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Addressing Rural America's Suicide Disparity Among Men:
How Mental Health Stigma Is Communicated Through Storytelling Networks

by

Lindsey Jo Hand

Under the Direction of Holley Wilkin, Ph.D.

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2023

ABSTRACT

The suicide rate disparity of men in rural America has continued to increase year after year. While this is a complex public health problem with many contributing factors, this study examines the stigma of mental illness in men, a recognized contributing factor to increased suicide rates among rural men. Grounded in communication infrastructure theory and the model of stigma communication, this study sought to collect data for the first phase in the development of a stigma communication intervention program for Rabun County, GA, a rural Appalachian community in north Georgia. Twenty-four in-depth interviews were conducted with Rabun County residents to assess the communication infrastructure, where stigma narratives are encountered in the communication infrastructure, and what stigma narratives are present in the communication infrastructure. Findings showed that stigma narratives were most encountered on the micro-level, specifically through conversations with family and friends. On the meso-level, church organizations were also reported as highly influential in the spread of stigma messages surrounding men with mental health issues. Some of the most prominent stigma messages associated with men with mental illness were weakness, lacking faith, and dangerousness. Suicide stigma also appeared to be much stronger than the stigma of mental illness. Through this research, a theoretical model was also developed to aid in future intervention studies of this type. The model of stigma storytelling combines concepts from communication infrastructure theory and the model of stigma communication. Future research should use this model to continue the development and implementation of the multi-phase stigma communication intervention program in Rabun County. Additional research in this area should continue to explore how the stigma of mental health issues in men contributes to the rising rates of suicide rates. The stigma of suicide and suicidal ideation in rural populations should also be explored further as this topic

does not seem to be perceived the same as mental illness, suggesting the topic of suicide is more taboo, carrying a stronger stigma than mental illness in general.

INDEX WORDS: Rural health, Stigma communication, Suicide disparities, Mental health, Communication infrastructure theory, Model of stigma communication

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2023

Addressing Rural America's Suicide Disparity Among Men:
How Mental Health Stigma Is Communicated Through Storytelling Networks

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DEDICATION

I dedicate this dissertation to my husband and mother, my two biggest supporters who have shown me nothing but love, kindness, and encouragement throughout this whole process. I couldn't have done this without either of you. I love you both so much.

And to Henry, my little miracle.

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	V
LIST OF TABLES	XII
LIST OF FIGURES	XIII
INTRODUCTION.....	1
1.1 What is “Rural”?	1
1.2 Rural Health	3
1.3 Appalachian Communities	4
1.4 Depression and Suicide	5
<i>1.4.1 Depression</i>	<i>5</i>
<i>1.4.2 Suicide.....</i>	<i>7</i>
1.5 Mental Illness and Suicide in Rural America.....	8
1.6 Contributing Factors to Suicide in Rural Areas	10
<i>1.6.1 Firearms.....</i>	<i>11</i>
<i>1.6.2 Geological Isolation</i>	<i>12</i>
<i>1.6.3 Considering Other Risk Factors</i>	<i>13</i>
1.7 Protective Factors Against Suicide in Rural Areas.....	14
1.8 Purpose of Study	15
1.9 Organization of Dissertation	16
2 LITERATURE REVIEW	17

2.1	Stigma.....	18
2.1.1	<i>Mental Illness Stigma.....</i>	20
2.1.2	<i>Understanding Depression Stigma</i>	22
2.1.3	<i>Gender, Masculinity, and Mental Health Stigma</i>	23
2.2	Mental Health Stigma Intervention Research.....	24
2.3	Model of Stigma Communication.....	27
2.4	Communication Infrastructure Theory	36
2.5	CIT and Health Intervention Research	40
2.5.1	<i>Hard-to-reach Populations</i>	44
2.5.2	<i>Storytelling and Health Outcomes.....</i>	46
2.5.3	<i>CIT and Stigma</i>	47
2.5.4	<i>Rural Health and CIT</i>	48
2.6	Rationale for Dissertation Study	51
2.6.1	<i>Theoretical Contribution.....</i>	52
2.7	Research Questions	54
3	METHOD	55
3.1	Research Design Overview	55
3.2	Population Sample and Recruitment	56
3.3	Procedure	58
3.4	Interview Guide.....	59

3.5	Interview Data Analysis.....	66
4	FINDINGS.....	68
4.1	Community Traits.....	71
4.1.1	<i>Theme 1: Cultural Traits</i>	71
4.2	RQ1: Communication Infrastructure and Storytelling System.....	76
4.2.1	<i>Theme 1: Storytelling System</i>	76
4.2.2	<i>Theme 2: Communication Action Context (CAC)</i>	78
4.2.3	<i>Theme 3: Field of Health Action</i>	85
4.3	RQ2: Men’s Mental Health Storytelling.....	87
4.3.1	<i>Theme 1: Interpersonal Network</i>	87
4.3.2	<i>Theme 2: Media</i>	88
4.4	RQ3: Stigma Narratives	89
4.4.1	<i>Theme 1: Weakness</i>	89
4.4.2	<i>Theme 2: Dangerousness</i>	92
4.4.3	<i>Theme 3: Shamefulness</i>	93
4.5	RQ4: Stigma Responses.....	94
4.5.1	<i>Theme 1: Emotional Reactions</i>	94
4.5.2	<i>Theme 3: Cognitive Responses</i>	96
4.5.3	<i>Theme 3: Message Effects</i>	97
4.6	RQ5, RQ6 and RQ7: Stigma Storytelling in the Communication Infrastructure	99

4.6.1	<i>Theme 1: Micro-level Storytellers</i>	99
4.6.2	<i>Theme 2: Meso-level Storytellers</i>	101
4.6.3	<i>Theme 3: Macro-level Storytellers</i>	102
4.7	RQ8: Counternarratives and Reducing Stigma	104
4.7.1	<i>Theme 1: Interpersonal Connections (micro-level)</i>	104
4.7.2	<i>Theme 2: Community Leaders/Community Organizations (meso-level)</i>	105
4.7.3	<i>Theme 3: Mass Media (macro-level)</i>	107
4.8	RQ9 and RQ10: Help-Seeking Perceptions and Outcomes	108
4.8.1	<i>Theme 1: Help-seeking Perceptions</i>	108
4.8.2	<i>Theme 2: Help-seeking Outcomes</i>	111
4.9	Additional Themes	113
4.9.1	<i>Theme 1: Trusted Sources of Information on Mental Health</i>	114
4.9.2	<i>Theme 2: Locals' Ideas for Reducing Stigma</i>	116
4.9.3	<i>Theme 3: Suicide</i>	118
5	DISCUSSION & CONCLUSION	119
5.1	Considering Culture	120
5.2	Communication Infrastructure Theory	122
5.3	The Model of Stigma Communication	126
5.3.1	<i>Exploring The Impact of Stigma Messages on Help-Seeking</i>	132
5.4	Stigma Storytelling	134

5.4.1	<i>Who Is Engaging in Stigma Storytelling</i>	136
5.4.2	<i>Counternarratives</i>	138
5.5	Additional Findings to Inform Intervention Research Design	140
5.6	Stigma Communication Intervention Program Recommendations	142
5.7	Theoretical Contribution: The Model of Stigma Storytelling	144
5.8	Future Studies	146
5.9	Limitations	148
5.10	Conclusion	150
	REFERENCES	152
	APPENDICES	173
	Appendix A	173
	Appendix B	176
	Appendix C	180
	Appendix D	188
	Appendix E	189
	Appendix F	190
	Appendix G	214

LIST OF TABLES

Table 1. Interview Guide Questions that Apply to Each Research Question	60
Table 2. Demographic Data	69
Table 3. Mental Health Experience	71

LIST OF FIGURES

Figure 1. Study Phase Plan 52

Figure 2. The Model of Stigma Storytelling..... 146

INTRODUCTION

Rural areas in the United States are often afflicted with poorer health outcomes than urban areas, resulting in various health disparities unique to rural areas. This study will focus on a particular disparity found in rural areas--suicide rates among rural-residing men, a complex issue that must be examined and understood from various lenses. The suicide rate of rural, American men is one of the highest in the country (CDC, 2017). This dissertation project explores factors contributing to this disparity by examining mental health and help-seeking stigmas and how these stigmas are communicated and learned in rural communities. The theoretical frameworks used for this study were communication infrastructure theory and the model of stigma communication. This research is intended to provide a framework for developing an intervention model specifically for addressing the stigmas of mental illness among men and seeking help for mental health care and support. This study is one step of many toward implementing effective interventions that reduce the stigma of mental health in rural areas among men, with the ultimate goal to reduce suicide rates among men living in rural areas.

1.1 What is “Rural”?

The definition of “rural” is somewhat abstract, and many people recognize rural areas based on geographical distance from a city and the appearance of small towns, agricultural landscapes and farmland, and low population density. However, defining “rural” has long been a challenge and depending on whether a population classifies as rural can often affect funding for services, resources, and federally or state-funded programs. The United States Census Bureau (2015) defines “rural” as “any population, housing, or territory not in an urban area.” What makes a population rural is based on the understanding of what is urban, which is understood with two types of geographies: urbanized areas (population \geq 50,000) and urban clusters

(typically suburbs) (population = 2,500 > 50,000) (United States Census Bureau, 2015). Non-metro areas, which are usually defined at the county level, are not considered the same as rural areas, and some counties will comprise of a mixture of rural and urban areas with some rural areas considered as being within a metro area (United States Census Bureau, 2015).

Another commonly used definition of “rural” is from the Office of Management and Budget (OMB), which designates counties as metropolitan (metro), micropolitan (micro), or noncore (HRSA, 2021). Metropolitan Statistical Areas (MSA), or metro areas, contain a central urban area of 50,000 people or more, micro areas contain a central urban area of at least 10,000 but less than 50,000 people, and all counties that are not part of a Metropolitan Statistical Area are considered rural (HRSA, 2021). This can include micropolitan and noncore areas (Rural Health Information Hub, 2019). Oftentimes, the OMB’s definition and the Census Bureau’s definition fail to identify the same populations as rural (Hart et al., 2005).

While there are shortcomings to both definitions, both understandings of what rural means have influenced the way in which the CDC’s National Center for Health Statistics (NCHS) approaches rural health. Specifically, urban-rural classifications are often used to examine the prevalence of particular health issues by county urbanization levels. Using the OMB’s definition as a framework, the NCHS (2017) has recognized six classifications of county urbanization, which are 1) large central metro (population \geq 1 million and a principal city); 2) large fringe metro (MSA population \geq 1 million and no principal city); 3) medium metro (MSA population \geq 250,000 but $<$ 1 million); 4) small metro (MSA population $<$ 250,000); 5) micropolitan (non-metro MAS population of \geq 10,000 but $<$ 50,000); and 6) noncore (non-metro and not part of MSA or micropolitan area) (NCHS, 2017).

This dissertation uses the National Center for Health Statistics (NCHS) and the CDC's approach to understanding rural health by recognizing that there are various levels of urbanization and rurality. Rural populations vary in size and geographical location, which this study recognizes and considers.

1.2 Rural Health

What constitutes as “rural” is not as clear cut as it would seem, but there is some agreement that rural populations have unique characteristics that make these communities more susceptible to health disparities and poor health outcomes. *Health disparities* are:

“a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” (Healthy People, 2020, para. 6).

Rural communities are varied, but some common risk factors for health disparities in rural areas include socioeconomic status and higher rates of poverty, higher rates of uninsured residents, limited or no access to healthcare specialists, geographical isolation, and limited options for employment (CDC, 2017; Rural Health Information Hub, 2019).

Though roughly more than 46 million Americans live in rural areas (CDC, 2017), rural health is often an overlooked and underfunded category of public health. Rural populations often face worse health outcomes and numerous health disparities compared with urban populations (CDC, 2017). Rural areas often have higher incidences of disease and disability, higher mortality

rates, and lower life expectancies (Rural Health Information Hub, 2019). These areas also tend to report higher rates of suicide, chronic pain, tobacco consumption, hypertension, and obesity, and residents of rural areas are more likely to die from heart disease, cancer, stroke, and unintentional injuries such as opioid overdose and vehicle crashes than those in urban areas (CDC, 2017).

While understanding why disparities in rural areas exist, each must be examined in its own context in order to better implement effective health interventions in rural communities. This paper will seek to understand the disparity of suicide rates among men living in rural areas, specifically in rural Appalachia as suicide rates among Appalachian men are some of the highest in the country.

1.3 Appalachian Communities

Deriving its name from the Appalachian Mountains in which most of the territory is located, Appalachia is a cultural region that extends across 13 states in the U.S., from Mississippi to New York. The region consists of 420 counties, containing 25 million residents living in parts of Mississippi, Alabama, Georgia, South Carolina, North Carolina, Tennessee, Kentucky, Virginia, Ohio, Pennsylvania, Maryland, New York, and all of West Virginia (Appalachian Regional Commission, 2021). Because the region is so expansive, there are ongoing debates as to what best defines Appalachian culture, but there is a general consensus that positive core values of the culture are reported to be a strong sense of community, strong ties and familial support systems, religion and faith in God, pride in self and family, self-reliance, justice, loyalty, strong work ethic, trustworthiness, and a sense of belonging in one's community (Deskins et al., 2006; McGarvey et al., 2011). Negative or more problematic norms of the culture are reported to be a fatalistic outlook, suspicion or distrust of outsiders, and a distrust in formal medical institutions (Deskins et al., 2006; McGarvey et al., 2011). Approximately 40% of the Region's

population is rural (American Psychiatric Association, 2018), and much of what is described as Appalachian culture aligns with general descriptions of cultural norms of rural communities. Appalachian communities often have worse health outcomes than non-Appalachian communities and have health disparities ranging from heart disease to cancer to mental health disorders (American Psychiatric Association, 2018; Marshall et al., 2017).

1.4 Depression and Suicide

1.4.1 Depression

Depression is a common and serious mood disorder and is often referred to as major depressive disorder or clinical depression, and those experiencing depression have persistent symptoms that last at least two weeks (American Psychiatric Association, 2013; American Psychological Association, 2020). It's important to note that having the blues or experiencing sadness is not the same as having clinical depression (American Psychological Association, 2020). Grief or bereavement is also not the same, but loss and grief can lead to clinical depression (American Psychosocial Association, 2020).

Symptoms can vary and include having a depressed mood, loss of interest in activities once enjoyed, changes in appetite, sleep disturbances, fatigue, increased purposeless physical activity, feeling worthless, feeling guilty, difficulty concentrating, difficulty making decisions, and thoughts of death and suicide (American Psychiatric Association, 2013; American Psychological Association, 2020). Some forms of depression are slightly different and develop under unique conditions and include persistent depressive disorder (depressed mood for at least two years), postpartum depression (major depression during or after pregnancy), psychotic depression (severe depression plus a form of psychosis), seasonal affective disorder (onset of depression during winter months), disruptive mood dysregulation disorder (diagnosed in children

and adolescents who have extreme anger and irritability), premenstrual dysphoric disorder (severe depression or anxiety before a menstrual cycle starts), and bipolar disorder (experiences changes in moods and includes low moods that meet the criteria for depression) (National Institute of Mental Health, 2018).

According to the National Institute of Mental Health (2017), depressive symptoms may sometimes present differently depending on the gender of the person. For instance, men who are depressed may express anger and aggression instead of sadness or hopelessness, which can often make recognizing depression in men difficult (National Institute of Mental Health, 2017). While depression is common among men, they are less likely to recognize they are depressed and less likely to seek treatment for depression (National Institute of Mental Health, 2017). Specific signs and symptoms of depression in men identified by the National Institute of Mental Health (2017) include the following:

- Anger, irritability, or aggressiveness
- Anxiety, restless, or feeling on edge
- Loss of interest in work, family, and activities once enjoyed
- Problems with sexual desire and sexual performance
- Feeling sad, empty, numb, or hopeless
- Lack of concentration and memory recall
- Fatigue
- Sleep disturbance
- Overeating or lack of appetite
- Suicidal ideation or suicide attempts
- Physical aches, pains, headaches, or digestive problems

- Inability to meet day-to-day responsibilities
- Engaging in high-risk activities
- Substance use
- Withdrawing and isolating from loved ones

1.4.2 Suicide

One of the noted symptoms of depression is suicidal ideation, and the worst outcome of depression is suicide. However, the risk for suicidal behavior is complex and does not only occur among those who are clinically depressed (National Institute of Mental Health, 2018). People who attempt suicide may not have a clinically diagnosed mental disorder but may do so as a reaction to a traumatic event such as loss of employment or an unexpected loss of a loved one. However, the likelihood of a suicide attempt is higher if a person has a mental health disorder such as depression, substance abuse, anxiety, borderline personality disorder, or psychosis (National Institute of Mental Health, 2018). The National Institute of Mental Health (2018) identifies the following as warning signs of suicide:

- Talking about wanting to die or kill oneself
- Talking about feeling empty, experiencing hopelessness, or having no reason to live
- Planning or looking for a way to kill oneself
- Talking about great guilt or shame
- Talking about feeling trapped or that there are not solutions
- Feeling unbearable physical or emotional pain
- Talking about being a burden to others
- Substance use more often
- Acting anxious or agitated

- Withdrawing from family and friends
- Change in eating and/or sleeping habits
- Showing rage or talking about seeking revenge
- Engaging in reckless behavior or taking unnecessary risks that could lead to death
- Talking or thinking about death often
- Extreme mood swings or sudden changes in mood
- Giving away important possessions
- Saying goodbye to loved ones
- Putting affairs in order/making a will

1.5 Mental Illness and Suicide in Rural America

It is estimated that one in five adults in America experience mental illness (NAMI, 2019), and though the prevalence of mental illness in rural residents is similar to that of urban residents, rural communities face unique challenges that often affect accessibility to services and care (Rural Health Information Hub, 2018). Some particular challenges for rural residents to finding effective care are living long distances from clinics, lacking insurance coverage for mental health services, the inability to recognize mental illness, ongoing shortages of mental health professionals in rural areas, and the stigma of having mental illness or needing to seek mental health care services (Rural Health Information Hub, 2018; World Health Organization, 2021). Though mental illness diagnoses vary, depression is one of the leading causes of disability worldwide, and the worst outcome to this particular mental illness is suicide (World Health Organization, 2021).

Suicide is a major public health concern. Since 1999, suicide rates have consistently been on the rise in U.S., with rural areas often impacted the most (CDC, 2018; Curtin et al., 2016;

Nestadt et al., 2017). This increase may not only reflect increases in actual suicides but may also potentially reflect more accurate cause-of-death reporting and documentation over the years.

There are also certain subsets of the U.S. population that are more at risk for suicide. While women are more likely to attempt suicide, men are about four times more likely to die by suicide (CDC, 2015). The rate at which men report depression and die by suicide in the U.S. is considered to be a national epidemic (Rochlen et al., 2005). The likelihood of dying by suicide is even higher (four to 5 times) if men are located in rural areas (CDC, 2015), and the gap between rural and urban suicide rates has steadily increased since the mid-2000s (CDC, 2017; Kegler et al., 2017; Steelesmith et al., 2019).

While depression and other mental illnesses can lead to suicide, it's important to note that not all suicides are a result of mental illness. Evidence shows that the prevalence of mental illness in rural areas is similar to that of urban areas, but suicide rates disproportionately impact rural populations (Rural Health Information Hub, 2018). Rural areas affected the most appear with higher levels of deprivation in the western United States, regions in Appalachia, and the Ozarks (Steelesmith et al., 2019). Appalachian communities have a disproportionately higher rate of mental health problems compared to the United States population, and the region's suicide rate is 17% higher than the national rate (Marshall et al., 2017). Residents in rural Appalachian counties are at an even higher risk with 21% of the population being more likely to die by suicide than those living in the larger metro counties (American Psychiatric Association, 2018; Marshall et al., 2017).

