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Alexis Paige Pritchett April 15, 2014

What's in a Name? Depression in College and Modern Labeling Theory

by

Alexis Paige Pritchett

Dr. Jeffery Mullis

Adviser

Department of Sociology

Dr. Jeffery Mullis

Adviser

Dr. Corey Keyes

Committee Member

Dr. Jill Welkley

Committee Member

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Alexis Paige Pritchett

Dr. Jeffery Mullis

Adviser

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Abstract

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In this honors thesis, I examine differences in perceived and personal stigma amongst groups of depressed, at-risk, and not-at-risk college students. This analysis was done using the Healthy Minds Survey, a sample of 5,689 college students in the United States. The study confirmed that perceived stigma is significantly higher than personal stigma for all three groups. Additionally, perceived stigma is significantly higher for the group of depressed students than the groups of at-risk and not-at-risk students. Finally, the group of depressed students reported a need for mental health treatment at a significantly higher rate than at-risk and not-at-risk students. These findings are reported to be evidence of modified labeling theory, and merit future research of the impact that personal and perceived stigma have on college students.

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Adviser

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INTRODUCTION

Mental illness has been considered a form of deviance throughout history. Sociology typically defines a deviant as a person who violates society's rules and expected behaviors. Societal norms dictate how individuals should behave, and those that do not follow those norms are deviants. Mental illness, regardless of the cause, would therefore be considered a form of deviance. History has defined mental illness in many ways: being possessed by demons; punishment for sins; or dissatisfaction of ancestors (Tausig, Michello, and Subedi 2003). Modern conceptions of mental illness are defined by a combination of biological and psychological causes that create deviant behaviors in an individual. Sociology aims to explain mental illness through societal tendencies; thus, it is necessary to look at society's stigmatization of mental illness in order to understand its effects on mental illness.

While any population can be susceptible to mental illness, undergraduate college students are a particularly vulnerable group. In 2013, the American College Health Association's National College Health Assessment found that 28.5 percent of students were stressed and more than 50 percent reported "overwhelming anxiety" (ACHA 2013). More than 30 percent reported feeling so depressed that it was difficult to function at least once in the last year; eight percent seriously considered suicide.

According to the same study, only 12.4 percent of students reported being treated for anxiety issues, and 10.7 percent reported being treated for depression (ACHA 2013). These numbers are notably lower than the number of students that report suffering from these issues. Because more students report having problems with depression or anxiety

than students who seek treatment for these issues, it is clear that some students refuse or do not know how to seek treatment for anxiety or depression.

Access to information may be the cause of not obtaining treatment: 47.6 percent of students reported that they did not receive information on depression or anxiety from their university (ACHA 2013). On the other hand, 49.7 percent of students reported that they were not interested in receiving said information, suggesting that students do not view their anxiety as a severe issue (ACHA 2013). Many students are not interested or are uninformed about their options to treat or discuss mental health issues in college. In addition, some students may avoid treatment because they fear the stigma of a psychiatric label.

Mental illness and other psychological conditions can have many negative consequences for college students. One study concluded that 64% of college dropouts left school because of a mental health related reason (Gruttadaro and Crudo 2012). The stigma of mental illness prevents many students from disclosing their illness and receiving treatment or accommodations. Of those with mental illnesses in the same study, only 50% of them reported their illness to their college. The number one reason for nondisclosure was a fear of how faculty would perceive them.

Students are also concerned with how other students may interpret their mental illness or their seeking of treatment. College is typically considered to be a competitive atmosphere, which may discourage students from obtaining treatment from their university and receiving a diagnosis (Gruttadaro and Crudo 2012). College students may be fearful of receiving a label like “depression” because that label implies that they are

not thriving in the college atmosphere; their classmates would consider them less competitive.

This research will focus on the effect of labeling on the mental health of college students. Do students diagnosed with depression perceive that others stigmatize them more than those who are undiagnosed? Are there differences in perceptions of stigma between those who are diagnosed with depression, those who are undiagnosed and at risk for depression, and those who are undiagnosed and not at risk? Previous labeling theory has focused on the effect that a label has on a person. Little research has been conducted on how fear of a label can negatively impact a person, specifically of a symptomatic individual who does not seek treatment. This research will focus on three groups of college students: those diagnosed with depression; those who are undiagnosed but considered to be "at risk" of depression; and those who are undiagnosed and "not at risk" for depression.

BACKGROUND TO THE PRESENT STUDY

What we now term "mental illness" has been defined and handled in diverse ways throughout human history. To place the current research in a larger cross-cultural and historical context, it is important to summarize previous frameworks for viewing mental illness. As Horwitz (1982) notes, every society has individuals that are considered mad, crazy, or insane. According to Horwitz, so many behaviors in different societies have been viewed as mental illness that the term "mental illness" is difficult to adequately and precisely define. The commonality of mental illness in these societies is that mental illness is "incomprehensible" behavior (Horwitz 1982). Horwitz defines the term

incomprehensibility as when "the categories observers use to comprehend behavior do not yield any socially understandable reasons for the behavior" (1982: 16).

It is crucial to understand how different societies throughout history have attempted to comprehend mental illness in order to understand how mental illness is viewed, labeled and stigmatized in today's society. This section will show how different societies both defined and treated mental illness. These understandings of mental illness have informed how we view mental illness today. I will begin with early conceptions of mental illness, and then discuss how those concepts have transitioned toward a modern definition of mental illness.

A Brief History of Mental Illness Stigma

According to Tausig et al. (2003), there are four main explanations for madness throughout history: loss of vital substances, presence of foreign entities, punishment for violation of cultural and societal norms, and actions caused by others. Loss of vital substances means the individual loses physical substances such as blood or bile, or a less physical entity like their soul. Presence of foreign entities referred to demon or spirit possession to explain symptoms of a seemingly supernatural nature, like bipolar disorder and schizophrenia[1]. More recently, these disorders are now explained by biology; the individual's neurons are overfiring and underfiring, causing the symptoms. Punishment for violation of cultural and societal norms means that the individual is being punished by divine or cosmic intervention—from Gods, spirits or the cosmos. The theory of actions

[1] Bipolar disorder and schizophrenia were not differentiated nor did they have names during this time period, but the symptoms of these disorders existed and were explained by the foreign entities theory.

caused by others has been used to describe how external stimuli cause mental illness. This theory can include curses by witches, or the effects of traumatic life experiences.

