6	7
Fast	1	2	3	4	5	6	7
Strong	1	2	3	4	5	6	7
Delicate	1	2	3	4	5	6	7
Predictable	1	2	3	4	5	6	7
Tense	1	2	3	4	5	6	7
Simple	1	2	3	4	5	6	7

Appendix D

Personal and Perceived Stigma Scales

Based on **your own opinion**, please rate your agreement with each item using the following scale:

1 (Not at all) 2 3 4 (Neutral) 5 6 7 (Absolutely)

Personal:

1. He/ She could snap out of it if he/ she wanted to.
2. His/ Her problem is not a real medical illness.
3. His/ Her problem is a sign of personal weakness.
4. He/ She is dangerous.
5. It is best to avoid him/her so you don't develop this problem yourself.
6. This problem makes him/ her unpredictable.
7. You would not tell anyone if you had a similar problem.

Please answer the following questions based on what how you believe the **general population** would respond.

Perceived:

1. Most people believe that he/ she could snap out of it if he/ she wanted to.
2. Most people believe this problem is not a real medical illness.
3. Most people believe this problem is not a sign of personal weakness.
4. Most people believe he/she is dangerous.
5. Most people believe it is best to avoid him/her so they don't develop this problem themselves.
6. Most people believe his/her problem makes him/her unpredictable.
7. Most people wouldn't tell anyone if they had a similar problem.

Appendix E

Devaluation and Discrimination Scale

Please rate Sam on each item using the following scale:

1 (Not at all) 2 3 4 (Neutral) 5 6 7 (Absolutely)

1. I would willingly accept Sam as a close friend

2. I believe that Sam is just as intelligent as the average person

3. I believe that Sam is just as trustworthy as an average person.

4. I would accept Sam as a teacher of young children in a public school

5. I feel that Sam is exhibiting signs of personal weakness.

6. I would not hire Sam to take care of my children, even if they had been well for some time

7. I think less of Sam.

8. I would hire Sam if they were qualified for the job

9. I would pass over Sam's application in favor of another applicant

10. I would treat Sam just as I would treat anyone

11. I would be reluctant to date Sam.

12. I would take Sam's opinions less seriously

Appendix F

Attributional Scale

Please rate your feelings of Sam using the following scale:

1 (Not at all) 2 3 4 (Neutral) 5 6 7 (Very Much)

Personal Responsibility:

1. It is Sam's own fault he is in the present condition.
2. How controllable do you think is the cause of Sam's present condition?
3. How responsible do you think Sam is for their present condition

Pity:

1. I would feel pity for Sam.
2. How much sympathy would you feel for Sam?
3. How much concern would you feel for Sam?

Anger:

1. I would feel aggravated by Sam.
2. How angry would you feel with Sam?
3. How irritated would you feel by Sam?

Fear

1. How dangerous would you feel Sam is?
2. I would feel threatened by Sam.
3. How scared of Sam would you feel?
4. How frightened of Sam would you feel?

Appendix G

Familiarity with Depression

Please respond to the following questions based on your own experiences.

1. Someone I know has struggled with depression currently or in the past.

   Yes

   No

2. What do you know about depression? (open-ended)

Manipulation Check

What do you think this survey was about?

Appendix H

Attitudes toward Psychology Concepts and Class Problems

Please use the following scale to answer the questions below. If you are unsure what a concept is, please mark it as "Don't Know".
1 (Strongly Agree) 2 (Agree) 3 (Slightly Agree) 4 (Neutral/Don't know) 5(Slightly Disagree) 6 (Disagree) 7(Strongly Disagree)