It also stands to reason that this disparity may be even greater in this region due to the opioid crisis (Heffernan et al., 2021). Appalachia is one of the most significantly impacted regions of the opioid crisis (Heffernan et al., 2019), and a sizable percentage of suicides may be

recorded as unintentional opioid overdoses if the person leaves no indication that they intended to take their own life (Stone et al., 2017). Due to this, it stands to reason that data on this disparity may be an underestimate since more suicides may be miscoded as accidental overdoses, indicating that this disparity between rural and urban suicides may be more profound than what is currently documented. While more research is needed in this area to investigate the extent to which this occurs, suicide and opioid use are intrinsically connected within this population. Both issues are considered dire public health problems within Appalachia and are referred to as “diseases of despair” (Case & Deaton, 2015; Meit et al., 2019).

This all suggests that unique factors in rural areas contribute to this disparity in rural suicide rates. While general risk factors for health disparities in rural areas have been identified in the previous section, the next section will discuss risk factors specific to suicide among men in rural areas.

1.6 Contributing Factors to Suicide in Rural Areas

While research in this area still has a ways to go, scholars have speculated that the rise in rural suicide rates in recent years is potentially attributed to social isolation, lack of employment, access to lethal means (firearms), the stigma of mental illness, and lack of access to mental health services (Kegler et al., 2017; Creighton et al., 2017). Macintyre et al. (2002) and Judd et al. (2006) have explored three categories of potential contributing causes to suicide among rural men into three categories: *compositional*, *contextual*, and *collective*. Each category explores the geographical variations in health, specifically suicide among men in rural areas. The *compositional category* comprises of the characteristics of individuals in a particular place (Judd et al., 2006) and refers to factors such as the presence of mental health problems, suicidal ideation, social isolation and individual socioeconomic status (SES). The *contextual category*

emphasizes specific characteristics of rural areas such as the structures in the local physical and social environment (Judd et al., 2006). Contextual factors include the decline in local economies, SES disparities in the community, and lack of availability and access to mental health services. The last category, *collective* factors, refers sociocultural and historical features of communities (Judd et al., 2006). This category considers masculine culture, stigma and community attitudes toward mental illness, help seeking norms, and access to firearms. While many potential contributing factors to the suicide disparity among men in rural areas have been identified by scholars, two of the most commonly studied and empirically examined factors are access to firearms and geological isolation.

1.6.1 Firearms

To date, scholars in public health have increasingly focused on the relationship between firearm ownership and accessibility to guns in rural areas, providing strong evidence that firearms in the home increase the likelihood of suicide (Branas et al., 2004; Kposowa, 2013; Mann & Michel, 2017). Death by firearms in rural areas is considered a public health crisis and are more likely to happen due to suicide than due to homicide or accidental firearm discharge (Branas et al., 2004). In rural areas, greater firearm ownership and availability of firearms are correlated with higher suicide rates and the likelihood that someone will take their own life using a gun (Judd et al., 2006; Mann & Michel, 2017; Morgan et al., 2018; Nedstadt et al., 2017).

Many scholars who examine the relationship between firearms and suicide among rural men have called for social change and stricter gun laws. Mann and Michel (2016) recommend that the public and major stakeholders advocate for urgent implementation and outcome evaluation for preventing suicide by firearms, while Nestadt et al. (2017) believe the public's awareness should be broadened on this issue. However, while studies on other countries show

suicide rates decrease with legislation that reduces firearm ownership and/or availability, policy-based restrictions to firearms in the United States may not work due to culturally engrained values toward gun ownership (Mann & Michel, 2016). Even modest efforts to reform gun ownership laws have been met with strong opposition (Kposowa, 2013). This presents a challenge to intervention efforts in rural areas. Because there is strong evidence that access to firearms increases the risk of suicide in a household, it makes sense to address this issue by reducing access to firearms. However, with the resistance in rural communities to do so, scholars must consider addressing other contributing factors as well.

1.6.2 Geological Isolation

Another body of research that has emerged from the study of rural suicide disparities is the examination of rural isolation. This encompasses isolation from one's community as well as physical distance from mental health clinics and services. People who live in rural areas are often isolated and have restricted access to specialized clinics or may have access to one clinic that provides basic, primary health care (Hollingsworth, 2018; Morgan et al., 2018).

Some scholars have proposed that telemedicine, specifically telemental health, is a viable option for people with restricted access to specialized care (Hand, 2021; Hollingsworth, 2018). Telemedicine may be one of the best ways to address suicide and depression among men in rural areas by improving access to mental health care and services that would not be accessible otherwise (Hand, 2021; Hollingsworth, 2018). While telemedicine may alleviate some of the challenges that occur due to geographical isolation, there is still progress to be made. Many rural areas have limited access to broadband and the technology necessary for telemental health appointments through teleconferencing software (Hand, 2021). Privacy may also be an issue as many people do not have a quiet, private place in the home for telemedicine visits (Hand, 2021).

However, aspects of telemental health care can be administered simply through phone calls, and though this cannot completely replace in-person care with a provider, it's a step in a positive direction in providing access to mental health care in rural areas.

Compositional factors such as social isolation, loneliness, and lack of belonging are well-established risk factors for suicide (Judd et al., 2006; Monteith et al., 2020). Social isolation, considered a result of geographical isolation, has also been attributed as a possible risk factor for elevated suicide rates in rural areas (McPhedran et al., 2013). However, rural communities are varied, and geographical isolation does not necessarily mean social isolation or an inevitable lack of social connection and social capital. For instance, McPhedran et al. (2013) found that while farming communities are generally more isolated geographically from urban areas, farmers are not necessarily more socially isolated, pointing to other factors that likely contribute to the elevated suicide rates in farming communities. While people living in rural areas may have access to a community and the ability to build social capital, COVID-19 has brought forth a renewed concern for social isolation in rural areas. Social isolation as a result of COVID-19 may exacerbate this suicide risk factor in rural areas (Monteith et al., 2020).

1.6.3 Considering Other Risk Factors

While understanding how accessibility to firearms and geographical isolation impact suicide and depression rates among men in rural areas is important to address, other risk factors need to be empirically explored and addressed as well. This is especially important because many of these factors are not mutually exclusive, and one can affect another. Lack of access to mental health services and isolation are often due to location and people residing in very remote areas with limited access to no access to public transportation, but these factors can also be related to economic decline (Kegler et al., 2017). Social isolation also occurs in very specific

types of rural communities as some rural communities may be far from an urban area, but the residents are not far from one another. Access to and attitudes regarding firearms and the stigma of mental health disorders are often considered cultural factors that contribute to this health disparity (Judd et al., 2006; Kegler et al., 2017), but these factors possibly contributing to higher suicide rates among rural men have not been adequately examined.

1.7 Protective Factors Against Suicide in Rural Areas

Protective factors against suicide have not been studied as rigorously or as extensively as the risk factors (CDC, 2019), but they are worth recognizing as they play an important part in developing effective suicide and mental health stigma interventions in rural communities. One of the mostly commonly cited protective factors against suicide in rural communities is social connectedness/social capital, which decreases the likelihood of suicides in rural areas (McLean, 2008; Steelesmith et al., 2019). Social capital encompasses social relationships and social connectedness in which people have strong interpersonal and community connections that allow them to access various community resources that positively influence one's health (McLean, 2008). Having strong social capital often results in having strong social support systems in which people experiencing depression or depressive systems can seek help and support among their social connections. Communicative social capital consists of "an information and problem-solving resource that accrues to residents as they become more integrated into their local communication network of neighbors, community organizations, and local media" (Matsaganis & Wilkin, 2014, p. 377).

Other protective factors have also been recognized by scholars. Religious participation or having a strong religious faith is also a protective factor against suicide, but this may vary according to the level of secularization within a community (CDC, 2019; McLean, 2008).

Gainful employment, access to treatment by health professionals, effective clinical care specializing in mental health treatment, skills in problem solving and conflict resolution, and self-efficacy are also recognized as protective factors against suicide (CDC, 2019; McLean, 2008). Most of these protective factors have been examined through studies that focus on suicide in general. Additional research is needed to better understand protective factors specific to rural men.

Monteith et al. (2020) have suggested additional strategies for addressing risk factors for suicide in rural areas during COVID-19. These potential solutions are as follows: maintaining social connectedness, engaging in value-driven activities, ensuring COVID-19 survivors are not stigmatized, dissemination of information on how to cope with interpersonal stress, messaging about interpersonal violence resources, support and information for parental coping during periods of stress, increase in interpersonal violence screenings by health care providers, firearm safety education, risk communication on firearm ownership and use, temporarily reducing access to firearms for at-risk individuals, increase access to firearm locks and safes, destigmatization of mental health care, public health messaging on obtaining mental health care, telehealth access, and access to free web-based applications for psychological support and mental health education. Monteith et al. (2020) have recognized the need for destigmatization of mental illness and seeking help for mental health in rural areas. This study will also attempt to address this stigma that persists in rural communities by better understanding what stigmas are present and how these stigma narratives spread in rural communities.

1.8 Purpose of Study

Suicide among rural men is a complicated public health problem and must be examined from various angles using various approaches (Kegler et al., 2017), and investigators must be

open to using multilevel designs that explore this issue (Kposowa, 2013). To address complex public health problems, we must recognize that problem solving is as much a social and political process as it is a scientific pursuit (Krueter et al., 2004). Researchers attempting to design interventions that address depression and suicide in rural areas must consider additional cultural factors unique to this population that might hinder seeking support for depression or suicidal thoughts. This dissertation examines the stigma of depression/mental illness in men and the stigma of seeking help for mental health problems. This stigma is potentially an important factor that hinders rural men from seeking help and finding support for mental health. Mental health stigma was examined using the stigma communication model and communication infrastructure theory. How people in rural areas learn about and perceive mental health problems in men is essential to better understanding and addressing this public health issue. Addressing and understanding other contributing factors such as how stigmas are learned and perpetuated in communities may aid in developing effective interventions that reduce suicide rates and successfully address this rural health disparity.

1.9 Organization of Dissertation

Chapter 1 has introduced the purpose of this dissertation and has provided necessary background information on suicide among men in rural areas. The prevalence of this issue as well as unique risk factors contributing to this issue were highlighted. Chapter 2 will provide a review of literature, which will highlight stigma of mental illness, masculinity and stigma, the model of stigma communication, communication infrastructure theory, and existing suicide prevention interventions focusing on mental health stigma. Chapter 3 will describe the methodology used in this study, which is a qualitative study in which semi-structured interviews were conducted and then analyzed using thematic analysis, specifically the Framework Method.

The research protocol and interview guide will be highlighted in this chapter as well. Chapter 4 will be a report of the research findings from the study. Chapter 5 will be the last chapter and will discuss the implications of the findings from the study, will highlight limitations of the study, and will make suggestions for future research. Chapter 5 will also introduce the Model of Stigma Storytelling (see Appendix E) as a potential stigma communication intervention tool, making specific suggestions for future research that incorporate this framework.

2 LITERATURE REVIEW

Current literature on high suicide rates in rural areas note epidemiological trends and correlations between firearm access, lack of access to services, and suicide, yet little research has focused on empirically identifying other contributing factors to this rural suicide disparity. To date, the majority of identified contributing factors to suicide among men in rural areas are purely speculative. More attention needs to be given to cultural milieu in rural areas that may contribute to high suicide rates among men in rural areas. Due to the complexity of the issue, there is not a suggested singular approach for mitigating this problem, and scholars must consider that many approaches must be taken to address this health disparity (Kegler et al., 2017). To address the persisting suicide disparity in rural areas, more needs to be understood about the stigma of mental illness, specifically how stigma is transmitted in communication networks in rural communities. Therefore, the primary objective of this literature review is to examine the stigma of mental health problems in men. The model of stigma communication and communication infrastructure theory will be explored and used as the theoretical basis for this research. The goal is to provide a foundation for effective suicide prevention and stigma reduction intervention programs within rural communities.

2.1 Stigma

Stigma is a complex phenomenon that in essence challenges one's humanity and is defined as normalized, profoundly negative stereotypes or attributes applied to a person or group (Dovidio et al., 2000; Goffman, 1963; Smith, 2007; Smith, 2019). A person who is stigmatized is devalued and often reduced to dehumanizing stereotypes that frame the person as "spoiled" or "flawed" in the eyes of those applying the stigma (Dovidio et al., 2000; Goffman, 1963). Goffman (1963) identified three types of negative attributes that contribute to the development of stigmas: 1) abominations of the body (physical deformation); 2) blemishes of individual character, and 3) tribal stigma of race, nation, and religion. Goffman (1963) also argued that stigmas are varied, and these variations can affect the perceived level of deviance or depravity. These variations are visibility (evident by others), publicity (whether others know), obtrusiveness (how much it affects social interactions), and relevance (Goffman, 1963).

Stigmas are a social phenomenon and occur as a social process in which socially constructed cues are given to distinguish and categorize people as a separate social entity (Dovidio et al., 2000; Jones & Corrigan, 2014; Smith, 2007). These categorizations and applied negative attributes to a specific person or group are spread through communication at various levels in which cues are received from interpersonal connections, community connections, and the media (Dovidio et al., 2000; Jones & Corrigan, 2014; Smith et al., 2016). The social construction of stigma involves two components, which are "the recognition of difference based on some distinguishing characteristic....and a consequent devaluation of the person" (Dovidio et al., 2000, p. 3). Link and Phelan (2001; 2006) have expanded on Goffman's (1963) understanding of stigma and identified components of this social process that combine to generate a social stigma: 1) people identify and label human differences; 2) stereotyping occurs

in which the labeled person or group is linked to undesirable characteristics; 3) the group doing the labelling otherizes the stigmatized group (separating “us” from “them”); 4) stigmatized people experience discrimination and loss of status; and 5) an exercise of power occurs in which each of the previous components are allowed to co-occur to facilitate the creation of a stigma.

There are four types of stigma that are most commonly studied in contemporary psychology and sociology literature, which are public stigma, self-stigma, label avoidance, and structural stigma (Corrigan & Kosyluk, 2014; Jones & Corrigan, 2014). *Public stigma*, the most commonly studied type of stigma, is a process in which members of the general population endorse and perpetuate the stereotypes associated with the stigmatized attribute, which typically leads to discrimination of some kind (Jones & Corrigan, 2014). Stigmas of this nature are often amplified and reinforced by the media, specifically portrayals of those with disease and disability, which are portrayed in an overwhelming negative manner (Jones & Corrigan, 2014; Wahl, 1995). This type of stigma can lead to *self-stigma*, which occurs when a person internalizes the stereotypes, prejudice, and discrimination perpetuated by public stigmas (Corrigan & Kosyluk, 2014). This type of stigma often affects the stigmatized person’s level of self-efficacy as they believe the negative stereotypes perpetuated about their stigmatized characteristic, which can lead to “self-discrimination” resulting in diminished hope, low self-esteem, and low achievement (Jones & Corrigan, 2014). *Label avoidance* is a type of stigma that hinders a person from seeking support or services in order to avoid being labeled or stereotyped (Corrigan & Kosyluk, 2014; Jones & Corrigan, 2014). A good example of this would be a person who avoids being associated with a mental health program in order to avoid being labeled as “crazy” or “nuts” (Corrigan & Kosyluk, 2014). This type of stigma can affect a person’s willingness to seek help for a disease or disability. Lastly, *structural stigma* refers to private and

public systemic social structures that intentionally or unintentionally restrict those with a particular attribute or characteristic (Corrigan & Kosyluk, 2014; Jones & Corrigan, 2014). Structural stigma typically enforces rules, regulations, restrictions and norms that systemically discriminate against those living with the stigmatized attribute (Jones & Corrigan, 2014). An example of this would be an employer not hiring a prospective employee because the employee discloses they have a mental illness. Structural stigma can also manifest as lack of funding for research in mental health as well as lack of resources for behavioral health institutions.

The effects of stigma can have dire public health consequences and can affect one's quality of life, including chances at gainful employment, secure housing, and access to medical care (Corrigan & Watson, 2002; Link & Phelan, 2006). People with greater resources such as prestige, status, and social capital are often able to avoid health risks and adopt protective strategies, and stigma, which can affect each of these resources, can place people at a considerable social disadvantage in which the exposure to risk increases and access to protective factors is limited (Link & Phelan, 2006). This can be especially damaging when the stigma is disease related. The stress associated with disease-related stigma can be particularly difficult to cope with, and people with stigmatized diseases often delay or completely avoid seeking treatment out of fear of being labeled, especially if the stigmatized illness or disease is "invisible" or concealable (Link & Phelan, 2006; Smart & Wegner, 2000). Mental illness is generally a concealable health-related problem that is highly stigmatized.

2.1.1 Mental Illness Stigma

Mental illness is a broad term that encompasses a myriad of diagnoses, symptoms, challenges, and abilities (Corrigan & Kosyluk, 2014). Serious mental illness is often the most severely stigmatized, which includes conditions such as major depressive disorder, bipolar

disorder, and schizophrenia (Corrigan & Kosyluk, 2014). While these illnesses can be debilitating and disabling, the stigma surrounding serious mental illness can arguably be just as disabling as the disorder itself (Corrigan & Kosyluk, 2014). Common stereotypes associated with mental illness are that people with mental illness are dangerous and/or incompetent, and that people with mental illness are somehow personally responsible for having their condition (Corrigan & Kosyluk, 2014). Each of these stereotypes can lead to discrimination of people with a mental illness. The perception of dangerousness assumes that people with mental illness are unpredictable and violent, responsibility applies blame and shame to the person with the disorder, and incompetence assumes that people with mental illness cannot work or live independently (Corrigan & Kosyluk, 2014).

Public stigma, self-stigma, label avoidance, and structural stigma are commonly experienced among those who have mental illness or are experiencing mental health problems. These stigmas in particular can be quite harmful to those with serious mental illness and result in discrimination such as avoidance and withdrawal from those in the community, coercion or forcing treatment without the patient's consent, and segregation in which people with mental illness are segregated from the rest of society (nursing homes, prison systems, state hospitals, etc.) (Corrigan, 1998; Corrigan & Kleinlein, 2005; Corrigan & Kosyluk, 2014). Public stigma can prevent people with mental illness from experiencing rightful life opportunities, most notably employment and secure housing (Corrigan & Kleinlein, 2005). Also notable, the U.S. health care system is not immune from the effects of public stigma of mental illness. People with mental illness are often discriminated against in health care systems, sometimes to the extent to where necessary medical procedures are withheld or denied due to mental illness stigma (Corrigan & Kleinlein, 2005). Lack of access to adequate care highlights some sociocultural

issues that likely illustrate structural stigma (Link & Phelan, 2001). Self-stigma can be particularly harmful for self-efficacy, self-esteem, and confidence in one's future (Corrigan & Kleinlein, 2005). This self-stigma along with label avoidance can deeply impact a person's willingness to seek help or treatment for their mental health (Corrigan & Klenlein, 2005; Dubin & Fink, 1992). Additionally, self-stigma is a risk factor in people with mental illness and is positively related to psychiatric symptoms as well as suicidal ideation (Göpfert et al., 2019), and many of the consequences of mental illness stigma such as shame, low self-esteem, hopelessness, and loneliness are predictors of suicidality (Oexle et al., 2017; Rüsche et al., 2014). This is specifically of concern for people who experience depression in which symptoms can be exacerbated by the stigma associated with the condition.