These four approaches differ mainly in the locus of control assigned to the individual. Responsibility for loss of substances or presence of foreign bodies lies outside of the individual, while punishment for norm violations is considered the fault of the individual for their actions (Tausig et al. 2003). Below I will provide some examples that serve to specifically illustrate these four main views and how they have changed over time.

Early non-Western societies had diverse ways of dealing with mental deviance, but they all converge on a common denominator: supernaturalism. For example, Ancient Palestinians believed that madness was inflicted by supernatural power and angry deities as punishment. Two types of madness appeared in Palestine: those inflicted by the "curse of madness" as punishment from an angry deity, or those given "divine inspiration" by a deity. The divinely inspired were not treated as mad because their behavior was a gift, rather than punishment (Conrad and Schneider 1980). Other Arab countries categorized mental illness into five categories: born mentally ill; bile imbalance; invaded by ghosts, spirits, or Satan; passionate love; and a group of "sane insane" with defective judgment (Tausig et al. 2003). Aboriginal Canadians also considered mental illnesses to be supernatural retribution for violating societal norms. In many societies of the time, there were little options for treatment of mental illness, since it was unwise to interfere with supernatural forces. Some West African tribes, however were the first societies to attempt to treat mental illness. They considered mental issues to be caused by ancestral anger or disturbances, similar to supernaturalistic causes in other societies. Rather than

noninterference, they believed that they could resolve mental illness by satisfying their ancestors. To keep their ancestors happy, they held many ceremonies in an attempt to alleviate symptoms of mental disturbance (Tausig et al. 2003).

Stigma in these societies generally depended on whether the individual was responsible for his or her mental illness and what purpose the behavior had. In Palestine, the divinely inspired were not stigmatized but those with the "curse of madness" were ostracized; in West Africa, the entire tribe felt it was their responsibility to cure mental illness by pleasing their ancestors, and thus did not stigmatize those with madness.

Ancient Greece was the first society to have a medical explanation for mental illness, claiming that madness was a disease with natural causes and rejecting supernatural theory (Conrad and Schneider 1980). The Greeks used herbal medicine and homeopathic treatment for madness including rest, diet, and mental exercises; in more extreme cases, severe bleeding and shock therapy with eels were used (Tausig et al. 2003). The family was responsible for controlling the mentally ill, and stigma for these individuals was minimal. At the turn of the 5th century B.C., conceptions of mental illness shifted to fault the individual, viewing individuals as responsible for their actions. Mental illness was separated into two groups: positive madness (prophetic and poetic) and negative madness (erotic and ritual). The main difference between positive madness and negative madness was the productivity that resulted from the madness and the individual's contributions to society (Tausig et al. 2003). An individual claiming to be a prophet or speaker for God was productive and valued in early western societies; an individual that did not provide such explanation for their actions was self-serving. The mentally ill with positive madness were revered; with negative madness, stigmatized.

Similarly, Ancient Rome held individuals responsible for their own mental state. However, mental deviance was considered a natural reaction to life's circumstances. As a result, Ancient Romans typically avoided stigmatizing the mentally ill.

With the fall of the Roman Empire and the beginning of the middle ages, mental deviance shifted to a psychiatric "dark age," muting the concept of madness as medical (Conrad and Schneider 1980). The group defining mental deviance shifted from the state to the church (Tausig et al. 2003). Initially, the church viewed mental deviance as the result of demonic possession. In some cases this resulted in town "fools"; in other cases it resulted in witches (Conrad and Schneider 1980). This possession was not the result of the person's actions but simply a part of life—some people would become possessed by demons, and some would not. Consequently, those who presented with mental illness were viewed as victims (Tausig et al. 2003). In the 1400s, the Catholic church—under pressure from the Protestant revolution—shifted its views and began to blame individuals for their mental illnesses. Demon possession resulted in the individual's inherent, evil nature. This view was one of the many that led to the Inquisition, labeling the mad as witches (Conrad and Schneider 1980). For the first time in history, mental deviance was both labeled and externally stigmatized: mad individuals were labeled as witches, and society feared them.

During the Enlightenment (roughly 1650-1800), control shifted from the Church back to the State. This change led to what Foucault referred to as the "Great Confinement" (cited in Conrad and Schneider 1980; Tausig et al. 2003), in which lunatics were to be separated from the able-bodied. This confinement consisted of removing nonproductive or counter-productive deviants from society—including criminals, the

handicapped, and the mentally ill—and placing them in undifferentiated institutions (Conrad and Schneider 1980). Deviance was viewed as a personal choice, and therefore those who were deviant were irrational and chose not to contribute to the emerging capitalist economy (Tausig et al. 2003). Initially, deviants were not distinguished by their symptoms; they were all treated as nonproductive. In the 1700s, facilities were created to handle the mentally ill as a group. The mentally ill were treated as animals, since neither the mentally ill nor the animals use reason (Tausig et al. 2003).

While the Great Confinement initially led to the removal of the mentally ill from society, the Protestant ethic of personal responsibility led to the belief that a therapeutic approach could cure or help the mentally ill. By 1850, asylums emerged as a way to separate the mentally ill from other deviants. These institutions were a place for the mentally ill to receive treatment, rather than simply acting as a holding cell for deviants (Tausig et al. 2003). Physicians began to respond to the mentally ill using "moral treatment"— the idea being that the mentally ill should be treated as children, and their mental health could be restored through self discipline (Conrad and Schneider 1980). This approach led to more scientific explanations of mental illness, and the idea that drugs, surgery and physical restraint could be therapeutic for the mentally ill (Tausig et al. 2003). This shift led to physicians having greater cultural authority to define and respond to the problem of mental illness (Conrad and Schneider 1980).