1. I think asking questions in class is a poor way to learn.
2. I think forgetting to do an assignment is a sign of weakness.
3. I agree with Freud's psychosexual stages of development.
4. I believe doing experiments on animals is cruel and inhumane.
5. I would be in a study group with a person with depression.*
6. I believe dreams have important psychological insights in them.
7. I believe people who are addicted to drugs end up homeless.
8. I believe people who take psychoactive drugs are harming their brain.
9. I believe psychology was created to study mental illness.
10. I believe the brain is really complicated.
11. I would go to a party at a person's house who has depression.*
12. I can think of different examples of using classical conditioning in my everyday life.
13. I would recommend a person who has depression for a job.*
14. I do not think the class syllabus is helpful.
15. I really enjoy learning about psychology.
16. I would move into the same apartment complex as someone who has depression.*
17. I think people who procrastinate are very busy people.
18. I think using reinforcement to strengthen a behavior is really beneficial to learning.
19. I would become friends with a person who has depression.*
20. I would interact with a person who cheated on an exam if I saw the person on campus.
21. I would invite a person with depression to my home.*
22. I would recommend a person who skips class a lot for a job.
23. I would speak to a person with depression if I saw the person on campus.*
24. I would take a job where I would be working with a person who has depression.*
25. I would talk to someone who only studies for exams the night before about a test.
26. I would trust a person with depression to look after my child.*
27. I would want to study with a person who asks a lot of questions in class.
28. I would want to study with someone who always argues with the teacher or T.A.
29. I would have lunch with a person with depression.*
30. I think most people lie when they have reasons for not turning in assignments on time.
31. I would rent a room from a person who is depressed.*
32. I think people who copy the PowerPoint word for word typically get A's on exams.
33. I believe people who read every assigned reading are prepared for class.
34. I would support having someone in my family marry a person with depression.*
35. I believe people who sit in the back of the class are lazy and don't care about learning.
36. I don't think people who send texts in class pay attention to the professor.
37. I believe people who ask many irrelevant questions in class are annoying.

* Indicate social distance measured utilized in analysis

Appendix I

Attributional Scale

Please use the following scale to answer the below questions.

1 (Not at all) 2 3 4 (Neutral) 5 6 7 (Very Much)

Personal Responsibility:

4. It is his/her own fault he/she is in the present condition.
5. How controllable do you think the cause of this present condition is?
6. How responsible do you think he/ she is for this present condition?

Pity:

4. I feel pity for him/her.
5. How much sympathy do you feel for him/her?
6. How much concern would you feel for him/her?

Anger:

4. I would feel aggravated by him/her.
5. How angry would you feel with him/her?
6. How irritated would you feel by him/her?

Appendix J

Situation Response Scale

Please use the following scale to answer the questions below.

1(Not at all) 2 3 4(Neutral) 5 6 7(Very much)

How serious do you believe he/she was being?

How comfortable were you with the class problem he/she gave you?

How sure do you feel that he/she is going to be okay?

How urgently do you feel you should respond to him/her?

Do you feel like you would disclose the information provided to a professor or mentor?

Appendix K

Student Fact Sheet

What year are you in school? (Please base this off of how many credit hours you have).

Freshman Sophomore Junior Senior Graduate Level

How many years have you been in a college program?

First year Second Year Third year Fourth year Fifth year + Graduate Level

What is your major?

Please provide a brief description of a problem you typically have in your college classes:

Appendix L

Student Fact Sheet Script for Confederate

What year are you in school? (Please base this off of how many credit hours you have).

Freshman Sophomore Junior Senior Graduate Level

How many years have you been in a college program?

First year Second Year Third year Fourth year Fifth year + Graduate Level

What is your major?
Undecided

Please provide a brief description of a problem you typically have in your college classes:

My classes are exhausting and I am really tired all the time. Most days I have a hard enough time getting out of bed and going to class. When I do go to class I am overwhelmed by the material and just worry about all the information I missed so far. Plus I went through a breakup and it's been hard adjusting to being away from home. I just want to end my life.

Appendix M

Demographics

1. **What is your age? ______**
2. **What is your race/ethnicity?**

   Latino/Hispanic White Black/African American Native Hawaiian/Other Pacific Islander Asian American Indian/Alaska Native Other (please specify)

3. **What is your gender identity? (Please circle one)**

   Male Female Genderqueer/androgynous Intersex
   Transgender Transsexual Other (please specify): ___________________

4. **What is your highest completed level of education? (Please circle one)**

   High school/GED Bachelor's degree Associate's degree Master's degree
   Doctoral degree Other (please specify): ___________

5. **What is your religious affiliation? (Please circle one)**

   Christian Catholic Jewish Muslim Hindu
   Buddhist Agnostic Atheist Other (please specify): ______

6. **If you are a student, what is your class year?**

   Freshman Sophomore Junior Senior (4+ years) Graduate