2.1.2 Understanding Depression Stigma

The public- and self-stigma of depression can make coping with the symptoms of depression all the more difficult, and those with depression are often reluctant to seek help due to the stigma associated with the illness (Barney et al., 2006). This is especially concerning given the prevalence of depression. Wolpert (2001) argues that the stigma of depression is largely negative due to the negative nature of the illness, which can make individuals with depression seem "unattractive and unreliable" (p. 221). For people who do not have depression, the illness can be difficult to understand and seen as a sign of personal weakness in those that experience depression (Wolpert, 2001; Yokoya et al., 2018).

Suicidal ideation, one of the most severe symptoms of depression, is also highly stigmatized, which can further prevent people from seeking help or support by sharing that they are experiencing thoughts of suicide (Miller, 2020). Suicide and stigma are inextricably linked in that suicide and suicidal ideation are stigmatized, but stigma can cause suicidal ideation and

suicide (Kučkalić & Kučkalić, 2017). The topic of suicide is typically considered taboo to discuss; however, talking about suicide can diminish the stigma and normalize seeking treatment (Miller, 2020). Additionally, it's important to note that while suicide is most often associated with depression, anxiety, and substance use, not all people who experience suicidal ideation, attempt suicide, or die by suicide have these conditions (Miller, 2020). The stigma of suicide and suicidal ideation must also be considered when addressing suicide among men in rural areas.

2.1.3 Gender, Masculinity, and Mental Health Stigma

While women are twice as likely to be diagnosed with depression, men experience higher rates of disability and mortality from depression (Bryant et al., 2014). The tendency for men to underreport depressive symptoms is likely in large part due to stigma of depression and the fear of being emasculated and labeled as weak (Bryant et al., 2014; Herbst et al., 2014). This stigma may be reinforced and even stronger regarding rural men seeking help for mental health as gender norms and ideals of rural masculinity (staying strong, pushing through, stoicism, independent, impermeable to risk, etc.) are often juxtaposed to perceptions of depression as a sign weakness (Crumb et al., 2019; Herbst et al., 2014; Roy et al., 2013). Rural men's hesitancy to seek help or treatment has been related to these perceptions of masculinity (Crumb et al., 2019; Herbst et al., 2014). This stigma can also result in difficulty with recognizing mental health care is needed for the individual (Creighton et al., 2017; Crumb et al., 2019; Roy et al., 2013). Creighton et al. (2017) found in their study that men appeared to associated mental illness with weakness and will often attempt to self-medicate with alcohol and/or other substances/drugs rather than seek outside support or professional help. Adherence to rural masculine norms is a barrier to recognizing depression as well as to seeking help for depression, as the most commonly associate stigma with depression is weakness.

Hegemonic ideals of masculinity in rural contexts can put a lot of pressure on men to “press on” and hide their condition rather than seek help (Creighton et al., 2017). Rural areas in general appear to stigmatize mental illness and seeking help for mental illness, and this stigma seems to be even more prevalent regarding men who have mental health needs. Unfortunately, being male in rural populations is a risk factor for suicidal ideation and suicide, and much of this is attributed to the stigma of depression as weak and emasculating (Herbst et al., 2014). When examining the stigma of depression in rural areas, gender must be taken into account. This dissertation will specifically examine the stigma of depression in rural men, which directly challenges rural gender norms and perceptions of masculinity. More specifically, this study will examine how this stigma is communicated and learned in rural areas by using the stigma communication model and communication infrastructure theory. By using these constructs, an intervention model for reducing the stigma of depression in rural men will be developed.

2.2 Mental Health Stigma Intervention Research

Designing and implementing sustainable health interventions requires several steps and can often take several years to fully achieve (Fleury & Sourya, 2012; Gitlin & Czaja, 2016). Intervention research and design is often done so by using an intervention pipeline model that identifies phases/steps researchers can use to identify where they are at in the intervention design process and where they need to be (Gitlin & Czaja, 2016). The elongated pipeline consists of four main phases, which are development, evaluation, implementation, and sustainability (Fleury & Sourya, 2012; Gitlin & Czaja, 2016). The development phase involves the inception of the intervention idea as well as formative research such as feasibility testing and pilot testing. The evaluation phase consists of testing for efficacy and effectiveness of the program. This is often where ecological validity is evaluated and tested. The implementation phase takes place after the

intervention program has been tweaked and revised (if needed) and is ready to be disseminated. The sustainability phase, the last phase, involves taking steps to keep the intervention program afloat and keep it maintained. This study will provide formative research in the *development* phase for designing a mental health stigma intervention plan for a rural community in Appalachia.

Unfortunately, there is no recognized, reliable strategy for reducing stigma surrounding mental health (Smith & Applegate, 2018). However, Corrigan et al. (2012) have categorized existing efforts to reduce stigma as protest, education, and contact, which some intervention programs have attempted to address. Protest, or social activism, highlights the injustices that occur as a result of stigma. This approach tends to shame people who stereotype, perpetuate stigma, and discriminate against people who belong to the stigmatized group (Corrigan et al., 2012). Educational approaches tend to challenge stigma message or inaccurate stereotypes about mental illness by replacing these messages with factual information (Corrigan et al., 2012). Educational efforts can come in the form of public service announcements and various media campaigns. Contact refers to having interpersonal contact with people who belong to the stigmatized group. People in the general population who interact with people who have mental illnesses are less likely to form prejudices against those with mental illness (Corrigan et al., 2012)

While several studies have assessed rural suicide rates among men and have identified possible contributing factors, few have moved beyond this to focus on the implementation of empirically based intervention programs or health campaigns. One of the largest scale interventions was the *Real Men. Real Depression* campaign spearheaded by the National Institute of Mental Health in 2003. The intervention's purpose was to address suicide and

depression among men, taking place on a national scale as a mass media campaign. The campaign was considered a success because it reached an estimated 34 million people through the television PSAs and another eight million through the website. However, the only measure of success was the reach of the campaign messages and not whether the messages educated or changed perceptions on depression.

The *Real Men. Real Depression* campaign did not use a theoretical framework, and Rochlen et al. (2005) suggest that future campaigns of this nature should consider incorporating theory from a social marketing perspective and models that provide insight into social psychological processes. While the campaign did not use an empirically based method to inform the design and implementation of the campaign, it was one of the first campaigns on this scale, and the reach was massive. It was a positive step toward addressing this public health issue (Rochlen et al., 2005).

Another notable intervention is the Community Response to Eliminating Suicide (CORES) program, which was developed in response to a high incidence rate of suicides over a short period of time in rural Australia. CORES is both a community-based and gatekeeper education model (Jones et al., 2015). Elements of this program include education and starting a conversation about a taboo topic, promoting community engagement and support from community, and providing training to community members. CORES has sought to do the following: 1) gather local people in the community to examine and understand their community, 2) foster an understanding of suicide, 3) develop the skills of local people to identify and respond to suicide at an early stage, 4) engage local people in the delivery of the program, 5) identify and link people to community and professional support services, and 6) empower the local community to own and manage the program (Jones et al., 2015, p. 2). This intervention design

promotes education and community involvement. It puts much of the responsibility of support on the community members.

While CORES is lacking in evaluative measures, the design is informed from an ecological model and is empirically based. For instance, this approach from CORES has similarities to Wilkin's (2006) piece that proposed a CIT-based approach could be used to strengthen ties between storytellers and encourage health stories that benefit the community. Since implementation, suicide rates in rural Australia have declined, establishing a correlation between the program implementation and reduced suicide rates. This program has shown that community-based gatekeeper programs can be effective and aid in the education and prevention of suicide (Jones et al., 2015). However, more research that is theory- and evidence-based needs to be explored in this area of intervention research.

This dissertation will only cover the prephase in the intervention pipeline, but the goal is to design and implement an intervention program that is theory-based and evidence-based, providing a foundation for a sustainable and effective mental health stigma intervention. This project will provide a theoretically grounded approach to intervention research, while expanding the model of stigma communication and communication infrastructure theory (CIT) research. This will ultimately lead to broader efforts in reducing the suicide disparity of men in rural areas.

2.3 Model of Stigma Communication

Smith's (2007) model of stigma communication presumes that communication plays a critical role in the creation, management, and performance of social stigmas (Smith, 2014; Smith & Bishop, 2019; Smith et al., 2016). Specifically, this model identifies the relationship between message choices, message reactions, and message effects (Smith, 2007, 2012, 2014). *Message choices* include marks, group labeling, responsibility, and peril. These stigma messages serve as

social cues that distinguish people, that categorize people as a separate social entity, that imply responsibility or blame on the stigmatized for their membership in the stigmatized group, and that link this distinguished group to physical and social peril (Smith, 2007).

Marks serve as cues that automatically trigger reactions to quickly recognize when a person belongs to a stigmatized group and allow for a quick social response to the person bearing the mark (Smith, 2007). The most effective marks are those that are observable, quickly recognized, and trigger emotions that lead to a behavioral response to remove someone from the social situation (Smith, 2014; Smith et al., 2016). Removal from a social situation can be the physical removal of the person from a social situation (asking them to leave) or by keeping physical distance from the stigmatized individual when encountered in social situations. Removal from social situations can also be done by ignoring the individual in public, treating them poorly when they are in social settings, or not inviting them to social or community events. The two qualities of marks are concealment and disgust (Deaux et al., 1995; Goffman, 1963; Smith, 2007). Some marks are more visible and can be difficult to hide or conceal; however, when concealment can be achieved, the person in the stigmatized group can allow people to “pass” in society (Goffman, 1963; Smith, 2007). Marks can also include cues of disgust and often involve contact with bodily substances, personal uncleanliness, ingesting substances that are not normally ingested, etc. (Smith, 2007). A visible, repulsive mark on a person can easily result in reactions of disgust and an effort to avoid or completely remove the person with the mark from any additional interaction (Smith, 2007).

Group labels are applied to the stigmatized group in which the label often includes words describing the mark or suggesting peril (Smith, 2007; Smith et al., 2016). Group labeling brings attention to the group’s stigma, further solidifies that the stigmatized group is a separate social

entity and differentiates the stigmatized group from “normal” people (Smith, 2007). Group labels can lead to overgeneralizations and the perpetuation of stereotypes, further encouraging the separation of the stigmatized group from the community (Smith, 2007; Smith et al., 2016). Link and Phelan (2001) argue that group labelling is especially apparent when illnesses and health conditions are involved, and the label becomes the group’s whole identity. For instance, calling people with schizophrenia “schizophrenics” or people with leprosy “lepers” only identifies a group of people through their illness, further separating the group from the community. Saying “schizophrenic” instead of a “person with schizophrenia” totally erases a person’s identity and only provides a group label to that person (Smith et al., 2016). More derogatory terms to label the group (e.g., schizos, crazies, lunatic) can be used to further dehumanize and devalue the group (Smith et al., 2016).

Responsibility involves the perception of control one has over their stigmatized condition, in which people often assume that those in the stigmatized group have chosen to have the stigmatized condition as a result of immorality or a character flaw (Smith, 2007). This is also known as etiology, which describes the cause the stigmatized condition (Smith et al., 2016). The stigma of depression is a good example of this as having a depressive disorder is often attributed to weakness and lack of strength, lack of willpower, or choosing to not be happy. A sense of responsibility can be key to stigma messaging, as the level of responsibility or control one has over their condition often relates to how much empathy the community has for those in the stigmatized group (Smith, 2007). Perceived choice and control contribute to perceptions of the level of responsibility a person has to manage their stigmatized condition and minimize their risk to the community (Smith, 2007). Etiology content can assist in developing stereotypes that

perpetuate the idea that the person with the stigmatized trait is morally flawed and has chosen to be in the stigmatized group (Goffman, 1963; Smith et al., 2016).

Peril involves cues in the message content that emphasize the danger a stigmatized group poses to the rest of the community (Deaux et al., 1995; Smith, 2007; Smith et al., 2016). This is often done by using words or phrases that signal danger and/or advocate for avoidance of the stigmatized group (Smith, 2007). These messages can also include consequences statements, which highlight what will happen when the warnings are not heeded and the stigmatized group is not avoided (Smith, 2007; Smith et al., 2016). Message content that emphasizes peril can create and perpetuate the belief that members of the stigmatized group can and will likely harm the community in some way (Smith, 2007; Smith et al., 2016)

Each of these types of stigma messages (marks, group labeling, responsibility, and peril) involve various affective and behavioral reactions (Smith, 2007; Smith et al., 2016). Smith's model refers to these reactions as *message reactions*, which include cognitive reactions, access to relevant social attitudes and stereotypes, and emotional reactions. These types of reactions to stigmatized groups motivate communities to remove those in the stigmatized group in order to remove the social threat and restore social order (Smith, 2007). Common emotional reactions include disgust, anger, and fear, which can encourage cognitive reactions to negative messaging about the stigmatized group (Smith, 2007; Smith et al., 2016). Cognitive reactions can include perceived responsibility, perceived dangerousness, and group labeling. These cognitive reactions to these emotions activated by the stigma messages can shape message processing and make relevant social attitudes and stereotypes more accessible (Smith et al., 2016). When these attitudes are more accessible, people are more likely to orient toward the familiar stigma message and spend more cognitive effort toward interpreting it (Smith, 2007). The more one is

exposed to the stigma message and processes the message, the more persuasive the message is likely to be (Smith, 2007). Smith (2007) argues that the three emotions of disgust, anger, and fear allow greater access to stereotypes and social categories, which “encourage formed or activated beliefs to become even more accessible attitudes” (p. 473). The qualities in stigma messaging that elicit emotional and cognitive reactions can also be the appealing qualities that make others share the stigma message within the community, as sharing messages that cause an emotional reaction can enhance social bonding and interaction (Smith, 2007). Additionally, when information is provided through a social network, the stigma message can be even more persuasive and can increase a person’s likelihood to remember, disseminate, and agree with the stigma message (Smith, 2007).

Message effects include the development of stigma attitudes, isolation and removal of the stigmatized target, and sharing stigma message with others (Smith, 2007; Smith, 2014). Those who are “marked” and recognized themselves as belonging to the stigmatized group are more likely to isolate themselves from the community, and those recognized by the community as “marked” are more likely to be avoided or ostracized from the community (Smith, 2007). Stigma attitudes formed by the stigma messages encourage the sharing of these messages in a community, which contribute to social categorization, stereotyping, and social avoidance of the stigmatized. Each of these can lead to systemic discriminatory behavior at a community level in which the stigmatized are ostracized and isolated from the community. This kind of social avoidance and rejection can directly affect one’s mental and physical health (Smith, 2007). This fear of being labelled, rejected, and ostracized can lead to attempts to conceal the condition and can not only affect disclosure to community members but also healthcare professionals, hindering help-seeking behaviors for the condition (Smith, 2007; Smith & Morrison, 2006).

Smith (2012) was the first to empirically test the model of stigma communication. Smith (2012) did this by conducting a 2x2x2x2 experiment on a hypothetical infectious disease alert in which elements of the model of communication were measured. In this study, the hypothetically infected group were assumed to be in the participants' communities but were essentially an unknown group of people. Specific cognitive reactions explored in this study were perceived responsibility, perceived dangerousness, negative affect, group entitativity, and cynical worldview. Smith (2012) measured outcomes as intervention support, dissemination likelihood, and stigma beliefs. The three emotions disgust, anger, and fear were strongly correlated and together were considered as negative affect (Smith, 2012). Participants were assigned to one of sixteen conditions. The study found that message content variations along with cognitive and affective reactions predicted almost half of the variance in the support for intervention policies such as removing or isolating infected people, requiring mandatory treatment for infection, and publicly mapping and tracking the locations of the infected (Smith, 2012). The message content and the reactions to these messages also predicted the likelihood of dissemination of the message content to others (Smith, 2012). Perceived dangerousness was the strongest predictor of outcomes, which included stigma beliefs, intervention support, and the likelihood of information dissemination. Negative affect was also a strong predictor of all three outcomes. Interestingly, attributions of responsibility were not predictive at all for any of the outcomes (Smith, 2012). Attributions of responsibility may have not been predictive because the disease was fictitious with no social stigma attached. The results may have been different had a real stigmatized disease or condition would have been used in this study. Overall, this study provided support for the model, specifically highlighting that message choices can and do influence message reactions and message effects/outcomes (Smith, 2012).

Smith (2014) extended the 2012 test of the model by conducting a factorial experiment to better understand how stigma-related processes work in an interpersonal context rather than intergroup context (Smith, 2014). This study also explored additional variables not included in the seminal study by Smith (2012), which were frustration and sympathy (affective reactions) and disgust sensitivity (personality trait) (Smith, 2014). In this study, the participants were asked questions about a hypothetical acquaintance infected with a hypothetical infectious disease rather than an unknown group of people. The findings in this study were consistent with findings from the 2012 study testing of the model. Additionally, frustration was a strong predictor of regulation support (message effect in which participants support regulations to control the interactions and lifestyle of infected person) and dissemination likelihood (message effect in which participant is likely to tell others about their acquaintance's infection), and disgust sensitivity was a strong predictor of cognitive and affective reactions (Smith, 2014). The findings from Smith's (2014) study suggest that the model of communication can be used to understand intergroup and interpersonal contexts of stigma communication.

Smith et al. (2019) recently proposed an updated model of stigma message effects in which *message judgments* are introduced as an additional factor in the communication of stigma. This model is adapted from Smith's (2007) model of stigma communication and examines the transmission of stigma and the interpersonal communication process, which is an important step in understanding how stigmas are formed, communicated, and become norms within a community. While the model of stigma communication involves several cognitive and affective mediators of stigma communication, the only empirically recognized mediators of stigma-related outcomes are perceptions of danger and negative affect (anger, fear, and disgust) (Smith et al., 2019). Through their study, Smith et al. (2019) introduce message judgements, an additional

psychological mechanism that serves as a mediator between danger appraisal (i.e., perceived dangerousness) and social transmission (i.e., message dissemination).

Smith et al.'s (2019) study used another fictitious infectious disease to test the model in which participants were exposed to a written news story about the disease. The conditions were high versus low stigma message content with a between-subjects design. Outcomes measured were stigma beliefs, regulation support, social distancing, and sharing of information. This study assessed person-oriented danger appraisal based on reactions to the health news story, which may be somewhat different than norms and stigmas perpetuated in communities through less direct means (not on an interpersonal level). Smith et al.'s (2019) study also provides a great foundation for exploring stigma communication through network analysis methods. In this study, participants imagined that a sociogram represented their network. A sociogram is a diagram that represents individual relationships and patterns between those relationships in a group or specific population. In this scenario, the participants were the main node or focal person in their sociogram. They were then asked to identify 18 other people to be represented in their sociogram, which gave the researchers an idea of how social transmission of the stigma message could likely occur. Survey results showed that after reading the news story, participants mostly considered those who were infected to be more dangerous (greater danger appraisal), which predicted stronger stigma beliefs, stronger support for regulation of those who were infected, and a stronger desire to distance from those infected. Results from the sociogram showed how transmission of the stigma message might occur, with most participants picking nodes that were the highest in closeness and centrality in their network (meaning they are central to their network), and 88% selecting someone else in their network to share the health story with. Results from the sociogram also showed that the more shock value in the message and the more common

ground a message had, the more participants were likely to share the information more widely in their interpersonal network (Smith, 2019).