Public hospitals became a more prevalent response to mental illness during the 19th century, supplanting the private-run madhouses that were a lucrative business during the 1600s and 1700s, particularly in England. These hospitals served two purposes: to provide treatment for curable illnesses, and to provide therapeutic oversight for incurable

illnesses. The United States took a more modern psychiatric approach to mental illness. It was believed that mental illness was a combination of moral lapse and physical disorder. The physical disorder was actually the result of behavior. For the first time, mental illness was considered a combination of both behavioral deviance and a physical issue (Tausig et al. 2003). Psychiatrists believed that moral deviance resulted in an inability to resist amoral behavior; as a result, treatment focused on restoring what was considered to be moral behavior. Hospitals were thought to help with this by removing the individual from the environment that contributed to the deviant's behavior (Tausig et al. 2003). This institutionalization of mental illness was effective for some patients, but not others. Nonetheless, it was one of the earliest periods of believing that mental illness and deviance could actually be cured (Conrad and Schneider 1980).

By the 1850s, however, the optimistic view that hospitals could cure insanity began to be questioned. It was revealed that many of these hospitals were not curing the number of patients that they claimed to cure (Conrad and Schneider 1980). Because short-term patients were quickly cured, the majority of patients in mental hospitals were long-term patients. These hospitals began to focus more on warehousing the patients, rather than treatment of the individual (Tausig et al. 2003).

Other theories on mental illness emerged at this time. One medical model emphasized the role of physical defects, diminishing the role of the individual (Conrad and Schneider 1980). In contrast, psychoanalysis in the early 20th century emphasized the conflict between an individual's desires and the needs of society, which gave the individual more responsibility for their madness. Sigmund Freud's role in defining

mental illness treatment was to open "a dialogue with madness" for the first time (Conrad and Schneider 1980:53).

By the 1940s, three main theories of mental disorder existed simultaneously in the United States: loss of vital substances (genetics), the presence of foreign bodies (life circumstances) and the violation of taboos. According to Tausig et al. (2003), hospitals became the dominant mechanism for warehousing the mentally ill. These institutions were criticized for their lack of treatment for the mentally ill. In 1955, the number of patients in mental hospitals began to decrease sharply, mainly due to the development of effective psychotropic medications, which in turn inspired the belief that outpatient treatment would be possible. In addition, institutions received less funding during this time due to public criticism, and families were less likely to commit their loved ones to mental hospitals. While the number of patients in mental hospitals decreased, the number of inmates in prisons increased (Steadman et al. 1984), which suggests that mental deviance is an issue that society has difficulty handling within communities, especially if adequate resources such as transitional housing are lacking (Kelley 2009).

While many ancient views of madness are considered today to be barbaric, some treatments and thoughts on mental illness hundreds of years ago are still held today. The main difference between mental illness two thousand years ago and mental illness today is in its origins: in ancient societies, madness was supernatural; in modern western society, it is considered to be a combination of biological and environmental circumstances. Stigmatization of mental illness has always existed, although in different forms. Madness was always considered to be a departure from societal norms—a deviant

condition—and therefore those who suffered from it have been dealt with differently than other individuals.

One explanation for the treatment of mental illness today originates from the Catholic Church's treatment of witches during the Inquisition. Szasz (1970) argues that the aspects of identifying mentally ill in both the Inquisition and the modern mental health system are similar. The goals of the two, however, differ: the goal of the Inquisition was to identify and eliminate witches, while the goal of the contemporary mental health system is to identify and cure the mentally ill. Even today, society aims to identify the mentally ill deviants in order in an attempt to "cure" them and therefore remove any deviant behavior from society. The goal of treating mental illness has always been to purge deviant behavior, a goal that treatment shares in common with the earlier, more punitive responses to madness.

Explanations of Modern Stigma: Labeling Theory

As noted previously, college students often do not receive information about depression and anxiety. Labeling theory can be used to explain this occurrence: students do not seek treatment for their condition because they fear labels such as "depressed" or "mentally ill" and the stigmas associated with these labels. Rosenfield (1997) finds that the stigma of these labels negatively affects an individual's quality of life; however, receiving services for illness is associated with positive perceptions of the self, brought about by effective treatment. Thus, it is necessary to look further into how labeling affects both diagnosed and undiagnosed college students, as their tendency for treatment may affect their quality of life.

Labeling theory began with Scheff's (1966) theory of mental illness. Scheff's model of mental illness proposes that once an individual is labeled, that individual is subjected to "uniform responses" (Link et al. 1989:402). Societal views of the mentally ill are shaped by simplifying stereotypes, and as a result this group experiences discrimination. Scheff argued that labeling leads to negative social responses, and the individual's self-identity will form around that label and the negatively associated views. In this sense, self-identity is socially derived, as Cooley's (1902) classic formulation of the "looking-glass self" would suggest. A modified labeling approach, as presented by Link et al. claims that the label itself could have negative consequences for the individual due to perceived stigmatization before that stigma ever occurs. It is the *anticipation* of being stigmatized that matters here. As a result, the individual is even more susceptible to disorder.

Link et al.'s modified labeling approach includes five steps through which negative outcomes are created. First, society conceives of mental illness in a negative way. Second, an individual is diagnosed and hence formally labeled with mental illness. Third, the labeled individual responds by withdrawing and secluding himself from society. Fourth, negative consequences from seclusion occur such as lower self-esteem or the inability to sustain a job. Finally, the individual may be susceptible to another mental illness or may have a more difficult time managing their current mental illness (Link et al. 1989).

The Link et al. study sampled community residents as well as psychiatric patients to determine whether their experiences fit the framework of this modified labeling theory. The researchers used indicators of perceived stigma to find differences between the two

groups. "Perceived stigma" refers to an individual's sense of societal views of mental illness—how does society regard the mentally ill? The researchers found that both non-diagnosed community members and psychiatric patients perceived the social stigma of mental illness; the repeat-treatment patients reported the highest perceived stigma (Link et al. 1989).

My research picks up where Link et al.'s study ends. I draw upon the concept of perceived stigma and personal stigma (Golberstein, Eisenberg and Gollust, 2008) to refer to the individual's own opinions of mental illness. Whereas *perceived stigma* is how an individual believes others stigmatize mental illness, *personal stigma* is how an individual stigmatizes mental illness himself. Previous research on perceived and personal stigma have focused on the correlation between perceived stigma and help-seeking tendencies, and the disparity between perceived and personal stigma (see, e.g., Golberstein et al. 2008 and Eisenberg et. al 2009). My research will focus on whether or not there is a difference in perceived stigma and personal stigma amongst three groups: not mentally ill and not at risk; not mentally ill but at risk; and mentally ill. Will non-mentally ill but at risk individuals report higher personal and perceived stigmas than the diagnosed mentally ill and the non-mentally ill groups? If modern labeling theory affects those diagnosed with depression even if society does not know they are diagnosed, it is possible that those not diagnosed but at risk for depression could be affected by the label of depression simply by suffering the symptoms. Research on college students will lead to a better understanding of how labels affect individuals who are both diagnosed with a mental illness and at risk for a mental illness.

My hypotheses are listed below:

1. There will be a significant difference between perceived and personal stigma within all three groups.
2. Of the three groups, those undiagnosed but at risk for depression will have the highest personal stigma of mental illness.
3. Of the three groups, those diagnosed with depression will have the highest perceived stigma of mental illness, followed by those at risk for depression.
4. Of the three groups, those at risk for depression will report a need for mental health treatment significantly less than those diagnosed with depression.

DATA AND METHODS

This paper utilizes data collected from the Healthy Minds Study, conducted by the Healthy Minds Network (see www.healthymindsnetwork.org). Since 2007, the Healthy Minds Network has collected over ten thousand survey respondents from almost 100 colleges and universities in the United States. It focuses primarily on mental health and illness, and asks questions about the stigma of receiving mental health treatment. The questionnaire asks if the respondent has been diagnosed with a mental illness, and provides a list of illnesses for the student to specify. In addition to asking questions about students' diagnoses of mental illnesses, the questionnaire attempts to identify students who are at risk for psychiatric conditions such as depression, anxiety disorder, eating disorder, bipolar disorder, schizophrenia, or general phobia. These questions have been

used to determine whether the respondent is at risk for a mental illness. Here, I focus specifically on depression. Because this data includes a depression diagnostic measure, I will be able to compare those who are diagnosed with depression as well as the undiagnosed at risk and not at risk, based on this diagnostic measure. Table 1 (see next page) shows the depression indicators, along with the percentages for the year 2007, the year chosen for the present study because it included more questions relevant to testing my hypotheses.

These questions are taken from the Patient Health Questionnaire (PHQ-9), a set of nine questions that many doctors use to clinically determine a patient's risk for depression (Spitzer, Williams, and Kroenke n.d.; see Kroenke and Spitzer 2002). Each question asks whether the patient has experienced one of the symptoms listed in the DSM-IV in the past two weeks. Each response category is coded from a range of 0 (none of the days) to 3 (nearly every day). The scores are added, and the resulting composite score determines the patient's risk level for depression. The depression measure ranges from 0 to 27. The mean and median in the 2007 Healthy Minds sample are 6.35 and 5.00, respectively, and the standard deviation is 4.98. The validity of the nine item scale has been examined elsewhere and found to be acceptable (see, e.g., Kroenke and Spitzer 2002). For the 2007 sample of the Healthy Minds study, the interitem reliability of the index as assessed by Cronbach's alpha is also acceptable (alpha = 0.858) and interitem correlations ranged from 0.223 to 0.581. In short, the index appears to exhibit acceptable levels of validity and reliability.

As shown in Table 1, across all 9 items the most typical responses tend to be "not at all" or "several days." Questions regarding lack of sleep, energy and appetite have the

Table 1. Indicators and Percentages for Depression Index, Healthy Minds Data 2007.

Question: In the last few weeks, how often have you been bothered by any of the following problems?	**Not at All 0**	**Several Days 1**	**More than Half the Days 2**	**Nearly Every Day 3**	**n of respondents**
1.Little interest or pleasure in doing things	44.6%	41.8%	9.7%	3.9%	5681
2.Feeling down, depressed or hopeless	41.2%	45.9%	9.1%	3.8%	5675
3.Trouble falling or staying asleep, or sleeping too much	37.2%	35.8%	16.0%	11.0%	5680
4. Feeling tired or having little energy	17.8%	49.6%	20.9%	11.7%	5675
5.Poor appetite or overeating	45.1%	32.6%	14.5%	7.8%	5671
6.Feeling bad about yourself—or that you are a failure or have let yourself or your family down	54.1%	31.1%	9.9%	4.8%	5678
7.Trouble concentrating on things, such as reading the newspaper or watching television	54.9%	30.5%	9.5%	5.1%	5675
8. Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	77.9%	16.4%	4.1%	1.6%	5685
9. Thoughts that you would be better off dead or of hurting yourself in some way	89.8%	8.0%	1.3%	0.9%	5681

highest rate of responses for "more than half the days" or "nearly every day," which may be the result of the high demands of college life. The most severe symptoms of depression listed in this questionnaire are thoughts of suicide or hurting oneself (see question 9). For this question, 1.3% of respondents reported they had thoughts of suicide or self-harming more than half the days in the last two weeks; less than one percent of respondents reported they had these thoughts nearly every day in the past two weeks.

Table 2 (see next page) reports percentages for risk of depression in college students among the non-diagnosed.[2] As noted earlier, risk of depression is assessed on a scale from 0-27. Spitzer and colleagues use the following cutpoints to distinguish levels of risk: 0-4 represents minimal risk for depression; 5-9 is mild risk; 10-14 is moderate risk; 15-19 is moderately severe risk; and 20-27 is severe risk (Kroenke and Spitzer 2002). Based on Table 2, 48% of students not diagnosed with depression have a "minimal risk" of depression, that is, they scored lower than 5 on the PHQ-9 index. Thirty-eight percent of those not diagnosed with depression had a score of 5-9, putting them at "mild risk" for depression. Roughly 13% of the non-diagnosed had a moderate risk of depression with scores ranging from 10-14. Approximately one percent of the non-diagnosed had a score of 15-19, which places these students at a moderately severe risk of depression. Only one student out of the 5102 undiagnosed students had a score greater than 20. A possible explanation for why there are so few students with moderately severe or severe risks of depression according to this index is that the symptoms required to obtain these scores are so severe that it would be difficult for a student to function without seeing medical or psychological help in some way.

[2] Those diagnosed from depression have been excluded from this table in order to determine which undiagnosed individuals are at risk and not at risk for depression.

Table 2. Percentages of College Students at Various Risk Levels for Depression, Non-Diagnosed Only, Healthy Minds Data 2007.