Most of the studies covered in this section tested the model of stigma communication using hypothetical infectious diseases, lending insight into how stigma messages are transmitted in communities. More studies testing this model should focus on actual stigmatized diseases and conditions, including mental health conditions. Conditions that are already stigmatized may yield different results and would provide a more accurate assessment of stigma communication. Specifically, more needs to be known about how communities form and communicate stigmas surrounding mental illness. Using the model of stigma communication, this study will focus on understanding how stigma messages surrounding mental health problems in men are transmitted in rural areas and how these stigma messages affect help-seeking attitudes.

In a 2019 study, Smith et al. showed that opinion leaders can be identified in networks/communities using this model, and the way in which the stigma is developed and transmitted can be better understood. Communication infrastructure theory (CIT) is similarly focused on understanding how information spreads in communities. However, CIT takes a socio-ecological approach, recognizing various levels of communication simultaneously rather than focusing on one level of communication. Most studies using the model of stigma communication only examines one level of communication (e.g., interpersonal communication). Therefore, CIT will be used along with the model stigma of communication in order to expand the model of stigma communication to examine how stigma messages surrounding mental health problems are transmitted in communities.

This approach requires the researcher to examine various levels of influence specific to a community, and this dissertation project will use this approach to understand how stigmas

surrounding mental illness in men are spread and learned in a rural community on various levels. By understanding the multiple influences on people's perceptions of mental health and seeking help for mental health, a multi-level intervention can be designed to address mental health stigmas in rural communities. This will be done by integrating the model of stigma communication and communication infrastructure theory.

2.4 Communication Infrastructure Theory

CIT, a social-ecological theory, is built upon the assumptions of media system dependency theory (MSD) (Ball-Rokeach, 1985), which suggests that people use media resources to make sense of who they are, to make sense of the world around them, to know how to behave correctly in social situations, to make personal decisions, and to seek entertainment (Ball-Rokeach & Defleur, 1976; Ball-Rokeach & Jung, 2009; Whaley & Tucker, 2004). MSD assumes that people will depend on certain media to fulfill specific needs, and people rely on some forms of media more than others. The level of media dependence depends on the level of social stability. When social instability is experienced, people are forced to reevaluate their choices and belief systems, often increasing reliance on the media to meet various needs (DeFleur & Ball-Rokeach, 1989). This theory recognizes the micro-dynamics of communication at various levels, and eventually Ball-Rokeach broadened beyond a media systems approach to examining the ecology of the city (Friedland, 2018). While CIT has roots in MSD theory, CIT takes a less media-centric approach (Ball-Rokeach & Jung, 2009). The evolution of MSD theory to CIT was essentially moving away from a mass media effects theory to a "theory of communication effects where media become part of a larger storytelling system" (Ball-Rokeach & Jung, 2009, p. 17).

Communication infrastructure theory has been developed and refined through Ball-Rokeach's Metamorphosis project, which was created to address concerns surrounding civic engagement and how changing media systems affect democracy (Friedland, 2018). Ball-Rokeach et al. (2001) conceptualize a communication infrastructure as a storytelling system set in its communication action context (CAC). Storytelling systems are comprised of macro-, meso-, and micro- levels of storytelling agents (described below). These agents are not only distinguished by their size but also by main storytelling agents and the imagined audience at each level (Ball-Rokeach et al., 2001). These levels of storytelling agents are interdependent, and "storytelling at one level affects storytelling at other levels" (Ball-Rokeach et al., 2001, p. 398). CIT essentially extends the ecological focus on relationships found in MSD theory by exploring the strength of the relationships between multi-level actors with one another (Ball-Rokeach & Jung, 2009). Recognizing this interdependence may be beneficial in understanding how stigma of mental illness in men is communicated and at various levels in a storytelling system.

Macro-level agents are in the form of mass media, political institutions, religious institutions, and other central institutions that can produce storytelling and have the resources to disseminate information to mass audiences (Ball-Rokeach et al., 2001). Macro-level agents disseminate stories that impact broad populations such as cities, nations, and international regions in which the imagined audience is broadly defined by a region (Ball-Rokeach et al., 2001). The meso-level includes smaller, locally based organizations and community media that specifically serve residents of a particular area (Rokeach et al., 2001). Messaging on this level is typically more focused on a particular part of a population, often targeting specific ethnic groups, class groups, gender groups, and other lifestyle groups in a community (Ball-Rokeach et al., 2001). Meso-level storytelling provides a crucial link between macro- and micro-level

storytelling (Ball-Rokeach et al., 2001). The micro-level includes interpersonal networks such as friends and family. While this level is smaller in nature, micro-level agents, or interpersonal networks, are the most prevalent source of storytelling in specific communities (Ball-Rokeach et al., 2001).

A neighborhood storytelling network (STN) is a triangulated, multi-level network comprised of community members, local media/geo-ethnic media, and community organizations that are local storytellers who can highlight and sometimes offer locally based resources that help members of the community achieve their goals and overcome barriers (Literat & Chen, 2013; Wilkin et al., 2011). Integrated connections to the STN is positively correlated with civic engagement; specifically, community cohesiveness, feelings of collective efficacy, and participation in civic activities (Ball-Rokeach et al., 2001; Kim & Ball-Rokeach, 2006; Wilkin et al., 2011). The link between storytelling actors can be strengthened or even repaired by interstitial actors, who can potentially bridge the gap between micro- and meso-level agents, resulting in a more integrated STN (Matsaganis & Golden, 2014). Interstitial actors are often useful for health interventions and can act as agents of health storytelling.

While the STN can be used as a device to disseminate health information (Abril et al., 2015), the level to which people receive the information and health goals can be attained is related to the communication action context. The CAC includes the physical, psychological, sociocultural, economic, and technological features of a geographical area that facilitates or hinders communicative action (Ball-Rokeach et al., 2001; Literat & Chen, 2013). Physical features can include physical infrastructure and places that bring people together such as community centers, parks, and religious buildings such as churches. Psychological features involve whether people feel comfortable enough to engage with one another or if they are fearful

of interactions. Sociocultural features include inclinations of individualism and collectivism based on similarities in class, ethnicity, and culture (Ball-Rokeach et al., 2001). Economic features refer to the availability of time and resources to engage in day-to-day interactions and conversations. Technological features involve access or lack of access to technology.

The CAC varies on the level of openness or closedness in which an open context encourages people to engage in communication with one another and a closed context discourages engagement (Ball-Rokeach et al., 2001). Availability of safe meeting locations, work conditions, ethnic and linguistic diversity among residents, access to transportation, and physical and technological infrastructure are all elements that may enable or hinder connections to the STN (Wilkin et al., 2011). To account for potential barriers and to increase the success of outreach efforts, identifying comfort zones and communication hot spots is encouraged (Ball-Rokeach et al., 2010; Wilkin et al., 2011). Comfort zones are businesses and community institutions that residents are comfortable with and feel closely connected to (i.e., they represent a combination of positive psychological and physical CAC features). Communication hot spots are places where community members tend to gather and engage with one another in conversation. When the CAC facilitates a strong STN, positive health outcomes can be experienced at the individual and community level (Ball-Rokeach et al., 2010; Moran et al., 2016).

The more integrated an individual is in their STN, the more likely they are to have communicative social capital, which aids in connecting the individual to local resources and services built through everyday communication (Matsaganis & Wilkin, 2015). In a community with a great deal of social capital, people are more likely to be able to rely on others for support, whereas communities lacking social capital cannot provide the same sort of support or resources,

often resulting in negative health outcomes (Matsaganis & Wilkin, 2015). Communicative social capital is also related to collective efficacy in that these social connections can lead to community mobilization, which can address barriers to health and reduce disparities (Matsaganis & Wilkin, 2015). People who are better connected in their community tend to be more likely to feel that they can count on their neighbors to address common problems in the community (Ball-Rokeach et al., 2001; Matsaganis & Wilkin, 2015; Wilkin et al., 2015). Belonging, collective efficacy, and civic participation all contribute to civic engagement in a community, which tends to lead to more integration in the storytelling network (Kim & Ball-Rokeach, 2006). Essentially, a person's civic engagement is contingent upon their connections to a strong STN with an open and conducive CAC (Kim & Ball-Rokeach, 2006). And, this interplay between the STN and CAC leads to what Matsaganis and Golden (2015) refer to as the "field of health action".

The field of health action is "the sociomaterial context that comprises of a place-specific set of structural conditions and interpretive resources, within which residents may be more or less inclined to seek particular health-care services and respond favorably to a health-promotion intervention" (Matsaganis & Golden p. 168). Put simply, field of health action includes elements of the CAC, such as physical locale and availability of health-related resources, as well as the meaning people in the community attach to these elements (Matsaganis & Golden, 2015). By understanding the field of health action in a community, researchers and practitioners interested in designing health interventions can identify factors that constrain or enable healthcare seeking behaviors.

2.5 CIT and Health Intervention Research

Communication infrastructure theory can be quite useful in designing interventions that target health disparities, which can often occur in "hard-to-reach" populations. These populations

often do not readily benefit from community-based providers, potentially due to a communication disconnect between individuals and community organizations (Matsaganis et al., 2014). CIT allows for developing interventions that take place on a community level, often providing connections to resources that are available on the local level (Matsaganis et al., 2014). Disadvantaged communities experiencing disparities often experience unique community-level barriers that exacerbate negative health outcomes and disparities. CIT acknowledges these potential barriers as well as untapped community resources, presenting a theoretical approach to developing effective interventions in these disadvantaged communities (Harrington, 2013).

For instance, Matsaganis et al. (2014) used CIT to develop an intervention to address reproductive health disparities in African American women in a small city, specifically targeting communication between residents and community-based organizations. Over the course of several years, the theory was used to implement an intervention that addressed the communication gap between micro- (individuals) and meso-level (community-based organizations) actors. By bridging this communication gap, the goal was to bring together underserved African American women with community-based organizations that could offer these women locally available resources and reproductive health services (Matsaganis et al., 2014). In this particular intervention, this goal was achieved as after four years, utilization of community resources and reproductive health services among the African American women's population increased by 25% (Matsaganis et al., 2014). In a different paper based on the same intervention project, Matsaganis and Golden (2015) also explored how the field of health action hindered or enabled reproductive health-seeking behaviors, posing challenges to the community-based reproductive health intervention. These challenges included lack of availability of reproductive healthcare services, no access to transportation and/or limited access to public

transportation, lack of geo-ethnic media sources providing information on reproductive health, and concerns surrounding privacy and seeking services and/or information for reproductive health. Reproductive health is often a taboo health topic, and even being seen in a setting that provides services for health issues that are socially stigmatized can make a person feel that their privacy has been compromised (Golden, 2014; Matsaganis & Golden, 2015). This is something to consider when implementing intervention programs for stigmatized health conditions in small communities.

This particular intervention study (Matsaganis et al., 2014; Matsaganis & Golden, 2015) is a good example of how CIT can be used to design and implement health communication intervention programs in underserved populations. However, other studies using CIT can also inform the design and implementation of health interventions. For instance, Wilkin, Katz et al. (2015) used CIT to explore strategies to address obesity among African American and Latino residents in an urban neighborhood. Specifically, the study examined how connections to communication resources in the neighborhood and communication with family members can affect exercise habits and eating behaviors. This health issue and population were chosen because U.S. Latinos and African Americans are at a disproportionately high risk for obesity and health conditions associated with obesity such as diabetes, hypertension, and heart disease (Wilkin, Katz et al., 2015). Connections to the STN were positively related to levels of exercise but not significantly related to the consumption of fruit and vegetables (Wilkin, Katz et al., 2015). While familial connections are typically considered micro-level actors, they were not included in the measurement used for the STN in this study that focused on interpersonal storytelling about the neighborhood. In this study, family interaction was not only positively related to exercise levels but also to fruit and vegetable intake, which suggests that family

members likely help one another overcome barriers to access to healthy foods and that familial influence on healthy attitudes and behaviors can be quite effective. Family connections can provide potential opportunities to share community resources and connect individuals to neighbors, local/ethnic media, and community organizations that would not have been encountered otherwise (Wilkin, Katz et al. 2015). Familial, micro-level connections may be especially useful in designing and implementing health interventions that target populations disproportionately affected by a particular health issue. Another study that demonstrates how research using CIT can inform on intervention design and strategy is by Wilkin, Gonzalez et al. (2015), in which meso-level storytelling is examined.

Wilkin, Gonzalez et al. (2015) examined how ethnic media can be used for health storytelling in communities where health disparities are prevalent. Based on a study that showed that macro-level agents (e.g., Spanish-language television) can play a significant role in health storytelling for newer immigrant Latinos in predominantly Latino communities (Wilkin & Ball-Rokeach, 2006), Wilkin, Gonzalez et al. (2015) examined health storytelling through Spanish-language television, arguing that these outlets may make a difference in reducing health disparities in these communities when they highlight health issues. However, pan-ethnic media do not necessarily connect viewers with local resources (Lin & Song, 2006), and may not put people in contact with health organizations and additional health resources, which was demonstrated in Wilkin, Gonzalez et al.'s (2015) study. Macro-level ethnic storytellers have limitations and are only one component of a storytelling network (Wilkin, Gonzalez et al., 2015), but they can be useful for disseminating specific health information that can address health disparities within their target audience.

2.5.1 Hard-to-reach Populations

Wilkin et al. (2011) have demonstrated that CIT offers a theoretical approach to understanding how to best reach an audience with health information. This can be quite useful in aiding scholars with identifying ways to find and reach “hard-to-reach” populations as these populations are often those disproportionately affected by health disparities. This is especially useful in designing intervention research strategies that target populations that disproportionately experience certain health issues. Wilkin et al. (2011) recognize that a community’s STN may not be well integrated if there are weak or missing links between storytellers, which can occur on various levels in the STN. Additionally, because research has shown that individuals who are more integrated into the STN have higher the levels of civic engagement, this implies that those who are less integrated into the STN are likely to be less civically engaged. Some individuals are simply less connected to the STN than others. These “hard-to-reach” populations are really best described in terms of their lack of connections to the STN, and typically rely on isolated storytellers in interpersonal networks (family and friends) rather than campaigns, media, and community organizations (Wilkin et al., 2011). By using CIT to engage in a community outreach strategy, researchers are engaging in diagnosing a community’s communication infrastructure, which means identifying specific storytellers that people rely on for achieving goals in everyday living and isolating elements in the communication action context that enable storytelling (Wilkin et al., 2011). Wilkin et al. (2011) engaged in creating a community outreach strategy to raise awareness for the 9-1-1 Project by including both the STN and two specific elements of a communication action context in the Atlanta area—comfort zones and communication hot spots.

Through this study, CIT was demonstrated to be a useful and cost-effective approach to reaching populations that are typically difficult to reach in health research (Wilkin et al., 2011).

The authors also emphasized that CIT may be useful in creating and strengthening connections between storytellers, and that discursive spaces (hot spots and comfort zones) must also be considered in future projects using CIT. These spaces are often great for bringing community members together, but attention must be paid to potential barriers community members may face when trying to get to or access these spaces. This study by Wilkin et al. (2011) specifically showed that the whole communication infrastructure must be considered, not just the neighborhood storytelling network.

More recently, communication asset mapping (CAM) has been introduced as a technique to use when diagnosing a communication infrastructure and can be quite useful in identifying community comfort zones and hot spots. CAM is a methodology that “leverages residents’ knowledge of their communities to identify communication resources within a specific geography” (Estrada et al., 2018, p. 775). The CAM approach is used to map local spaces and assess their ability to serve as local storytellers and was developed specifically to identify existing communication strengths and use those strengths as a means to build healthy communities (Villanueva et al., 2016). This technique can map out a fuller picture of the communication ecology by providing a guide to communication resources in which individuals can access health information and where organizations can have a better idea of the most appropriate and effective places to disseminate health information (Estrada et al., 2018; Villanueva et al., 2016). CAM seems most promising applied to participatory and community-based research, as this method solicits various perspectives on communication assets from many stakeholders in the community (Villanueva et al., 2016).

2.5.2 Storytelling and Health Outcomes

Research has shown that integration into the storytelling network is associated with health knowledge, attitudes toward health-related topics, and health behaviors (Wilkin, 2013; Wilkin et al., 2018). Examining storytelling and health outcomes can also aid in informing on designing and implementing health interventions that are effective and sustainable. A good example of this is Wilkin's (2013) study showed that the type of storytelling matters and may affect people's attitudes toward certain health issues. The degree to which people are personally impacted by the health issue along with the type of story being told appears to affect whether people have negative or positive attitudes toward specific health issues and health resources (Wilkin et al., 2018). The extent to which individuals are connected to their local STN can also impact health knowledge as those who are most connected tend to be more knowledgeable of various health issues (Wilkin et al., 2018). However, this does not seem to apply to stigmatized health issues as there was no significant difference between levels of connection to the STN and knowledge of stigmatized diseases; i.e., most tend to have less knowledge about stigmatized diseases (Wilkin et al., 2018; Wilkin, 2021).

Additionally, an integrated storytelling network can lead to problem recognition, which is the first step to solving a problem in a community and designing effective interventions (Kim, 2018; Kim & Ball-Rokeach, 2006). By connecting to a storytelling system, individuals in the community can get information about problems in the neighborhoods and where useful resources can be found (Kim, 2018; Kim & Ball-Rokeach, 2006). However, there should be a connector between problem recognition and problem-solving (Kim, 2018). While being integrated into an STN can lead to positive change and problem-solving, negative storytelling can also impact a community. Villanueva and Wenzel (2018) argue that negative storytelling can result in a lack of

positive spaces for public discourse and local democracy and that positive storytelling is needed in order to encourage discourse and civic engagement. More research is needed in this area to better understand how stigmatized health issues are discussed in communities and how information is shared that may perpetuate stigma surrounding particular health issues.

2.5.3 CIT and Stigma

Jung and Kwesell (2021) integrated CIT with stigma theory to examine storytelling surrounding nuclear disaster. The authors measured the perceived stigma of residents of Shinchimachi, Fukushima. In 2011, an earthquake and tsunami caused a nuclear disaster in Fukushima, Japan. This led to concerns about nuclear contamination of food and goods coming from this region. Specifically, this study examined the stigma of nuclear disaster and what stories were being told among Shinchimachi residents about Fukushima and the nuclear disaster. The focus was on negative stories about Fukushima and how these stories spread on a macro-level. The study also examined how residents perceived stigma of their home and coped with the stigma of Fukushima. Jung and Kwesell (2021) found that participation in community organizations can moderate negative relationships between stigma perception and future outlook (the ability to recover and community resilience). The authors suggested that interventions that utilize community organizations and storytelling networks are essential to help people overcome and reduce stigma in communities. While CIT is most often used to identify where messaging can be most effective in health communication interventions, this study is quite unique in that it examines how stigma messages in a communication ecology can be identified and countered.

This dissertation research will expand on this type of research by using CIT with the model of stigma communication, further refining the understanding of how stigma narratives spread in communities. Similar to Jung and Kwesell's (2021) research, this study will seek to

identify where the stigmas are mostly spread surrounding men with mental illness and where to target stigma communication intervention efforts that may reduce the impact of stigma communication. This dissertation research will also explore the transmission of stigma narratives in a rural area, which will not only expand upon stigma communication research, but will also expand upon CIT, which has mostly been used for intervention research in urban areas.