Risk Level	Frequency	N of respondents
Minimal (a score of 0-4)	48.0%	2449
Mild (a score of 5-9)	38.0%	1937
Moderate (a score of 10-14)	12.9%	659
Moderately Severe (a score of 15-19)	1.1%	56
Severe (a score of 20-27)	0.0%	1

For the purposes of my study, students that have a moderate risk, moderately severe risk or a severe risk will be considered to be "at risk" for depression. Kroenke and Spitzer (2002) use 15 as the at-risk cutpoint. While "moderate risk" (a score of 10-14) is typically considered to be a gray zone (see Kroenke and Spitzer 2002) for diagnosing mental illness, I have chosen to include it in my "at risk" group. Students reporting a score greater than 10 are reporting, on average, that they experienced depressive symptoms several days over a two week period; as such, they should be considered in the "at risk" group for depression, even if they do not necessarily suffer from undiagnosed depression.

Students were also asked to report whether they have been diagnosed with depression in the past. Of the 5598 college students, 496 reported being diagnosed with depression. Table 3 (see next page) shows percentages for three groups: diagnosed with depression; not diagnosed but at risk for depression; and not diagnosed and not at risk for depression. In Table 3, the at-risk group includes respondents that had a moderate, moderately severe or severe risk of depression. Those undiagnosed and not at risk for depression includes students that did not report depression and that had a risk level for depression of minimal or mild.

Table 3. Percentages of Students Diagnosed with Depression, At Risk and Not at Risk, Healthy Minds Data 2007.

Group	Frequency	N of respondents
Diagnosed with Depression	8.9%	496
Not Diagnosed but At Risk	12.8%	716
Not Diagnosed and Not at Risk	78.3%	4386

Based on the responses given, 12.8% of the respondents had a moderate, moderately severe or severe risk of depression at the time they took the survey. Approximately nine percent had been diagnosed with depression; this proportion is consistent with the ACHA (2013) findings that 10.7% of college students are diagnosed with depression. Approximately 78% were not diagnosed and were not at risk for depression. These are the three groups that will be used for the purposes of studying levels of stigma in college students.

The data will be analyzed using SPSS (Statistical Package for the Social Sciences) to determine whether these at-risk and diagnostic distinctions affect a person's views on perceived and personal mental health stigma. Six questions are asked about the stigma of receiving mental health treatment: three beginning with "Most people," and three beginning with "I would":

1. Most people would willingly accept someone who has received mental health treatment as a close friend
2. Most people believe someone receiving mental health treatment is just as trustworthy as the average person
3. Most people would think less of someone who has received mental health treatment
4. I would willingly accept someone who has received mental health treatment as a close friend
5. I believe someone receiving mental health treatment is just as trustworthy as the average person

6. I would think less of someone who has received mental health treatment

For the purposes of this research, the first three items are indicators of perceived stigma (perceived societal views), and the last three items are indicators of personal stigma (the student's own personal views). The response categories for all six questions are based on a six-point scale where 1 represents "strongly agree" and 6 represents "strongly disagree." The responses to each of the questions from each group will be averaged. In order to test my first hypothesis, I will use dependent t-tests to determine if there are significant differences between perceived and personal stigma for each group. To test my second and third hypotheses, I will create a composite measure for two types of stigma: perceived stigma and personal stigma. I will use a one-way analysis of variance (ANOVA) to determine whether there are significant differences in these types of stigma for each of the groups of diagnosed, at risk and not at risk for depression. If there are any differences, I will use independent t-tests to determine which groups are significantly different from one another. To test my fourth hypothesis, I will determine what proportion of students report that they believed they needed professional help for their mental health in the past year. I will then use two-proportion z tests to find any significant differences in the reported need for help between the three groups.

First, I hypothesize that within all three groups, perceived stigma will be significantly higher than personal stigma. This phenomenon has been explored by Golberstein et al. (2008) and Eisenberg et al. (2009): in the student population, there is a significant difference between perceived stigma and personal stigma. My hypothesis is that these findings will be consistent with the diagnosed, at-risk and not-at-risk groups.

Second, I hypothesize that those undiagnosed but at risk for depression will have the highest personal stigma of mental illness compared to the other two groups. Their personal stigma can be explained by the fact that they have not been formally diagnosed with depression but suffer the symptoms, and have not sought treatment for fear of being diagnosed with depression.

Third, I hypothesize that the group of students diagnosed with depression will have the highest perceived stigma of mental illness. This difference can be explained by labeling theory: students diagnosed with a mental illness are affected by the "mentally ill" label, and will feel that others view them more negatively based on those labels. If labeling theory is an accurate prediction of stigma, then this analysis should reinforce labeling theory. Additionally, those undiagnosed but at risk for depression will have a higher perceived stigma than the not-at-risk group. Those at risk for depression are aware of their symptoms but have not sought treatment, and they will have a higher perceived stigma than those not at risk for depression because they fear being treated differently for their depressive symptoms.

Fourth, I hypothesize that those undiagnosed but at risk for depression will have a significantly lower proportion of students reporting the need for mental health treatment when compared to the diagnosed with depression group. After looking at perceived and personal stigma amongst the three groups, I will use the following question to determine each group's self-understanding of the need for mental health treatment: "In the past 12 months, did you feel you needed to seek professional help for mental health?" The response categories given to students are "yes" or "no." My fourth hypothesis is that those diagnosed with depression will report the highest need for treatment for mental

health problems, because they have been diagnosed with depression and have actively sought treatment in the past. I hypothesize that the non-diagnosed but at-risk group will report a lesser need for help mental health problems than the depressed group. Their higher perceived stigma will prevent the at-risk group from seeking help or seeing the need for help.

RESULTS

In order to test my hypotheses, I first created a frequency distribution for each stigma question (see Table 4 on next page). Four of the questions are phrased in a positive manner: most people/I would accept someone who has received mental health treatment as a close friend, and most people/I believe someone who has received mental health treatment is just as trustworthy as the average person. These questions will be referred to as *positive stigma* questions. For the positive *perceived* stigma questions, the modal responses are "agree" or "somewhat agree." For the positive *personal* stigma questions, the modal responses are "strongly agree" or "agree." Less than 10% of respondents reported they strongly agreed with the positive perceived stigma questions, which suggests that perceived stigma is higher than personal stigma—of which 43.5% and 30.3% reported they strongly agreed with the positive personal stigma questions.