2.5.4 Rural Health and CIT

CIT has generally been used to examine urban communities and neighborhoods (Embry, 2019; Estrada et al., 2018; Literat & Chen, 2013), and though a few studies have been applied CIT to rural communities, more studies need to examine the uses of CIT in rural populations and intervention research. Rural communities are often “hard to reach” communities that face multiple health disparities, which makes CIT particularly useful in understanding and addressing health communication needs in rural areas. Embry (2019) and Estrada et al. (2018) argue that rural storytelling networks may look quite different than that of urban neighborhoods due to sociocultural and geography differences. For instance, an intervention study by Matsaganis et al. (2014) in a small community in upstate New York showed that local media were less important than interpersonal connections, and peer health advocates in the community were needed in order to bridge the gap between micro- and meso-agents and to strengthen the storytelling network. Using an ecological approach such as CIT often requires the researcher to identify characteristics in communities that create barriers or encourage specific health behaviors and attitudes. This is especially useful in identifying health inequities in a rural community and creating a strategy to address those inequities effectively.

For example, Savage et al. (2018) used CIT to investigate oral health beliefs among young adults in rural Appalachia in order to address oral health disparities in the Region. The

study set out to better understand how communication and socio-cultural factors affect oral health in the Appalachian Region by examining culturally embedded influences on oral health (Savage et al., 2018). The authors argued that this was an important step in creating meaningful health policies and effective intervention strategies. By conducting focus group interviews, the authors sought to learn what stories young adults tell about social-contextual factors of oral health and how those stories reveal potential challenges of the region's field of health action (FHA). Savage et al. (2018) conceptualize the FHA as the physical places healthcare is provided as well as the subjective meanings attached to these places. Through their study, Savage et al. (2018) were able to determine multiple physical and socio-cultural factors that influenced various oral health outcomes. They found that oral health was not just influenced by environmental factors but also by personal characteristics such as heritage, affect, and cultural patterns (Savage et al., 2018). Specifically, they were able to determine potential solutions that would positively affect the FHA for oral health. These potential solutions were family influence, oral health knowledge, considering the prevalence of tobacco use, addressing dental fear and fatalism, and improving upon oral health providers' communication skills.

Abril et al. (2015) also used CIT to address a rural population, specifically cervical cancer screening needs in a rural Senegalese community. Though cervical cancer is the leading cause of women's cancer deaths in the country, cervical cancer screening practices are not common as few medical personnel are trained on how to perform a screening (Abril et al., 2015). The study mapped out the community's communication infrastructure, using CIT to assess health and cancer screening knowledge and detect barriers to cervical cancer screening practices. This study explored how familial communication affects health beliefs as West African women tend to rely mostly on mothers and other female relatives for information on reproductive and sexual

health (Abril et al., 2015). Unfortunately, this information is often surrounded in myth and misinformation, which can result in negative perceptions of contraception and family planning. Familial health communication can greatly impact health beliefs (Wilkin, Katz et al., 2015), and in this case can negatively impact health outcomes among rural Senegalese women. This study specifically pointed out the importance of including ethnic/local stakeholders in the STN, showing that collaborative led screenings resulted in awareness and increased knowledge about cervical cancer. The local connections that already existed in the community, such as community leaders and community radio programming, were useful in promoting cervical cancer screenings and increasing knowledge.

Estrada et al. (2018) and Embry (2019) both conducted studies using CIT in rural settings with the goal reducing rural information inequality and health disparities by including communication asset mapping in the CIT framework. Estrada et al. (2018) developed a communication asset map for a rural, majority-Latino community located in California. The participatory health communication asset mapping process included partner engagement, resident engagement, data analysis, concept development, map production, and implementation (Estrada et al., 2018). By following these steps, the authors aided the community in developing a tool to increase the capacity of the storytelling network by identifying community comfort zones and communication hotspots within the communication action context. By doing this, the authors enabled organizations and other storytellers to connect people in the community to the storytelling network, which could potentially help organizations disseminate health information that addresses various health disparities within the rural community more effectively (Estrada et al., 2018).

Embry (2019) used CAM to map the communication infrastructure of a rural community in Arkansas. This study focused solely on interpersonal communication agents (micro-level) in the community. While the Embry (2019) focused on a rural setting, the study did not address any particular health communication process but rather mapped out the communication hotspots and comfort zones in the community, which all seemed to be place in which people mostly communicate interpersonally with one another. Embry (2019) and Estrada et al. (2018) show how CAM can be used to better understand the unique communication ecology and communication barriers in rural communities.

2.6 Rationale for Dissertation Study

The long-term goal of this dissertation research is for this work to contribute to our understanding in and aid in the development of community-level suicide intervention programs, which could ultimately reduce suicide the suicide disparity of men in rural areas. This dissertation study provides foundational knowledge for what will eventually be an empirically based intervention program rooted in communication infrastructure theory and the model of stigma communication. The goal of this study is to conduct the initial formative research that will provide the groundwork for an intervention. This study will attempt to understand the nature of mental health storytelling in a rural, Appalachian county and specifically seek to understand stigma communication related to men's mental health and support seeking and treatment behaviors. This preliminary research will inform the next phases of intervention development by illuminating *what* stigma narratives exist in the storytelling network surrounding men's mental health and support seeking, *where* these stigma narratives are encountered in the storytelling network, and *who* in the community is sharing these narratives. Understanding each of these elements can potentially give insight into what specific stigma narratives will need to be changed

in the community, whether stigma messages are reinforced or challenged by storytellers on various levels of the storytelling network, where the best intervention efforts should be targeted, and who in the community may be effective in changing attitudes toward mental health issues in men.

Because interventions can often take many years to fully develop and implement (Gitlin & Czaja, 2016), this dissertation will only address the pre-phase step of the Development phase in the intervention pipeline, meaning that this is an exploratory study in which collected data will inform the design and implementation of a stigma communication intervention down the line. Formative research is essential for designing and implementing effective intervention programs (Fleury & Sourya, 2012; Gitlin & Czaja, 2016). This dissertation research will provide the foundational understanding for developing a sustainable and effective mental health stigma intervention in the future (see Figure 1).

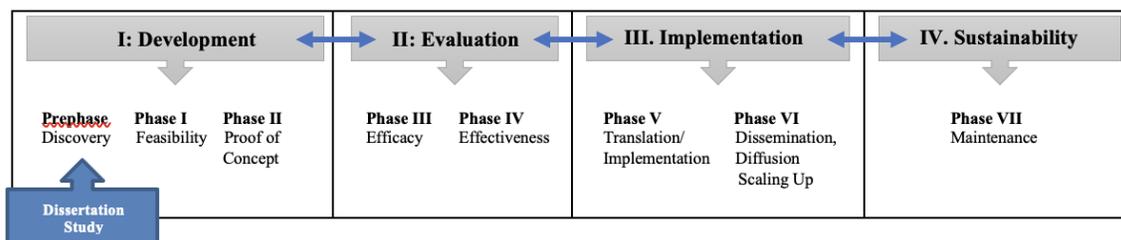


Figure 1. Study Phase Plan

2.6.1 Theoretical Contribution

This dissertation will further scholarship on mental health stigma by using elements from the model of stigma communication (Smith, 2007) and communication infrastructure theory (Ball-Rokeach et al., 2006). Stigma is a social process that often involves storytelling, and by using both theories to inform this research, this study will explore how mental health stigma

storytelling occurs throughout a rural community's communication infrastructure and where stigma storytelling tends to take place within *the* communication infrastructure.

For the purposes of this research, storytelling is understood through the lens of communication infrastructure theory. Storytelling in this context is more broadly understood as the messages surrounding a topic that occur at various levels of communication that contribute to a person's understanding or perception of that topic (Ball-Rokeach et al., 2001). Research has shown that individuals' connections to an integrated storytelling network is associated with increased knowledge of some health issues, attitudes toward health issues, and some health behaviors, but more research is needed to understand the types of health storytelling that are taking place and how those stories influence health outcomes (Kim et al., 2011; Wilkin, 2013). This study will contribute to this area of study.

This dissertation study will contribute to research on the model of stigma communication by exploring stigma message transmission on various levels (micro-, meso-, and macro-levels). Previous research on the model of stigma communication has primarily focused on the micro-level and has used hypothetical diseases within experimental contexts. This study offers an opportunity to examine stigma communication as it exists and is shared within real populations. This will also provide an opportunity to explore how the model of stigma communication can be used to design and implement stigma communication interventions.

Additionally, this study will contribute to stigma theory in general by introducing the concept of *stigma storytelling*. For the purpose of this study, *stigma storytelling* is defined as the multi-level transmission of stigma messages in a community. This concept has been derived from how stigma and storytelling are conceptualized in the model of stigma communication and

communication infrastructure theory. This research will expand the concept by introducing the model of stigma storytelling in Chapter 5.

2.7 Research Questions

The following research questions were answered through interviews and were informed by the model of stigma communication and communication infrastructure theory:

*Informed by Model of Stigma Communication

**Informed by Communication Infrastructure Theory

***Informed by Model of Stigma Communication and Communication Infrastructure Theory

RQ1: How is the storytelling system structured in Rabun County? **

RQ1a: What are the features of the storytelling system in Rabun County? **

RQ2: What types of stories are being told around men's mental health and treatment options? **

RQ3: What stigma message choices (e.g., dangerous, responsibility, etc.) are prevalent in rural communities about mental illness in men? *

RQ4: Which stigma message reactions (e.g., disgust, fear, etc.) are most frequently encountered after exposure to stigma messages? ***

RQ5: Where in the communication infrastructure are stigma messages about men with mental illness encountered? ***

RQ6: Who in the community is engaging in stigma storytelling (sharing of stigma messages with the network)? ***

RQ7: Which storytellers are identified as being influential in the development of mental health stigma beliefs? **

RQ8: Where in the storytelling network do people encounter messages that challenge stigma narratives?***

RQ9: How do stigma beliefs about men's mental health influence men's willingness to seek help (e.g., professional treatment and/or support from interpersonal connections)?****

RQ10: How do stigma beliefs about men's mental health influence others' perceptions of men seeking support for their mental health?****

3 METHOD

This section details the methods and procedures that was used to collect data for this dissertation research. Included are the research design overview, study procedures, participant recruitment, discussion of interview guides, and the analysis of data.

3.1 Research Design Overview

Intervention research relies heavily on experimental and survey research, but intervention designs often include qualitative components. The progression of intervention research often starts with qualitative research and progresses to using quantitative methods as researchers move through each phase of the intervention pipeline (Morrison-Beedy & Melynk, 2012). Formative research is imperative to design an effective and well received community intervention (Ayala et al., 2011). This dissertation research is in the earliest phase of formative research for the development of a stigma communication intervention for a rural community. Therefore, semi-structured interviews lasting approximately one hour was the methodology used in this dissertation study.

Informed by the model of stigma communication and communication infrastructure theory, in-depth semi-structured interviews were conducted with people living in rural

Appalachia, specifically Rabun County, Georgia. Rabun County was selected for this study because it is classified as rural by the criteria set forth by the USDA Atlas of Rural and Small-Town America and The Federal Office of Rural Health (FORH), and because Rabun County is in a high suicide rate cluster in the Southeast and in Appalachia (Steelesmith et al., 2019). Semi-structured interviews typically use an interview guide with questions the interviewer plans to ask, but the interviewer may probe further on certain topics with the participant, providing some structure and some flexibility in the interview process (Ayala et al., 2011). This methodological approach was used to better understand *where* stigma messages are encountered and transmitted within the community's communication infrastructure. Using the stigma communication model as a guide provided more insight into what stigma messages are present in the community, reactions to these messages, and whether these messages possibly impact perceptions of seeking help and help-seeking behaviors of men with mental health issues. Communication infrastructure theory also provided insight into *where* stigma storytelling tends to take place in the community, allowing researchers to more accurately target interventions in the community. Ultimately, the data collected was used to develop intervention strategies and will also be used to develop future studies down the intervention pipeline. The data will also be used to develop and eventually test the model of stigma storytelling (see Appendix E) in future studies.

3.2 Population Sample and Recruitment

Rabun County, Georgia, is considered a rural community located within Appalachia. There are roughly 13,500 people over the age of 18 (Census.gov, 2019), which was the target population for this study. Minors were not eligible to participate in this study. The perspectives of minors' views on men's mental health would be helpful in learning how and what children are learning about mental health and gender, providing additional insight into stigma message

transmission. However, this would be best investigated as a separate study that examines how stigma messages socialize children to view mental illness and whether children tend to share these stigma messages in their social groups. Because children and adolescents are still being socialized and have less agency in participating within the communication infrastructure, this population will not be included in this study and will be investigated in future studies for this intervention.

Snowball sampling was used to find participants as this method of sampling is useful when participants can be difficult to recruit or find in a community (Ghaljaie et al., 2017). Additionally, this type of sampling method provides the opportunity to continue sampling in the population until data saturation is complete (Ghaljaie et al., 2017). Initially, the author reached out via email to local leaders such as local clergy, people working at local medical centers, government employees, and local business owners to recruit participants. In the email, they were asked to participate using an IRB approved recruitment message and provided an informational recruitment flyer, which included a link to the study website (see Appendix D). Because community members working in these organizations were likely to be prominent community leaders and potential interstitial actors, meaning that they connect micro- and meso- level actors, their perspectives would be valuable for this study as they were more than likely well connected to the community. Once contact was established, the author asked these initial contacts/participants to share her contact information along with the recruitment flyer with their friends, family, or members of their community who may also be interested in participating in the study. They were asked not to recommend the study to more than two people.

Fourteen people who identified as male and ten people who identified as female were recruited for this study. Inclusion criteria were that participants must be part of the Rabun

County community and over the age of 18. Study participation was incentivized by offering a \$25 Amazon gift card to those who participated. Having a total of 12 to 15 respondents is considered an appropriate interview sample size (Lindlof & Taylor, 2011); however, this study sought to understand community stigmas and men's mental help-seeking behaviors. Interview responses were expected to potentially be different between those who identify as male and those who do not. Interviews stopped once data saturation was considered as achieved, which is defined as when new data are redundant of data previously collected (Saunders et al. 2018).

3.3 Procedure

Upon approval of the study by Georgia State University IRB, interview participants were recruited as described above. Respondents had the option to complete interviews through teleconferencing or a phone call. Prior to each interview, participants were emailed an informed consent form (see Appendix A) to their preferred email address, which included consenting to an audio recording of the interview. Because interviews were remote, oral consent was obtained instead of signatures on the consent forms. Respondents were assigned alternate IDs to be used in data analysis and reporting of research findings to ensure confidentiality and privacy.

Though one hour was allotted for each interview, on average, interviews were 43 minutes. Participants were told that they could skip questions or stop the interview at any time. Upon completing the interview, each participant was given a link to the study website, which included mental health resources and information on men's mental health. Each participant was also given an \$25 Amazon e-gift card upon completion of their interview.

The author attempted to establish a rapport with interview participants by sharing her own background as someone originally from rural Georgia. Due to the author's positionality, she is well acquainted with Southern, rural culture, and acutely aware of mental health stigmas

surrounding men specific to Southern, rural communities. Participants were encouraged to find a private place to complete their interviews so they could be as open and candid in interviews as possible. This was encouraged in the email with the consent form and again prior to the start of the interview. Participants were reassured that the interviewer would be placed in a private room during the entirety of the interview. Interviews were conducted via telephone or teleconference in the interest of safety due to COVID-19. With over 97 percent of Rabun County having access to broadband internet (Georgia Internet Coverage, 2021), the capability to meet via teleconference was not anticipated to be a problem.

3.4 Interview Guide

Interviews are often used to verify, validate, or give perspective on information obtained from other sources (Lindlof & Taylor, 2010). This study used semi-structured interviews to better understand what stigma narratives exist in the community and where in the community's communication infrastructure these stigma narratives are encountered and passed on to others in the community. Interviews also assessed who the main storytellers, or sources of stigma, are in the communication network.

Aspects essential to successful interviews are using a guide or script, providing the participant with an open and safe environment, and actively listening to participants (Lindlof & Taylor, 2010). An interview guide (see Appendix B) was used to aid in keeping interviews somewhat structured yet flexible enough to let conversation flow naturally.

The interview questions, which address topics such as stigma narratives, stigma reactions, and the community's communication infrastructure, were designed to inform the research questions (See Table 1). Questions were intended to assess which stigma narratives surrounding men with mental health issues exist in the rural community, where in the communication

infrastructure stigma messages are encountered, how stigma messages have influenced perceptions of mental illness in others and in themselves, how stigma messages impact seeking support, and how stigma messages impact perceptions of access to supportive services in the community. Results from these interviews will inform future research down the intervention pipeline on stigma, specifically perceptions of access to mental health services/resources and specific stigma narratives that exist in the community.

Demographic items were included in interview questions, specifically gender, age, race/ethnicity, religious affiliation, and education. Personal experience with mental health issues was also included, specifically if participants have had personal experience with mental health problems or if they know someone with mental health problems. Participants were also asked about perceptions of men seeking help for their mental health. Those who identified as male were also asked if they had ever sought help for their mental health.

Table 1. Interview Guide Questions that Apply to Each Research Question

Research Question	Interview Guide Questions
<p>RQ1: How is the storytelling system structured in Rabun County? RQ1a: What are the features of the storytelling system in Rabun County?</p>	<p>1. To begin, can you tell me a little about yourself and your community?</p> <ul style="list-style-type: none"> • Sample probe: How long have you and your family lived here? • Sample probe: What do you do for a living? <p>3. What types of stories do you hear about men who are experiencing mental health problems?</p> <ul style="list-style-type: none"> • Sample probe: Where have you heard these stories? The movies? The news? Family or friends? <p>8. Who in your community has ever mentioned something negative about mental illness? This could be anyone from a parent to a sibling to a friend to a community or religious leader.</p>

	<ul style="list-style-type: none"> • Sample probe: Have they ever mentioned anything specific about men and mental health? If so, do you mind telling me? • Sample probe: What do you think the people around you think about men who are depressed or are in therapy? Why? <p>9. Have you encountered any messages about men’s mental health that you consider to be more positive? Messages that might encourage seeking help or support for mental health? If so, where?</p> <ul style="list-style-type: none"> • Sample probe: Are there any kind of media sources you can think of? • Sample probe: What about a community leader or people you know well? • Sample probe: What about messages that encourage seeking help or support? Do you hear these types of messages? If so, where?
<p>RQ2: What types of stories are being told around men’s mental health and treatment options?</p>	<p>2. What do you think about men who have mental health problems?</p> <ul style="list-style-type: none"> • Sample probe: What are some phrases or terms that come to mind when you hear “mental illness” or “mental health”? • Sample probe: Where do you think these associations have come from? • Sample probe: Who do you think has had the most influence on these thoughts? <p>3. What types of stories do you hear about men who are experiencing mental health problems?</p> <ul style="list-style-type: none"> • Sample probe: Where have you heard these stories? The movies? The news? Family or friends? <p>4. What specific stereotypes have you come across about men who are mentally ill or have conditions such as depression?</p> <ul style="list-style-type: none"> • Sample probe: What stereotypes have you heard from others in your community about men who have mental health problems? • Sample probe: What stereotypes have you heard from others in your community about men with depression?

	<ul style="list-style-type: none"> • Sample probe: Have you come across any other negative stereotypes from other sources such as your church or the media?
<p>RQ3: What stigma message choices (e.g., dangerous, responsibility, etc.) are prevalent in rural communities about mental illness in men?</p>	<p>2. What do you think about men who have mental health problems?</p> <ul style="list-style-type: none"> • Sample probe: What are some phrases or terms that come to mind when you hear “mental illness” or “mental health”? • Sample probe: Where do you think these associations have come from? • Sample probe: Who do you think has had the most influence on these thoughts? <p>4. What specific stereotypes have you come across about men who are mentally ill or have conditions such as depression?</p> <ul style="list-style-type: none"> • Sample probe: What stereotypes have you heard from others in your community about men who have mental health problems? • Sample probe: What stereotypes have you heard from others in your community about men with depression? • Sample probe: Have you come across any other stereotypes from other sources such as your church or the media?
<p>RQ4: Which stigma message reactions (e.g., disgust, fear, etc.) are most frequently encountered after exposure to stigma messages?</p>	<p>5. How do you think most people in your community would react if a man shared with them that he was depressed? What do you think the most common reaction to a man with depression would be?</p> <ul style="list-style-type: none"> • Sample probe: How do you think people would react if he cried? • Sample probe: How do you think people would react if a man shared that he was mentally ill? • Sample probe: How do you think people would react to a man they knew saying he was in therapy?
<p>RQ5: Where in the communication infrastructure are stigma messages about men with mental illness encountered?</p>	<p>3. What types of stories do you hear about men who are experiencing mental health problems?</p>

	<ul style="list-style-type: none"> • Sample probe: Where have you heard these stories? The movies? The news? Family or friends? <p>4. What specific stereotypes have you come across about men who are mentally ill or have conditions such as depression?</p> <ul style="list-style-type: none"> • Sample probe: What stereotypes have you heard from others in your community about men who have mental health problems? • Sample probe: What stereotypes have you heard from others in your community about men with depression? • Sample probe: Have you come across any stereotypes from other sources such as your church or the media? <p>7. Can you think of where you have you encountered stereotypes about men and depression (or men and mental illness)?</p> <ul style="list-style-type: none"> • Sample probe: Are there any kinds of media sources you can think of? • Sample probe: What about community leaders or people you know well? <p>8. Who in your community has ever mentioned something negative about mental illness? This could be anyone from a parent to a sibling to a friend to a community or religious leader.</p> <ul style="list-style-type: none"> • Sample probe: Have they ever mentioned anything specific about men and mental health? If so, do you mind telling me? • Sample probe: What do you think the people around you think about men who are depressed or are in therapy? Why?
<p>RQ6: Who in the community is engaging in stigma storytelling (sharing of stigma messages with the network)?</p>	<p>3. What types of stories do you hear about men who are experiencing mental health problems?</p> <ul style="list-style-type: none"> • Sample probe: Where have you heard these stories? The movies? The news? Family or friends?

	<p>8. Who in your community has ever mentioned something negative about mental illness? This could be anyone from a parent to a sibling to a friend to a community or religious leader.</p> <ul style="list-style-type: none"> • Sample probe: Have they ever mentioned anything specific about men and mental health? If so, do you mind telling me? • Sample probe: What do you think the people around you think about men who are depressed or are in therapy? Why?
<p>RQ7: Which storytellers are identified as influential in the development of individual’s mental health stigma beliefs?</p>	<p>6. Who do you think has been the most influential in forming your views surrounding mental illness, specifically men who have mental illness, for example, do you tend to listen more to your friends, your family (parents or siblings), your preacher (if you have one), the media, or someone else?</p> <ul style="list-style-type: none"> • Sample probe: Who in your community seems to be the most influential when it comes to the topic of mental illness and men? • Sample probe: Who in your community seems to be the most influential when it comes to the topic of men seeking help for depression? <p>8. Who in your community has ever mentioned something negative about mental illness? This could be anyone from a parent to a sibling to a friend to a community leader.</p> <ul style="list-style-type: none"> • Sample probe: Have they ever mentioned anything specific about men and mental health? If so, do you mind telling me? • Sample probe: What do you think the people around you think about men who are depressed or are in therapy? Why?
<p>RQ8: Where in the storytelling network do people encounter messages that challenge stigma narratives?</p>	<p>9. Have you encountered any messages about men’s mental health that you consider to be more positive? Messages that might encourage seeking help or support for mental health? If so, where?</p> <ul style="list-style-type: none"> • Sample probe: Are there any kind of media sources you can think of? • Sample probe: What about a community leader or people you know well?

	<ul style="list-style-type: none"> • Sample probe: What about messages that encourage seeking help or support? Do you hear these types of messages? If so, where?
<p>RQ9: How do stigma beliefs about men’s mental health influence men’s willingness to seek help (e.g., professional treatment and/or support from interpersonal connections)?</p>	<p>10. ONLY FOR MEN—If you were struggling with your mental health, would you seek help? Why or why not?</p> <p>Sample probe: Where would you start? Who would you go to?</p> <ul style="list-style-type: none"> • Sample probe: Would you worry about what people would think if they found out you were trying to get help for your mental health? Why or why not? • Sample probe (if yes): Would you be more comfortable with talking to your family or friends? If so, which family members or friends? • Sample probe (if yes): Would you be more comfortable seeking professional help such as therapy or seeing a psychiatrist? Why or why not? • Sample probe (if no): Would you be ashamed to seek help? Why? <p>12. What are your thoughts on therapy or other kinds of treatment for men’s mental health? Please explain your answers.</p> <ul style="list-style-type: none"> • Sample probe for men: Would you ever seek professional help for your mental health? Why or why not? • Sample probe for other genders: Would you encourage a male in your life to seek professional help for their mental health? Why or why not?
<p>RQ10: How do stigma beliefs about men’s mental health influence others’ perceptions of men seeking support for their mental health?</p>	<p>11. ONLY FOR PEOPLE WHO AREN’T MEN—What would you think if a man in your life told you he was struggling with his mental health? Would you encourage him to seek treatment or find help in some way? If so, in what way?</p> <ul style="list-style-type: none"> • Sample probe: What would you think if he told you he was in therapy or seeing a psychiatrist? • Sample probe: Would you think differently of him? Why or why not?

	<ul style="list-style-type: none"> • Sample probe: Would you want to be a part of his support system as he addressed his mental health problems? Why or why not? <p>12. What are your thoughts on therapy or other kinds of treatment for men’s mental health? Please explain your answers.</p> <ul style="list-style-type: none"> • Sample probe for men: Would you ever seek professional help for your mental health? Why or why not? • Sample probe for other genders: Would you encourage a male in your life to seek professional help for their mental health? Why or why not?
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3.5 Interview Data Analysis

Audio of the interviews was professionally transcribed using transcription software called MediaSpace. MediaSpace is a private online media service that provides transcription services. Each interview transcript was reviewed and edited as necessary for accuracy. Two data files were created, one for responses from those who do not identify as male and one for those who do. Once transcripts were finished and reviewed, the software NVivo was used to code and conduct thematic analysis of the data. A thematic analysis is a method of qualitative analysis in which themes within a dataset are identified, analyzed, organized, and described (Braun & Clark, 2006; Nowell et al., 2017).

Specifically, this study used the Framework Method to perform a thematic analysis on the data. The Framework Method is a highly systematic approach to categorizing and organizing qualitative data, and often uses a deductive *and* inductive approach to analyze data (Gale et al., 2013). This approach consists of several stages, which are transcription, familiarization with the interview, coding, developing an analytical framework, organizing or charting the data, and interpreting the data (Gale et al., 2013). Once interviews were transcribed and edited for

accuracy, the researcher read through each transcript to become further familiarized with the interview data. In this stage, notes were taken to begin the process of organizing information and identifying where to make changes to the codebook. Initially developed from the interview guide (deductive; see Appendix C), the codebook was updated as transcripts were read through the first time. The codebook was considered to be a living document in which new codes were added as they were observed in the initial review of the data (inductive). Once the codebook was complete, it was used to conduct an in-depth thematic analysis of the transcripts.

While not necessary for qualitative analysis, conducting intercoder reliability ensures coding is consistent and as reliable as possible given the method of analysis (O'Connor & Joffe, 2020). The author and an additional coder used the codebook to code over 10 percent (3 transcripts = 12.5 percent) of the data in order to perform intercoder reliability. Two transcripts from interviews with men and one with a woman were used for coding reliability. The additional coder was trained on the concepts in the codebook, specifically concepts associated with communication infrastructure theory and the model of stigma communication. Once trained, each coder used the codebook to code the transcripts separately and did not collaborate with one another during the process of coding. Once both coders were finished, a coding comparison query was run in NVivo to measure intercoder reliability. Intercoder reliability was measured using Kappa Coefficient and was relatively high ($\kappa = .91$), ensuring the reliability and accuracy of the coding scheme. No major discrepancies arose in the process of coding, but each discrepancy in coding was discussed among the coders to resolve minor discrepancies and reach an agreement on data analysis. The researcher then coded the rest of the interviews using the codebook. Once coding was finished, the data was further organized to identify which themes

answered research questions posed by this study and to identify additional observed themes that will inform future studies on this topic. Interpretation of the data is in the subsequent chapters.

This method of analysis is especially appropriate for large volumes of textual data given that one hour of an interview transcript can generate between 15 to 30 pages of textual data (Gale et al., 2013). Interviews typically lasted between 45 minutes to 90 minutes, and in total, 288 pages of transcribed interview content were analyzed and coded for this study. Complementary to the Framework Method, the trustworthiness criteria established by Nowell et al. (2017) was also used in the process of data analysis. The trustworthiness criteria include showing “data analysis has been conducted in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis in enough detail to enable the reader to determine whether the process is credible” (Nowell et al., 2017, p.1).

4 FINDINGS

This chapter provides an in-depth description of this study’s findings, providing supporting quotes from participants. Sections are organized by broad categories that address the research questions and explore additional findings. Themes are provided under each category with topics that expand on each theme. Additional quotes related to codebook themes are included in Appendix E. A total of 24 interviews were conducted with 14 males and 10 females. The majority were Christian (n=19) either nondenominational (n=10) or Baptist (n=7). Age ranged from 18-85, with a median age of 46. Most had at least some college education (n=22), and most identified as white (n=18). For additional demographic details please see Table 2. Table 3 provide information on participants’ experience with mental health.

Table 2. Demographic Data

Gender	Totals
Male	14
Female	10
Religious Affiliation	
Christian-Baptist	7
Christian-Catholic	2
Christian-Nondenominational	10
Animism	1
Agnostic	1
No affiliation/Did not specify	3
Age	
18-25	1
26-35	1
36-45	6
46-55	7
56-65	4
66-75	3
76-85	2
Education	
High school	2
Associate's	2
Bachelor's	10

Master's or higher	10
Race/Ethnicity	
White/Caucasian	18
Black/African American	3
Hispanic or Latino	2
Indigenous/Native	1
Occupation	
Healthcare worker	1
Social or community services/nonprofit	5
K-12 education system	5
Law enforcement	1
Marketing/PR	1
Tech/software development	1
Local business owner	3
Clergy	2
Retired	3
Manual Labor	1
Unemployed	1
Where From Originally	
Appalachia/Rabun County	9
From surrounding areas (Southern)	9
Transplant from other regions	6

Table 3. Mental Health Experience

Reported Knowing Someone with Mental Health Issues	
Male	14
Female	10
Reported Personally Experiencing Mental Health Issues	
Male	13
Female	2
Reported Experiencing Suicidal Ideation	
Male	4
Female	0
Reported Knowing Someone Who Has Died by Suicide	
Male	7
Female	3

4.1 Community Traits

To better inform the eventual intervention design for this study, each interview started with asking participants about their community and culture. This was to assess participants' perceptions of their community's openness toward supporting mental health initiatives and also to assess the storytelling system and communication infrastructure. One theme identified under the category of community traits is *cultural traits*. Additional topics related to this theme will be discussed.

4.1.1 Theme 1: Cultural Traits

This theme pertains to any comments made about the community culture or general cultural traits of people in the community. All participants (n=24) mentioned cultural traits of

their Appalachian community throughout the interviews. Some of these traits were considered to hinder or be conducive to support for mental health education and support for men in the community. Topics associated with cultural traits included *self-sufficiency*, *community oriented*, *isolated*, *perceptions of masculinity*, *religious/Christian*, *community subgroups*. Topics related to this theme will be revisited as they relate to research questions. They give insight into barriers to help-seeking behaviors and mental health education and knowledge surrounding mental health and men.

Self-sufficiency was mentioned frequently by participants (n=16) as common among people in their community. This term was specifically associated with not asking for help when help is needed. Resourcefulness, resiliency, and problem solving appeared to be highly valued. The concern for burdening neighbors with problems was also mentioned as unneighborly and uncomfortable. Participant 17-F highlighted this community trait in her interview,

“Most everybody wants to be self-sufficient right. So, um, in fact, most of the time they won't even call like a professional to do stuff. They'll just call a family member or somebody else. So, if you've got a tree falling on your property, then you just deal with it yourself. If you've got, um, you know, plumbing or electric is like, you just deal with it all yourself. You don't really call for help at all.”

While people may feel that community members try to be self-sufficient, participants (n=20) also frequently suggested that the area was *community oriented*. Several participants mentioned that the community was extremely supportive of one another, especially those that belonged to community groups (churches and clubs). Sharing one's deepest emotions was still considered somewhat taboo, but several participants felt that if someone in their specific community reached out for help, their community would be as supportive as they could be. This

sentiment was shared mostly by those who reported being involved and strongly connected to their community. Participant 8-F highlighted this in her interview,

“People are very helpful with any kind of need when there's anything that the community needs. Everyone really pulls towards helping no matter their age, relationship, religion, demographics, political views. It doesn't matter.”

Though many participants regarded community as very important, *isolation* was also discussed (n=16) as inherent to living in a rural county. While many reported being personally connected well to their community, most people mentioned that many people who live in Rabun County are isolated, living in more remote, hard-to-reach areas. Even those who have substantial friend or community groups reported sometimes feeling isolated due to how remote parts of the county are. For instance, Participant 4-M stated, “Sometimes you, you feel, uh, so isolated, you know.” Geographical isolation was not the only type of isolation mentioned by participants.

Those who referred to themselves as *transplants*, which are people who are not originally from Rabun County, reported feeling somewhat isolated simply because they sometimes did not feel welcome or accepted by *originals*, or people who are originally from Rabun County or surrounding Appalachian areas. Participant 18-M discussed this sentiment,

“I feel like it's my home, but it's, you can tell the difference between somebody like me and, and somebody that's been here for generations and, and how they know everybody and all that... it's hard to keep up with all the connections because it's a small town because people have been here for so long. It seems like everybody is cousins with everybody in some way, shape or form.”

Perceptions of masculinity also came up quite a bit (n=21) when discussing community traits, especially those specific to gendered roles. Most of the perceptions discussed were similar

if not the same as the perceptions of masculinity highlighted in the introduction detailing Appalachian and Southern ideals of masculinity. Many interviewees discussed how the role of a man is to be a provider for his family. Men are expected to be strong and not seen as weak.

Participant 9-M discussed some of his perceptions of masculinity,

“Uh, I think a men's role is, is that, you know, you need to get a job. Um, either I always say this is what was told to me from my parents is that either, you know, go to college or go to the military and defend your country. And if you get married, um, you, uh, take care of your wife. Uh, you take care of your kids, no matter what you have to do. If you gotta get two jobs, make ends meet, then make ends meet. And I guess I've learned from my dad.”

Many participants (n=22) also described the community as heavily *religious/Christian*. Many people interviewed considered themselves Christian and active in a church community. While religious communities were reported as somewhat varied, Christian communities were discussed as having the most prominence and sway in the community. The town was described by Participant 8-F as a “very, uh, Christian, Catholic, Methodist, Lutheran town”. Participant 20-M discussed how religious groups were often at odds with the medical community on the topic of mental health,

“There's a lot of churches out there. A lot of Christian people that don't even believe that a psychiatrist is an actual doctor.”

Subgroups such as transplants and originals were mentioned frequently (n=14) as each person felt they belonged to a specific subgroup. These classifications came up organically as each person described their perceptions of their community and where they felt they fit within their community. Each person identified whether they belonged to the transplant or original

classification, but some mentioned additional subgroups/communities in the county. Several people mentioned that there is a large Hispanic community in the county that is well-connected and supportive of one another. Participants also mentioned that among the originals, two subgroups existed: Old Appalachia and New Appalachia. People who belong to the Old Appalachia group tend to be hard to reach, isolated, and adhere to the “old ways”. Those in the New Appalachian subgroup are culturally and regionally Appalachian, but they have embraced modernity and technology. People belonging the New Appalachian group are also considered to be more connected and accessible to the rest of the community. Participant 7-M, who has lived in Appalachia his whole life shared valuable insights into these categorizations,

“And here in Rabun County, Georgia, we have a mixture of, uh, people. Uh, I think it's the best way to put it. We have Old Appalachians. Uh, they are, uh, anti-government uh, they prefer staying at home. They don't like outsiders....and the New (Appalachians) are, uh, usually related to the Old Appalachians, but they're people who do yoga on the side of the mountain. They like the internet. They'll shop at Walmart or Food Lion by Lowes. They often are, are better educated and, uh, they, uh, work to make change through the system. Then it's people that have moved here from other parts of the country, uh, from Connecticut, Massachusetts, New York, Rhode Island, they have moved here from California. A lot of them have, uh, moved to Florida upon retirement found it was too hot then they moved into the mountains of Northeast Georgia. They're called “half backers”. We have, uh, a good number of those here in the area or people that are just wanting to retreat from society itself. Uh, then the other part of the group that is here that make up a large part of it are, uh, the people that are the doctors, lawyers, uh, wealthy business, people from major cities around here who have, uh, weekend homes and summer homes.

So you have a lot of tourism here and people that are part-timers, some of those stay full time.”

4.2 RQ1: Communication Infrastructure and Storytelling System

Research Question 1 asked: *How is the storytelling system structured in Rabun County?*

Research Question 1a asked: *What are the features of the storytelling system in Rabun County?*

The research question was assessed by broadly asking participants to discuss their community and what they like and do not like about living in Rabun County.

4.2.1 Theme 1: Storytelling System

The storytelling system and communication infrastructure were assessed to better understand where people access information, spread information, and where a stigma communication intervention would be most effective. This theme referred to anything pertaining to the person’s connectedness to the communication infrastructure and the expression of reliance on parts of the communication infrastructure. Topics identified under this theme were *interpersonal networks, community organizations, and media.*

Throughout each interview, participants (n=24) mentioned their *interpersonal network* as an important source of information and connection. This category included familial connections and friends in the community. Participants reported (n=12) that many people in the community live near extended family members and consider family to be an incredibly important part of their network. Participant 16-F addressed this in her interview,

“A lot of the families that are here live on like communes. So, they all live in the same property. Um, you know, you’ll have like five or six houses on the same plot of land mm-hmm. Um, and so taking care of your family might include extended family, also, um, aunts, uncles, parents, children, grandchildren, that kind of thing.”

Many (n=20) also considered their peers in church groups and community clubs to be a vital part of their interpersonal network. Participant 8-F felt that due to the community being small, it was hard not to be connected to one another,

“Um, I mean, we do, we do share and we try to help, like I said, this is a pretty tight community, so no matter who's going through something we're all gonna find out.”

Community organizations were also regarded as important sources of information and connection. Many participants (n=9) belonged to a local church or community group such as the Rotary Club and Lion's Club, regarding these organizations as reliable sources of communication and knowledge on various community issues. Others belonged to music groups and soccer leagues (n=7), expressing that these groups helped them feel they belong and can connect with others in the community regularly. Many participants (n=12) expressed how vital these organizations were to the community's wellbeing, sharing various initiatives their organizations have been a part of. Participant 13-F mentioned several prominent community organizations in the community she is involved with,

“I do volunteer with the animal shelter. I do things with the historical [society], with the church, with the...Special Olympics, Boy Scouts, and um, a couple of other different things.”

Media were also mentioned (n=18) as sources of information and clearly a part of people's communication infrastructure, but the use of media appeared most often to serve the function of connecting with one's interpersonal network on social media, specifically Facebook, which Participant 17-M highlighted,

“It seems like everyone still uses community. They, they have these little community groups on Facebook. They use a lot of Facebook, um, some Instagram, um, but it looks

like they, they resort to Facebook a lot and they have community groups and they put community information out there.”