Two questions in the set of stigma questions are phrased in a negative manner: most people/I would think less of a person who has received mental health treatment. These questions will be referred to as *negative stigma* questions. The modal response for the negative *perceived* stigma question is "somewhat agree," with 41.9% of respondents reporting that they somewhat agreed that most people would think less of a person who

Table 4. Percentages for Stigma from All Respondents, Healthy Minds Data 2007.

Question	Strongly Agree 1	Agree 2	Somewhat Agree 3	Somewhat disagree 4	Disagree 5	Strongly Disagree 6	n of respondents
Most people would willingly accept someone who has received mental health treatment as a close friend.	8.5%	30.9%	35.2%	17.1%	7.2%	1.1%	5578
Most people believe someone receiving mental health treatment is just as trustworthy as the average person.	6.2%	24.9%	32.7%	24.5%	9.9%	1.7%	5571
Most people would think less of a person who has received mental health treatment.	2.7%	18.3%	41.9%	18.9%	15.8%	2.5%	5514
I would willingly accept someone who has received mental health treatment as a close friend.	43.5%	37.5%	15.2%	2.7%	0.8%	0.2%	5573
I believe someone receiving mental health treatment is just as trustworthy as the average person.	30.3%	36.3%	22.9%	8.4%	1.6%	0.5%	5565
I would think less of a person who has received mental health treatment.	0.5%	2.4%	8.3%	14.5%	33.8%	40.6%	5563

has received mental health treatment. On the other hand, the modal response for the negative *personal* stigma question is "strongly disagree," with 40.6% of respondents reporting that they strongly disagreed that they personally would think less of a person who has received mental health treatment. In fact, almost 90% of respondents reported that they "somewhat disagreed," "disagreed," or "strongly disagreed" that they would personally think less of a person who has received mental health treatment.

Table 5 (see next page) is an average of each response from three groups: diagnosed with depression, not diagnosed but at risk, and not diagnosed and not at risk. Each of the responses from "strongly agree" to "strongly disagree" was coded from one to six. As is expected based on the percentage distribution for each question, the highest mean response—meaning the question the students most disagreed with—was "I would think less of a person who has received mental health treatment." The mean response from diagnosed students answering this question is the highest at 5.06, and the mean response from undiagnosed but at-risk students answering this question is the lowest at 4.97. The lowest mean response—meaning the question the students most agreed with—was "I would willingly accept someone who has received mental health treatment as a close friend."

Of the two groups of questions, the *perceived stigma* questions' averages are the closest to a neutral response of neither agree or disagree (an average response of 3.5)[3]. For each of the *positive* perceived stigma questions, the undiagnosed and not-at-risk students had the lowest means of 2.87 and 3.11. Their responses indicate more agreement towards the positive perceived stigma questions. The diagnosed students had the highest

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[3] Neither agree nor disagree is not an option in this survey; an average response of 3.5 is an average score between somewhat agree and somewhat disagree.

Table 5. Mean Responses for Stigma from Groups of Depressed, At Risk and Not at Risk Students, Healthy Minds Data 2007.

Question	**Mean response from diagnosed students**	**Mean response from undiagnosed but at risk students**	**Mean response from undiagnosed and not at risk students**
Most people would willingly accept someone who has received mental health treatment as a close friend.	2.95 (n=480)	2.84 (n=709)	2.87 (n=4299)
Most people believe someone receiving mental health treatment is just as trustworthy as the average person.	3.25 (n=478)	3.11 (n=706)	3.11 (n=4297)
Most people would think less of a person who has received mental health treatment.	3.15 (n=475)	3.27 (n=702)	3.37 (4248)
I would willingly accept someone who has received mental health treatment as a close friend.	1.73 (n=479)	1.76 (n=709)	1.82 (n=4294)
I believe someone receiving mental health treatment is just as trustworthy as the average person.	2.08 (n=479)	2.08 (n=708)	2.19 (n=4288)
I would think less of a person who has received mental health treatment.	5.06 (n=479)	4.97 (n=706)	5.00 (n=4287)

means of 2.95 and 3.25, which indicates less agreement towards the positive perceived stigma questions. The mean response from undiagnosed but at-risk students falls between these two groups at 2.84 and 3.11, respectively. Those diagnosed with depression had the lowest mean for the *negative* perceived stigma question, indicating more agreement with the statement "Most people would think less of a person who has received mental health treatment." The undiagnosed and not at-risk students had the highest score, indicating less agreement with the statement.

The *personal stigma* questions have a higher range of responses than the perceived stigma questions. The diagnosed students' means are lower for the *positive* personal stigma questions at 1.73 and 2.08. The undiagnosed and not-at-risk students reported the highest means at 1.82 and 2.19, while the undiagnosed but at-risk students fall in the middle with 1.76 and 2.08. These means all fall below 3.5, indicating that all three groups, on average, tend to agree with positive personal stigma questions. On the other hand, the *negative* personal stigma question has the highest mean for each group: the mean for those diagnosed with depression is 5.06; the mean for those undiagnosed but at-risk for depression is 4.97; and the mean for those undiagnosed and not at-risk for depression is 5.0.

These means show a trend: the diagnosed students appear to have the highest negative perceived stigma, while the undiagnosed and not at-risk students appear to have the lowest negative perceived stigma. On the other hand, those diagnosed with depression reported the lowest negative personal stigma when compared to the undiagnosed and not-at-risk group. The undiagnosed but at-risk group means fell consistently between these two groups.

In order to create measures of perceived and personal stigma, I summed the responses to the relevant items to create two composite measures. In order to include the negative stigma questions, I reverse coded these items to ensure a consistent directionality in the question phrasing. The Cronbach's alpha for the three-item perceived stigma scale is 0.698, demonstrating some degree of interitem consistency. The Cronbach's alpha for the three-item personal stigma scale is 0.787, again demonstrating some degree of interitem consistency. For each individual in the survey, the higher their composite score, the higher their personal or perceived stigma towards mental illness. The range of possible scores for perceived and personal stigma is between 1 (strongly agree with positive questions about mental illness) and 6 (strongly disagree with positive questions about mental illness).