Most participants (n=21) regarded social media as a good source of information on various topics, but the sources of information were usually people they knew who were sharing memes or resharing posts about various topics, including mental health. Several participants (n=6) did not watch television and regarded news media as polarizing and stressful. Participant 20-M reported that he didn't “even watch the news in the United States anymore.” Local news was mostly accessed through word of mouth or the local newspaper, *The Clayton Tribune*.

4.2.2 Theme 2: Communication Action Context (CAC)

In communication infrastructure theory, the communication action context refers to features of a communication infrastructure that can enable or constrain communication between storytellers (Ball-Rokeach et al., 2001). It is vital in understanding where communication interventions are best implemented within the communication infrastructure (e.g., communication hotspots and community comfort zones). This theme referred to factors in the area that promote communication between residents and/or recognition of factors (or lack thereof) in the area that hinder communication between residents. While the researcher looked for CAC features that have been identified in previous research, the analysis remained open to unique features of this communication environment. Topics identified in the data were: *schools, safety, area appearance, resources for residents, goods and services, healthcare resources, social salience, culture, transportation, and work conditions*. The discussion of topics begins with factors considered to provide an open CAC, which are schools, safety, and area appearance. Factors considered to provide both an open and closed CAC are then discussed, which are resources for residents, goods and services, healthcare resources, social salience, and culture.

Lastly, factors considered to contribute to a closed CAC are discussed, which are transportation and work conditions.

Schools were mentioned favorably several times, and many participants (n=10) regarded the school system in Rabun County as very good. Rabun county has a small but thriving public school system along with several private schools. Participant 22-F felt that “It's [Rabun County] is a great place for kids to go to school.” Schools were also seen as locations where residents could get to know one another and form community, making them a potential community comfort zone and/or communication hotspot. In the intervention design, schools should be considered as a factor contributing to an open CAC.

Another factor contributing to an open CAC was *safety*, which was mentioned as a key positive trait of Rabun County. Many participants (n=19) felt that their community is incredibly safe and idyllic for raising families. Crime was considered low, and public spaces were considered safe. Participant 11-M discussed Rabun County’s low crime stating that Rabun County had “lower crime rates and things of that nature.” This feature was considered one of the most appealing aspects of Rabun County.

Another factor contributing to an open CAC was *area appearance*, which was discussed many times by participants (n=18) with each person expressing how beautiful Rabun County is. Participants reported enjoying the nature trails and hiking along with picturesque landscapes filled with mountains and lakes. Many felt that despite some of the challenges of isolation or having a hard time integrating, the beauty of the area made living there worth it. Participant 24-F mentioned her love of Rabun County’s beauty,

“I love Rabun County. I think that it is, I haven't traveled everywhere, but it's a very special place, you know? Um, it's one of the most beautiful places I've seen in the entire world.”

While schools, safety, and area appearance were highlighted by residents as positive aspects of the community, which would contribute to an open CAC, most of the factors discussed were not as straightforward. Residents highlighted positive and negative aspects of several CAC factors, specifically resources for residents, goods and services, healthcare resources, social salience, and culture. The way in which each of these topics was discussed hinted that they could be both a catalyst and hindrance to connection and communication within the community.

Several participants (n=18) mentioned *resources for residents*, focusing mostly on community services such as the health department, community websites, and the local food bank. Participant 19-F mentioned several of these resources,

“Locally in this county, um, there's lots of opportunities for people and there's lots of help out there for people. We have, um, the local health department. We have the Lion's Club, which sponsors the dental clinic, which helps low income, uh, people. Um, there's lots of things such as the Food Bank, uh, different food services. Um, there are, um, different vouchers that people can get that are, that if they're low income from City Hall, from an office that operates out of city hall out there. Um, just different opportunities for people to actually help them, you know, with things, if they're having a hard time.”

Community websites and social media accounts were mentioned several times (n=8) as great resources for residents who want to stay connected and in the know about what is happening in the county. However, participants also mentioned the lack of resources for those

living in low-income households, sharing that there are only so many services provided in the county for those struggling with poverty. Participant 20-M spoke to his own struggles with money, accessing resources, and the stress he feels from low wages. A quote from his interview illustrates his frustration,

“Um, trying to put food on the table, especially right now I have no time to do anything. And the stress that builds up is enough to destroy you. I mean, truthfully, sometimes I look at my own life and I think, I don't know how I'm gonna make it... the act of daily survival is slowly killing me.”

While some highlighted community resources not related to healthcare, most conversation around resources in the community were related to healthcare resources.

Healthcare resources were highlighted by every participant in this study. All felt that the county did not offer adequate access to healthcare resources, especially mental healthcare. Participant 10-M put it simply, “There are not enough mental health facilities available to people in Rabun County.” While the county provides some variety with primary care service providers, specialists are hard to come by, resulting in residents seeking care in neighboring areas. These neighboring areas can be quite far away as some participants reported seeking specialized care nearly two hours away on a regular basis. This issue was highlighted by Participant 14-F,

“If you need...a psychiatrist, you need to a psychologist, you need a Parkinson's doctor, you need anything, you have to go to Gainesville.”

According to Participant 1-F, the health department provides quite a bit of support to the community, including mental healthcare when in crisis; however, the department has a small staff and can only provide so much care to people. Several participants were not aware of any long-term counseling services available in the area.

Goods and services were mostly mentioned in the context of access to goods and cost of living in surrounding areas. According to several participants (n=16), the county thrives on tourism as it is located in the mountains with picturesque scenery; however, this has affected residents' ability to afford living in Rabun County. The cost of housing and the cost of living have sharply risen in the area, widening the wage gap and causing financial strain for permanent residents, which was raised by Participant 16-F who stated,

“There's such a stark divide between the wealthy and the poor, right. Um, middle class is actually probably the smallest population in Rabun County.”

Participants felt that they had somewhat adequate access to goods and services, but also mentioned that if a person lived farther out in the county or were living in poverty, they likely had limited access to most things. Internet access was also considered a challenge (n=6). Though access the broadband is high in Rabun County, the quality of the broadband service was not considered very good, especially in more remote areas. Participant 11-M discussed this in his interview,

“Rabun County, for all the wonderful things, it still has a shortage of high-speed internet. Um, you know, not the legacy definition of high speed as 25 megabytes per second.”

Considered part of the socio-cultural category of the original CAC research (Ball-Rokeach et al., 2001), *social salience* refers to the ability to move in and out of social groups in the community. One of the cultural traits of this community included the fragmentation of the community into subgroups. Some participants (n=12) felt that they could relate to and communicate well with people in the community, regardless of social status or whether they belonged to a particular group. However, others (n=8) reported feeling somewhat limited to the groups they belonged to or did not feel as if they were welcome in certain subgroups within the

community. Participant 16-F discussed in her interview how difficult it had been to integrate into the community even though she had been there for many years,

“Um, it's a very closed system. So, um, my partner was born and raised here, but in general, they're really not open to outsiders like me.”

Also a sociocultural feature, *culture* plays a pivotal role in whether the CAC is open or closed. Cultural traits have already been detailed in previous sections in this chapter, and some of these traits were directly related to whether people felt they could connect or could not connect with others in the community. Specifically, self-reliance and isolation were considered hinderances (n=9) to connecting with people in the community. Others (n=14) felt the emphasis on community in their culture enabled connection with others. For instance, Participant 8-F mentioned how connected the Hispanic community was through soccer leagues,

“I will say as far as connectivity, we have a very large Hispanic community here that plays soccer a lot. It's very active and that I have been able to connect with other people around the area because of activity in this community.”

The last two factors discussed are considered as hindrances to an open CAC.

Participants did not have positive feelings toward transportation and work conditions. Most felt that lack of transportation was the reason many people could not access services and goods in the county. Work conditions were also considered by participants to be dire and unreliable, making the wealth gap in the county widen even more.

Transportation was mentioned by many participants (n=19) as an issue in Rabun County. Several participants expressed concern about how remote parts of the county are, which can make getting access to services and goods complicated, especially for low-income families who

may not have a car or may share one car among the whole family. Participant 16-F described this issue at length,

“We just don't have any transportation. Most of the folks don't have cars, and typically will just like walk if they can...Um, so a lot of the families have like one vehicle for the whole family. And when I say the whole family, I meant extended family, too. And the area itself is just really rural. So, you know, like it, it's just really wide, so it's not something, you know, it's mountainous and the hills are rough. The driveways, sometimes you can't even get a vehicle up them. So that's part of it too. But in general, a lot of people don't have transportation.”

Work conditions were mostly related to how the county relies quite a bit on tourism for revenue. According to several participants (n=8), many residents work in low-income service jobs during busy seasons but have a hard time making ends meet due to the cost of living increasing over the years. Several mentioned that well-paying work is hard to find, but even those with middle class incomes still struggle. Participant 2-M mentioned this issue in his interview,

“We're in a big kind of crisis here of providing homes for people to, to live in. But yet there's no jobs here because the industry here is tourism and there's no, there's no big money from tourism.”

What this data demonstrates is that the community is safe, beautiful, and has some important community resources, but there are challenges that some members may face to connect to those resources based upon a wealth divide that seems to be increasing, a lack of transportation options for those who are poorer, and the need to leave the county to find various goods and services.

4.2.3 *Theme 3: Field of Health Action*

In communication infrastructure theory, the field of health action refers to the health-related meanings people attach to elements in the CAC (Matsaganis & Golden, 2015). For the purpose of this study, the analysis related to the field of health action was focused on whether residents may or may not be inclined to seek mental health care services and/or respond favorably to a health-promotion intervention. This theme aided in assessing if participants felt that parts of the CAC enabled or hindered access to mental health care. Topics identified under this theme were *hinderances to seeking care* and *catalysts to seeking care*. These topics overlap with the CAC topics.

Hinderances to seeking care varied among participants, but those related to the CAC were lack of healthcare resources, transportation, work conditions, and culture. Many (n=22) expressed that mental healthcare resources were near to nonexistent in the county. Due to this scarcity, mental health resources were seen by many as only accessible in neighboring counties, which are roughly two hours or more away. Participant 10-M discussed how this had hindered him from seeking care,

“There have been times when I thought, geez, I wish I, I wish there was somebody or, you know, some organization, group practitioner who was close by that, that I could connect with. I can't think of any. I don't know that I have ever passed a, maybe one office with maybe a psychologist or something on the door, but I just, you know, I feel that there have been times in the last few years when I could have gotten back into therapy and, and, and I would've definitely benefited from it.”

Transportation was also a concern as many people (n=14) shared that they knew people who simply could not easily get from their home to places that offered mental healthcare

services. This is also an issue of geographical isolation (n=7) as many places in the county are quite remote. Work conditions (n=6) were mentioned as a hinderance due to stigma and the possibility of being fired for getting treatment for mental health. Participant 7-M expressed his concerns about this,

“Uh, across the board is going to be the word denial...it's you just don't talk about it. Uh, it can affect, uh, your ability to get a job. If, uh, your, uh, working for someone and they're provided health insurance, you go for mental health, you suddenly find your job's eliminated. Uh, you're considered a risk.”

Culture was also a hinderance to seeking care as many participants (n=15) expressed that they and people in their community, especially men, were self-reliant and felt that they could take care of their mental health needs on their own. Participant 22-F spoke to this issue,

“I just think that oftentimes men see their issues, their problems with things, as something that they should be able to fix on their own.”

The most commonly mentioned (n=16) *catalyst to seeking care* was one of the cultural traits of the community, a feeling that people and organizations were community oriented. This community feature was seen as people being encouraging and understanding of the mental healthcare needs for people in their community. Participant 17-M mentioned how supportive people in the community can be when someone is struggling,

“I think, I think in today's atmosphere in this community, um, people would be more apt to offer assistance or look for ways to help if someone was struggling with their mental health.”

Schools were also considered by some as (n=8) catalysts to seeking care for people's children who needed mental health care. Participant 19-F felt that school counselors were a good place to start for mental health support for kids enrolled in K-12 schools,

“The parents. I think if the parents here, if they have a problem, if they would go to their counselors, I'm not saying the school's always the answer, but for the kids that are school age, if they would go to the counselors and worked together, there are, there are options out there.”

4.3 RQ2: Men's Mental Health Storytelling

Research Question 2 asked: *What types of stories are being told around men's mental health and treatment options?* This question was broad and allowed for participants to consider how they have heard others talk about men's mental health and men seeking treatment for their mental health. This question seemed to be the hardest for participants to answer. They knew they had heard people talk about men with mental health problems but identifying where was difficult. The most common themes identified were *interpersonal networks* and *media*.

4.3.1 Theme 1: Interpersonal Network

Participants (n=22) most frequently recalled encountering stories about men with mental illness from their interpersonal network, particularly from *family* and *friends*.

Most participants (n=19) mentioned stories about mental illness they had encountered from their *family* members about other family members who were experiencing mental health issues, usually an uncle or cousin. Specific stories were not shared by participants, but people remembered hearing various things about men with mental illness from family about other family members. Not all stories were considered by participants as negative or disparaging to

the family members. Participant 2-M shared that his mother told him about several men in his family who had mental health issues,

“My grandfather and my uncles all struggled with mental health. Um, and it became more heightened after my uncle's, um, being in the war. Um, and so that's kind of stuff that I've known and have talked with my mom about for, for years.”

Several participants (n=6) had also heard stories from *friends* about mutual friends or acquaintances in the community. This appeared to be mostly in the form of gossip in which friends were telling stories about the person being dangerous or “crazy”, warning each other to stay away from the mentally ill person. Participant 1-F shared her experiences with this,

“I mean, you do, you do hear a lot of times, I think in the small towns, um, you know, some of the things that I have heard from people I know, um, like he or she is crazy, he or she, you know, that kind of thing. Um, and that's unfortunate because I think sometimes that's just, that's kind of judging.”

However, others (n=3) mentioned hearing stories about a friend's success in rehab or a friend overcoming extreme hardship, hinting that the stories showed admiration for people getting help and successfully treating their mental health problems.

4.3.2 Theme 2: Media

Participants (n=9) also mentioned hearing stories of men with mental illness in the media. Specific topics identified under this theme were *news media* and *entertainment (film and television)*.

Several people (n=8) felt that news media stories were overwhelmingly negative and at time attributed violence to mental illness. News media was generally considered to be a negative source of stories about men and mental health. Participant 21-M discussed this in his interview,

“I mean, just from on the news, I hear, uh, you know, we, we watch Fox News a lot, and I hear a lot about, um, men who maybe have served in the military. Um, just stuff that I've heard on the news. I mean, it stems from, like I said, drugs and alcohol politics, uh, men who served in the military maybe have, you know, post traumatic syndrome, things like that.”

Others (n=7) mentioned entertainment media as a source of stories about men with mental health issues. Most participants (n=7) could not name specific shows or films nor specific stories, but they reported seeing stories about men with mental health issues in entertainment media at some point. Participant 17-M recalled that most stories he saw in entertainment media rely on stereotypes,

“I think that's where a lot of the stereotypes came from originally was from, uh, television and the media. I mean, just in general movies, TV shows and stuff like that.”

4.4 RQ3: Stigma Narratives

Research Question 3 asked: *What stigma message choices (e.g., dangerous, responsibility, etc.) are prevalent in rural communities about mental illness in men?* This question assessed components of the model of stigma communication, focusing on what types of stigma messages people in the community use and have encountered. While participants seemed to have a hard time recalling specific stories, they did not have a hard time identifying stigma messages surrounding men and mental health. Themes identified were *weakness, dangerousness, and shamefulness*.

4.4.1 Theme 1: Weakness

Weakness was the most commonly referred to stigma narrative associated with men who have mental health issues (n=23). This falls under the stigma message of personal responsibility

as this association with depression implies that one is simply not trying hard enough to not be depressed (Smith, 2007; Crumb et al., 2019). This supports research that weakness is one of the most common stigma messages surrounding men who face mental health struggles (Crumb et al., 2019). Topics identified under this theme were *disease/disorder related*, *perceptions of masculinity/emasculatation*, and *sin/lack of faith*.

When weakness was mentioned by participants, it was often *disease/disorder related*. Men with depression were referred to several times as being widely considered weak by others; however, it's worth noting that many participants (n=12) said they did not personally believe men with depression were weak. Participant 10-M spoke to how he believes men with depression are often viewed,

“I would say that I think that to some degree for men, um, there's a tendency to, uh, even, uh, in, in terms of, um, self-actualization, if that's the right term think that, uh, depression and things of that nature are signs of weakness and that, you know, we are supposed to be strong, uh, creatures and, uh, be able to overcome, uh, things that, that happen to us.”

While most male participants (n=11) personally did not feel other men were weak if they experienced depression, the same was not always true when considering their own mental health struggles. Most (n=13) of the male participants reported experiencing mental health issues at some point in their lives, and many (n=9) reported feeling like they were weak or somehow responsible for not being able to cope with what they were experiencing. Participant 2-M shared this sentiment in his interview,

“So now I don't wanna go get medicine because then the realization is, yes, you have a problem and you need something for it. I'm like, no, that means I'm a failure. I'm weak.”

Several participants (n=7) brought up addiction but did not seem to regard addiction as a mental health problem but rather a problem with willpower or resorting to self-medicating for other mental health issues. Participant 19-F mentioned this when discussing her adult son who struggles with alcoholism and self-medicating for his mental health issues,

“My oldest son is now, he's uh, he's an alcoholic. And it's because he didn't get the help that he should have gotten back then [for his mental health], and he refused it, and he wants to ignore it...and he turned to alcohol to deal with it.”

Perceptions of masculinity were also mentioned frequently (n=17) when discussing weakness. Expectations of men to be strong or tough was brought up many times among participants. Having mental health issues and needing help for those issues was often perceived as emasculating. Participant 1-F described her observations on this,

“Men I think are primarily that role model where they should have everything together, you know what I'm saying? And it's like, if, if they don't, they're not as manly or, you know, it's a, it's a feminine or weakness kind of thing, you know?”

Participant 6-M also shared his thoughts on mental illness and emasculation,

“I mean, it's basically emasculation, basically for the most part. So, whether it's like a weakness and, and for the most part, that's like masculinity, right. Is like how strong you are, I guess...one way or another, I guess, either called weak or called feminine.”

Also attributed to weakness of character was *sin or lack of faith*. Several participants (n=9) discussed how mental health issues in men were sometimes considered a lack of faith in religious communities. Experiencing mental health issues was often attributed to sin or simply not praying hard enough. Participant 7-M described his observations related to this phenomenon,

“They keep it quiet, uh, in the old Appalachian culture. And that's the culture that I grew up in. Uh, it's considered a weakness.. suck it up, man. Just get over it. Uh, you know, you, you just gotta deal with life, uh, grow up. Uh, it it's, it's the mentality that if you've got a mental health issue, uh, if you're in the church, it's because of a sin in your life. If you're outta the church, it's maybe the cause of, uh, your parents or your own behavior, but it's, it's, it's always a stigma.

Participant 16-F also discussed her observations,

“A lot of the clergy would, um, say, you know, just needed to be prayed out of you or you needed to believe stronger.”

4.4.2 Theme 2: Dangerousness

Dangerousness (n=5) was also associated with men who have mental health issues.

Dangerousness is a common stigma associated with mental illness and falls under the category of peril (Smith, 2007). One topic was identified under this theme, which was *violence*.