Table 6 (see next page) displays the mean responses for these composite stigma measures for each of the depressed, at-risk and not-at-risk groups. Of the three groups, the highest perceived stigma was from those diagnosed with depression (3.33), followed by those at risk for depression (3.19) and then those not at risk for depression (3.14). The highest personal stigma was from those not at risk (2.00), followed by those at risk (1.96), and then those diagnosed (1.91). These numbers indicate a tendency for students diagnosed with depression to believe that others stigmatize mental illness, more so than the groups of at-risk and not-at-risk students. The mean personal stigma score for those diagnosed indicates that they have a lower personal stigma than the other two groups.

Table 6. Mean Scores for Composite Stigma from Groups of Depressed, At-Risk and Not-at-Risk Students, Healthy Minds Data 2007.

Stigma Type	**Mean Score from Diagnosed Students**	**Mean Score from Undiagnosed but At-Risk students**	**Mean Response from Undiagnosed and Not-at-Risk Students**
Perceived Stigma	3.33 (sd=1.03)	3.19 (sd=0.94)	3.14 (sd=0.89)
Personal Stigma	1.91 (sd=0.90)	1.96 (sd=0.83)	2.00 (sd=0.83)
P-value	0.000	0.000	0.000

In order to test my first hypothesis, I used dependent t-tests to find whether each group's perceived and personal stigmas were significantly different. Table 6 displays the significance results for each group. For those diagnosed with depression, the p-value was 0.000. For those at risk for depression, the p-value was 0.000. For those not at risk for depression, the p-value was 0.000. For each of the three groups, there is a significant difference between perceived and personal stigma. Perceived stigma is significantly higher than personal stigma for those diagnosed with depression, those undiagnosed but at risk for depression, and those undiagnosed and not at risk for depression. This suggests that students believe others will be more prone to stigmatizing than they themselves would be.

In order to test my second and third hypothesis, I used SPSS to run a one-way analysis of variance (ANOVA) test for each of the composite measures for perceived and personal stigma. Table 7 (see next page) shows the results of each of these ANOVA tests. The perceived stigma analysis test reported an F statistic of 4.358 with a p-value of 0.000. This p-value indicates that there is a statistically significant difference in perceived d stigma between the three groups of diagnosed, at risk and not at risk of depression. The personal stigma test reported a p-value of 0.143, indicating no statistically significant difference between the three groups for the personal stigma composite measure.

Table 7. ANOVA Results for Composite Perceived and Personal Stigma scales between Groups, Healthy Minds Data 2007.

Stigma (Between Groups)	Df	F	Significance
Perceived Stigma	15	4.358	0.000
Personal Stigma	15	1.388	0.143

Table 8. Pairwise T-test Significance Results for Composite Perceived Stigma Scales by Groups, Healthy Minds Data 2007.

Group	Diagnosed	At Risk	Not at Risk
Diagnosed	*	*	*
At Risk	0.016	*	*
Not At Risk	0.000	0.127	*

Because there is a statistically significant difference between the groups for perceived stigma, I conducted pairwise t-tests to find which groups had statistically significant means (see Table 8 above). Comparing those diagnosed with depression with those at risk for depression resulted in a p-value of 0.016; comparing those diagnosed with those not at risk resulted in a p-value of 0.000; and comparing those at risk to those not at risk resulted in a p-value of 0.127. These results indicate that there is a significant difference between those diagnosed with depression compared to those at risk and not at risk, but no statistically significant difference between those at risk and not at risk for depression.

In order to test my fourth hypothesis, I used the question, “In the past year, did you think you needed professional help for mental health?” Of all the respondents, 35% answered yes to this question. I then ran a crosstab analysis of this question to compare each group of not at risk, at risk and diagnosed with depression (See Table 9 on next page). Of those diagnosed with depression, 77% reported that they needed professional

help for mental health in the past year. Of those at risk for depression, 57.6% of students reported a need for professional help for mental illness in the past year. Of those not at risk for depression, 27.2% reported a need for professional help for mental illness in the past year.

I used a chi-square test of significance to find if these groups were significantly different in their reporting of need for professional help for mental health. The chi-square test reported a significance value of 0.000. After finding that there is a statistically significant difference between these three groups, I used z-tests for two proportions to test two groups at a time. Comparing those diagnosed and at risk for depression resulted in a significance of 0.000; comparing those diagnosed and not at risk for depression resulted in a significance of 0.000; and comparing those at risk and not at risk for depression resulted in a significance of 0.000.

Table 9. Percentages of Students Reporting the Need for Professional Help for Mental Health in the Last Year by Group, Healthy Minds Data 2007.

Group	**Yes**	**No**	**N of Respondents**
Diagnosed	77.0%	23.0%	482
At Risk	57.6%	42.4%	705
Not at Risk	27.2%	72.8%	4278

My first hypothesis was that there would be a significant difference between perceived and personal stigma between all three groups. The data support this hypothesis. For each group, the p-value was less than 0.05. For each group, the perceived stigma was significantly higher than the personal stigma. For those diagnosed with depression, this difference was 1.42; for those undiagnosed but at risk for depression, this difference was 1.23; for those undiagnosed and not at risk for depression, this difference was 1.14.

My second hypothesis was that of the three groups—diagnosed with depression, at risk and not at risk—those at risk for depression would have the highest personal stigma of mental illness. The data do not support this hypothesis. In fact, there was no statistically significant difference between the three groups and personal stigma.

My third hypothesis was that of the three groups, the diagnosed group would have the highest perceived stigma of mental illness, followed by the at-risk group. The data support the first half of this hypothesis: there was a statistically significant difference between depression group and the other two groups, and the depression group's mean score was higher than the at-risk and not at-risk groups. The at-risk group did have a higher mean score for perceived stigma than the not-at-risk group, but this difference was not statistically significant.

My fourth hypothesis was that the at-risk group would report a significantly lower need for mental health treatment than the diagnosed group. This hypothesis was supported by the data; the diagnosed group reported the highest proportion of students with a need for professional mental health treatment, followed by the at-risk group.

DISCUSSION

The purpose of this research was to determine whether modern labeling theory is applicable to college students, and whether an unlabeled individual may be affected by labels. While some of my hypotheses were not supported by this data, the results show interesting trends between the three groups. It is important to note that there was no statistically significant difference in personal stigma between the three groups, and that the difference between the three groups' personal stigma ranged from 0.04 to 0.09. The

lack of a significant difference between the three groups appears to indicate that personal stigma does not differ based on a diagnosis or risk of depression.

Personal stigma was significantly lower than perceived stigma for each group, indicating that college students, on average, believe that others stigmatize mental illness more than they do themselves. The low reported personal stigma may be the result of response bias; an individual will report that they disagree with the negative personal stigma questions more than they actually do, and report that they agree with the positive personal stigma questions more than they actually do. Response bias may play a role in the difference between personal and perceived stigma, but it appears to be unlikely to change the statistical significance of the findings, as the mean difference between personal and perceived stigma for each group is greater than one point.

The ANOVA test for perceived stigma revealed a statistically significant difference between the three groups. Pairwise t-tests showed that the statistically significant difference was for those diagnosed with depression, which had a lower perceived stigma score than those at risk and not at risk for depression. By looking at the means, those at risk for depression had a lower perceived stigma than the not-at-risk group, although this difference was not found to be statistically significant. Finally, the data showed that those diagnosed with depression reported needing help for mental health more than those at risk for depression, and those at risk for depression reported needing help for mental problems more than those not at risk for depression.

The difference in perceived stigma in those diagnosed with depression compared to those at risk and not at risk for depression supports modern labeling theory. Because this group has a “depressed” label, they believe that they are viewed more negatively as a

result of that label. Based on the fact that there was no difference in personal stigma between the three groups, however, the actual stigma towards mental illness—as reported by college students—is quite low. There is a disparity between an individual's personal stigma of mental illness and the perceived stigma of mental illness.

A student's reporting of the need for mental health treatment is clearly related to whether a person is diagnosed with depression, at risk for depression or not at risk for depression. A high percentage (77%) of students diagnosed with depression reported that they needed professional help for mental health. This high percentage can be explained by the fact that this group has already demonstrated help-seeking behavior by obtaining a diagnosis for their symptoms. Over half (57.6%) of the at-risk group reported that they needed professional help for their mental health. This percentage is interesting because it demonstrates that many at-risk individuals in college understand when they need help for mental health. Almost one-third (27.2%) of students that were not at risk reported the need for help for mental health in the past year. These high percentages suggest that professional help for mental health may be considered as simple as talking to a counselor, as opposed to seeking weekly psychiatrist sessions or being prescribed medication for symptoms. It is also important to note that the question does not ask for whether the individual has sought treatment for mental health, but rather if they believed the needed professional help for their mental health. Regardless, the percentage of students reporting the need for professional help for mental health is promising, as these students can recognize when their mental health is not what they want or expect it to be, and when they need to seek professional help.

Goffman's (1963) two levels of stigma—discreditable and discredited—are particularly useful for understanding perceived stigma in those diagnosed and those not diagnosed with depression. Discreditable stigma refers to an individual's stigma that has not been discovered by others; discredited stigma refers to an individual's stigma that has been discovered by others. An interesting aspect to the idea of discreditable stigma is that to be diagnosed with depression is for an individual to discover their own stigma, thus discrediting themselves. For Goffman's purposes, an individual's stigma is still discreditable if it has not been discovered by others; their stigma is discredited when it has been discovered by others. The nature of a diagnosis for depression is that others may not actually know that the individual has depression. Unlike many other stigmatized groups, there are few physical characteristics of depression; a diagnosed individual can choose not to disclose to others that they have depression. If an individual's depression is unknown by others, then others cannot stigmatize them for the label—merely the visible symptoms, if there are any. Additionally, based on Goffman's (1959) theory of dramaturgy, an individual diagnosed with depression may appear "normal" to an undiagnosed individual because that diagnosed individual is displaying a personality consistent with someone who does not have depression. An undiagnosed individual may report low personal stigma for those who have had mental health treatment simply due to a lack of experience with the true symptoms of depression, which a diagnosed individual attempts to hide to the public.

CONCLUSION

Future research should explore whether the findings from the present study are robust to a higher cut-point on the PHQ depression scale. For example, Kroenke and Spitzer (2002) suggest that 15 demonstrates a risk for depression; here I used 10 to distinguish the at-risk from the not-at-risk groups because my purpose was not to diagnose depression so much as to assess the extent of depressive symptoms in this relatively young population. We know that epidemiological measures of depression can overestimate the prevalence of actual depression (see Horwitz and Wakefield 2007). No inference is intended here that these at-risk students are actually clinically depressed.

In my research, the difference in personal and perceived stigma as reported by college students shows that there is a gap between our own personal stigma—or lack thereof—towards mental illness, and our perceived stigma of how "others" view mental illness. The fact that there is a disparity between these two types of stigma suggests that there are some factors instructing us on how we perceive others stigmatize mental illness, and how we view and treat mental illness ourselves. Perhaps the educational system teaches us not to stigmatize mental illness, while the mass media show the mentally ill as harassed or looked down upon by others. Perhaps our being told not to stigmatize mental illness—if we are indeed told not to do so—tells us that mental illness is stigmatized, and therefore gives us a false impression of how others perceive mental illness. My analyses cannot answer these questions, but these are questions that could be answered in future research.

My research provides evidence consistent with modern labeling theory in college students. Students with a "depression" label perceive a higher stigma towards that label

than students who are not diagnosed. The undiagnosed students do not identify with the label, and as a result perceive less stigma towards it. Students diagnosed with depression may also experience that stigma towards them, which would result in a higher perceived stigma than those who do not have personal experience with mental illness stigma.

The low personal stigma as reported by college students is promising. It shows that many students do not highly stigmatize the seeking of help for mental health treatment. The fact that those undiagnosed with depression reported low stigma of mental health treatment should be provided to those diagnosed with mental illnesses on campus, in an effort to decrease perceived stigma for those students and lessen the effects that the label “mentally ill” has on them.

Based on the difference between perceived and personal stigma within the three groups as well as the higher perceived stigma in the diagnosed group, more education should be provided to society about mental illness in order to reduce stigma and attempt to remove associated stigmas from those labeled as mentally ill. The results in this study support the idea that stigma against mental illness is less than it may have been in the past. Even so, the results of this study suggest that there is much to be done before we can eliminate stigma in the future.

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