Violence was connected to men with mental illness several times. Some participants described their personal experiences with men in their lives expressing emotions violently when experiencing mental health issues. Others mentioned conversations they've had with others about men with mental illness being dangerous. For instance, Participant P16-F described conversations she's had with colleagues about the topic,

“Um, I think there's a general stereotype that people with mental health are dangerous. I've had conversations with judges about like gun control rights, and their theory is basically that all of the major, um, like shootings are caused by mental health issues.”

4.4.3 Theme 3: Shamefulness

Most participants (n=19) recognized the association of shame with men who experience mental health issues. Male participants also talked about the shame they have personally experienced when having mental health issues. The topics identified under this theme are *labeled as crazy* and *self-stigma*. Each of these topics relate to group labels often associated with mental health problems (Corrigan et al., 2002; Smith, 2007).

Several participants (n=6) mentioned how men who have mental health issues risk being *labeled*. The most common label discussed by participants was the label of “crazy”, and most men expressed wanting to avoid this label so that they are trusted and taken seriously in their community. This particular label was mentioned several times as a reason to avoid seeking support and/or professional help, which will be discussed in the next section addressing stigma responses. Participant 20-M discussed how disclosing mental health problems to peers made him uncomfortable due to being labeled,

“The minute you say that [you are having mental health problems], they think you're crazy and they call you crazy.”

Participant 15-F also spoke to her perceptions of men avoiding the label of “crazy”,

“They're the leaders of the home, you shake it off and you go on and you just tough it out, you know...you don't ever want to be defined as crazy.”

Self-Stigma was mentioned by nearly every male participant (n=13). Most of the male participants began interviews talking about how they believed mental health issues are common and that most people experience mental lows. The feeling was that men who have some mental health struggles is totally normal. However, when asked about their own mental health struggles, nearly each man (n=13) mentioned feeling shame when they were struggling with their own

mental health. Most men (n=11) in this study initially felt that they were being weak or needed to stay strong for their loved ones. Self-stigma and worrying about what others would think, especially about one's strength as a man, appeared to be one of the strongest stigmas associated with men with mental health issues and seeking help. Participant 13-M spoke to this issue and his need to be perceived as dependable and strong by his family,

“Uh, I'm expected to be the strong guy, you know? Yeah. Make the money, manage things, take care of two homes, et cetera, et cetera. So, I think it [mental health problems and seeking care] would be, um, perceived as a negative.”

4.5 RQ4: Stigma Responses

Research Question 4 asked: *Which stigma message reactions (e.g., disgust, fear, etc.) are most frequently encountered after exposure to stigma messages?* This research question also assessed components of the model of stigma communication, examining how people react to stigma messages when they encounter them, which are categorized by Smith (2007) as message effects. Themes identified were *emotional reactions*, *cognitive reactions*, and *message effects*.

4.5.1 Theme 1: Emotional Reactions

Emotional responses typically are characterized by Smith (2012) as disgust, fear, and anger; however, participants didn't mention these reactions enough for these to be considered themes in this study. Topics identified under this theme were *embarrassment/discomfort* and *sympathy*.

Embarrassment, associated with the stigma narrative of shame, was mentioned several times (n=12). Every single man interviewed shared a time in their lives when they experienced anxiety, depression, or other mental health struggles. Each man that brought up embarrassment spoke to the struggle of seeking support from loved ones and/or professional help due to feeling

embarrassment over their mental health. Many (n=9) reported waiting to seek care until they were in crisis due to the feelings of embarrassment. Some (n=4) expressed feeling somewhat embarrassed during the interview due to the extent mental health issues were shared with the interviewer. Participant 3-M mentioned why he would be uncomfortable disclosing mental health issues to someone or crying in front of another person,

“You know we say it’s better dead than to cry in front of someone. We fear embarrassment. We don’t want to be embarrassed.”

The emotional discomfort associated with embarrassment was mentioned several times, especially among male participants (n=10). None of the women interviewed expressed feeling discomfort when learning a man has mental health issues; however, many men expressed some discomfort (n=9). This discomfort was often related to the embarrassment of discussing their own mental health issues with others, but some male participants shared feeling uncomfortable or embarrassed when a male friend shared too much about their personal lives with them. A few participants (n=6) also perceived others as feeling uncomfortable with a man openly sharing they have mental health issues or are just feeling sad. Participant 10-M discussed how men may feel discomfort when seeking support from one another,

“Maybe it's because I there's this lingering idea that people don't really wanna hear about your problems. Um, and...in many cases though, you, you make them uncomfortable. So, you know, I, and maybe, I, I don't know if I'm just using that as an excuse, but I do tend to be more, you know, self-reliant and, and keep, and keep my problems to myself... I'm not gonna go to one of my friends and, you know, try to, you know, to help me through a difficult situation.”

Sympathy was also a common emotional reaction to stigma narratives surrounding men who have mental health issues. Many (n=22) of the respondents displayed a great deal of compassion for men experiencing mental health problems and shared that the common belief that a man with depression is weak or dangerous was not correct. They expressed sympathy for those who had been labeled as “crazy” or “insane”. Some participants (n=6) also felt that others in the community shared this same sympathy. Participant 19-F shared that she believed “there’s certain people [in the community]...that...would show sympathy.”

4.5.2 Theme 3: Cognitive Responses

As mentioned in Chapter 2, cognitive reactions can include a variety of reactions to stigma narratives (Smith, 2012). Topics identified under this theme were *self-stigma* and *personal responsibility*. While these topics were defined and discussed in section 4.3 as a common stigma narrative, these two categories also appeared to be the most frequent cognitive reactions when respondents were discussing stigma messages. Male participants (n=12) tended to frequently internalize stigma messages about men with mental health issues, feeling shame or a sense of failure when sharing their own mental health struggles. Perceived responsibility was also a common cognitive reaction as many participants (n=17) mentioned weakness and not trying hard enough as being the first thing they thought about when discussing men with mental health problems. Participant 19-F shared her thoughts when discussing men with mental health issues,

“You’re supposed to be strong, and you’re supposed to not show any weakness and you’re supposed to, you know, be all these things.”

4.5.3 Theme 3: Message Effects

While message effects are not the same as stigma responses, these effects happen as a result of stigma responses (Smith, 2014; Smith, 2007). Because so many participants discussed message effects, this theme was included under this research question. Topics identified under this theme were *avoidance/ostracization of person*, *label avoidance*, and *silence/denial*.

Avoidance/ostracization of person was mentioned several times by participants (n=16) when asked how they felt others would react to a man experiencing a mental health issue, especially if the man was visibly upset or crying. Many felt that they personally would not want to avoid a man publicly experiencing mental health issues but that many in the community would avoid and ostracize the person. Some participants (n=4) shared their personal experience with feeling ostracized by loved ones in their community due to their mental health issues. Participant 19-F believed there were people in the community “that would say, ‘well, you know, I don’t wanna be around somebody that’s depressed.’”

Label avoidance was also mentioned many times (n=8) as a response to stigma narratives. Specifically, the desire to avoid being labeled as “crazy”. The desire to avoid being labeled crazy hindered seeking help professionally as well as seeking support from loved ones. Participant 16-F mentioned her experience with this,

“I think that’s the majority of the men that I know who have a hard time even going to treatment, even when it’s required. They’re like, well, I’m not crazy.”

Participant 7-M mentioned his experience working with men in AA who avoid seeking care for fear of their car being spotted outside the facility and then being labeled an alcoholic.

“I realized that I had a church full of, uh, men who were struggling with alcoholism and some women, but primarily men. Being the bright, uh, young pastor that I was, we

needed AA. So, we start AA and suddenly these men start disappearing and they, they do not attend. And so I sat down with a couple of 'em said, Hey, you know, just, we're just trying to help. What's going on?' They said, 'Well, word's out that everybody comes on Thursday nights is an alcoholic. Uh, cause we got certain people driving by the church, looking at cars and knowing who own, what car they're going out.'"

Many participants (n=11) also mentioned *silence* as a go-to response to mental health stigma, especially regarding men. People simply don't talk about it, and they are encouraged early on in life to keep it to themselves. The topic is often seen as taboo, regarded as uncomfortable to discuss, even in general terms. Participant 19-F expressed her views on the local religious community's avoidance of the topic,

"There's a lot of churches that won't talk about a lot of things anymore. Yeah. Um, avoid certain subjects. Well, that's, you know, we don't do that. We don't handle that [mental health] here."

Participant 5-M also shared his thoughts about men keeping silent and avoiding the topic,

"I would say most of the people, I know the men wouldn't say anything or want anybody to know."

Participant 17-M also discussed learning to keep quiet about mental health at a young age and how his family avoided the topic of men in the family with men who have mental health issues,

"They don't, they wanna bring up, they don't wanna, you know, mention it. And you just were taught at a young age. Don't ask Uncle John about the war. That's just the way it goes, you know."

4.6 RQ5, RQ6 and RQ7: Stigma Storytelling in the Communication Infrastructure

RQ5, RQ6, and RQ7 were grouped together because each research question is closely related to stigma storytelling within the communication infrastructure. Themes and topics overlapped frequently in the findings for these three research questions during analysis. Research Question 5 asked: *Where in the communication infrastructure are stigma messages about men with mental illness encountered?* This question assessed which part of the communication infrastructure stigma messages were mostly encountered and spread, which is also referred to as stigma storytelling in this study. Research Question 6 asked: *Who in the community is engaging in stigma storytelling (sharing of stigma messages with the network)?* This research question bridges the gap between assessing what types of stigma narratives are being told and who in the community is engaging in spreading these narratives. Research Question 7 asked: *Which storytellers are identified as being influential in the development of mental health stigma beliefs?* This research question assessed who in the community might be influential on attitudes toward men who experience mental health issues.

Themes identified to answer these research questions were separated into *micro-level*, *meso-level*, and *macro-level* storytellers and several specific types of storytellers at each level were identified as important or influential.

4.6.1 Theme 1: Micro-level Storytellers

The micro-level of communication consists of interpersonal connections one has in their community. Nearly every participant (n=23) mentioned encountering stigma messages at this level of communication. This level of the communication infrastructure was where participants encountered stigma messages the most (RQ5). Topics identified under this theme were *family* and *friends*.

Family was mentioned the most by participants as a source of stigma messages. Many men (n=8) felt that they learned from their father or father figures early on that expressing sadness or feeling depressed was not manly. Participant 20-M spoke about conversations he had with his father,

“My father would say, ‘You need to be a man at all... costs, you can't show emotion. You have to, you have to be the rock in your family... you're not allowed to show weakness in any way.’”

Others (n=4) mentioned having male family members who had mental health issues that no one in the family was supposed to talk about with others outside the family. Participants (n=8) also mentioned casual family conversations when visiting with family members who live in the same area. Conversations would sometimes be about other locals experiencing some kind of hardship or mental health struggles. Participant 1-F shared her experience with her family,

“Yeah, my, my family has said some of that for sure. Okay. Um, you know, just, um, saying like they're crazy, their family's crazy, you know, that kind of thing for sure. Um, it's not easy to admit that I don't think, but you know, I have heard that for sure.”

Family was largely considered where most stigma messages are encountered (RQ6) and considered the most influential in the development of mental health stigma beliefs (RQ7). This was especially so for men encountering stigma messages from male role models.

Friends were also where stigma messages have been encountered, starting early on in life and into adulthood. Most participants (n=18) reported encountering messages from friends in the form of conversation or gossip about other people in the community (RQ5, RQ6). Participants did not report finding friends as overly influential in their beliefs on men with mental health issues (RQ7), but some men did express feeling uncomfortable with talking to other men about

their mental health. Participant 7-M shared that he believed most stigma narratives came from family and friends rather than the media,

“Uh, well it's “just suck it up” is a common expression. Okay. Hey, you're just, that's a hand God dealt, you just live with. And that's as common among the unchurched as the church...It, it, it doesn't come outta the media. It comes from family, friends, relatives. And, and, and it comes out the church.”

4.6.2 Theme 2: Meso-level Storytellers

The meso-level of communication consists of community organizations or community leaders that provide the community with information. Those at the meso-level often act as a bridge between micro-level and macro-level actors. Topics identified under this theme were *religious communities* and *local media*.

Religious communities were mentioned several times as sources of stigma messages (RQ5, RQ6). This will be addressed in another section, but it's important to note that this was not the experience of every participant. Some (n=4) found their religious leaders to be sources of support and very open to discussions on mental health. However, several participants (n=9) encountered stigma messages from their religious communities, who often attributed mental health problems to not being faithful enough or needing to pray harder. Personal responsibility appeared to be the most common stigma narrative encountered from religious leaders. Seeking professional, medical help was also stigmatized in some of these communities, with the implication that seeking help outside of the church and God was displaying a lack of faith. Religious leaders were regarded as highly influential on people's beliefs about mental health. Several participants (n=9) reported having bad experiences in their religious community due to

stigma perpetuated within the church. Participant 20-M shared his thoughts on how religious communities approach mental health,

“But the problem again is when you're in the religious groups, um, they're really mean. I'm just telling you the truth. I'm not from here. I don't, I don't buy that stuff that they put out, but they were just so mean to people. If they were to come to say, for instance, if you were to go to some of these people up here and say you were depressed, they try to cast a demon outta you or something.”

Local media was mentioned by a few participants (n=5) as a source of mental health stigma in the community (RQ5). In particular, the local newspaper, *The Clayton Tribune*, publishes arrests and drug charges. Many people in the community struggling with drug addiction also have this struggle publicly displayed in the newspaper. Participant 12-F discussed this in her interview,

“I mean, uh, the newspaper publishes when people are arrested on drug charges and other related things. They, uh, basically publicly shame people who have problems with addiction and it does have an effect.”

4.6.3 Theme 3: Macro-level Storytellers

The macro-level includes any sources of information that tell stories on a mass scale. Topics identified under this theme were *news media*, *film and television (entertainment media)*, *celebrities*, and *social media*.

As noted in the analysis for RQ1, stigma messages encountered in *news media* were largely related to acts of violence, especially mass shootings committed by men (RQ5). Participant 2-M mentioned this in his interview,

“I mean, you know, reading news about what's happening in, in the Senate right now with, with gun laws being passed, but also seeing some of the, the stuff that's happening with, uh, violence in schools and seeing that some of it may be related to mental health issues. Um, some just may be that people are just lunatics...because what they're not wanting to do is put guns into the hands of people that have mental health problems.”

Film and television (entertainment media) were also regarded as a source of stigma messages surrounding men and mental health (RQ5). Some participants (n=7) said they remembered seeing films showing negative portrayals of men with mental health problems, but none of the participants could remember specific films. Some participants (n=5) mentioned common tropes they've seen in films such as veterans with PTSD being violent or older men having mental health issues. Participant 24-F mentioned a common trope associated with men who have mental health issues,

“Yeah, I think on television, there's definitely more of a depiction of, um, a man with mental illness as far as being outwardly disheveled.”

Celebrities with mental health issues were also mentioned several times by participants (n=5) as a source of stigma messages (RQ5). The most commonly mentioned celebrity was Robin Williams. A number of participants (n=5) associated him with mental health problems that lead to suicide. Participant 16-F shared her thoughts on male celebrities with mental health problems,

“I've heard a lot of things about like Robin Williams when he committed suicide and, um, what's that guy's name? Kim Kardashian's husband, Kanye um, you know, and his mental health issues. I don't know. I think, um, the general consensus is just like, well, people just use that stuff to like benefit themselves or change the narrative to gain sympathy or,

you know, know that kind of thing rather than it being a legitimate issue that people need help.”

Social media was also mentioned as a source of stigma messages (RQ5). Social media is included in the macro-level category since conversations around social media messages were broad and did not indicate messages were coming from interpersonal networks. Most participants (n=6) who reported encountering stigma messages on social media seemed to come across these messages on social media pages for news organizations or groups they follow on the social media site. Facebook was mentioned more than any other social media outlet as a source of stigma messages. Participant 2-M mentioned Facebook as a source of stigma messages,

“I see stuff about it [gun violence] on maybe Facebook pages and stuff like that regarding people that have specifically mental health issues.”

4.7 RQ8: Counternarratives and Reducing Stigma

Research Question 8 asked: *Where in the storytelling network do people encounter messages that challenge stigma narratives?* This question was intended to identify additional pathways to reducing stigma using a stigma communication intervention. By investigating this question, support systems already embedded in the community were identified and could be leveraged when implementing an intervention program. Themes identified were *interpersonal connections, community leaders/community organizations, and social media*.

4.7.1 Theme 1: Interpersonal Connections (micro-level)

Interpersonal connections were mentioned by many (n=9) of the male participants as sources that challenge stigma narratives, changing their perspectives on mental illness. Female participants (n=7) also discussed where they had heard counternarratives. Topics identified under this theme was *significant others* and *family*.

Some (n=3) men felt that their *significant others* had helped them overcome self-stigma and realize that there is no shame in seeking help for mental health treatment. Once receiving support and encouragement from their loved one, the stigma did not seem to feel as strong for several participants. Female participants (n=4) also discussed how they had tried to help their significant others understand that having mental health problems was normal and could be treated. Participant 2-M shared,

“So my wife's actually been the person that's really changed my perspective [on mental health].”

Family was also mentioned several times by participants (n=7) as sources of counternarratives to stigma messages on men's mental health. This was usually through parents who spoke about other family members with mental health issues, displaying compassion and empathy toward the family member or prominent female family members discussing mental health care positively. Participant 9-M discussed how his family changed his perception of his own mental health struggles,

“I, uh, definitely had some support and understanding from my family, especially my aunt and mom. They helped me a lot with understanding that what I was experiencing was normal.”

4.7.2 Theme 2: Community Leaders/Community Organizations (meso-level)

Community leaders and organizations were by far the most mentioned sources of stigma counternarratives (n=17). Topics identified under this theme were *existing efforts* and *positive messaging from community leaders*.

The county already has existing efforts to address the mental health needs of the community. These efforts not only include reducing stigma but focus heavily on mental health

education and support services for people in need of care. Community organizations such as the Food Bank, the Lion's Club, the Mental Health Task Force, and the Rotary Club take part in various community efforts to address mental health needs in the area. Many of these efforts are to educate and promote seeking care for mental health. Participant 9-M spoke to some existing efforts he was personally involved with in the community that highlighted mental health awareness,

“Um, there is, um, Lake Rabun Association. They really want to help people in the community. Um, and also, uh, you know, Rotary I'm in Rotary, too. Um, they wanna do whatever they can do to help people in the community.”

Participant 11-M highlighted the Mental Health Task force, which is a new initiative in the county directed at addressing mental health care needs in the community,

“And I think you see that in things like the fact that we're trying to start a task force, that we do have organizations that their mission is to address mental health issues and mental health at large and, and things of that nature.”

Positive messaging from community leaders was also mentioned as a source of stigma counternarratives (n=9). This included church leaders who openly talk with their congregations about addressing their mental health needs and local leaders, such as law enforcement, who have initiated various efforts to bring more awareness to the mental health needs of the community. Participant 1-M shared,

“I do know we have one county commissioner that is, um, big into mental health right now, and really trying to push that and, and be involved.”

Participant 16-F shared that the sheriff is also involved in mental health awareness efforts in the county,

“Um, the sheriff, um, he has actually done a good bit for substance, for reducing stigma of substance abuse and kind of helping with that.”

4.7.3 Theme 3: Mass Media (macro-level)

Mass media was also mentioned many times (n=9) as a source of information on mental health awareness and promotion. The topics identified under this theme were *social media* and *celebrities*.

Several participants (n=8) mentioned social media as a source of counternarratives specifically aimed at recognizing the signs of depression and normalizing getting care for one’s mental health. Most participants (n=6) discussing counternarratives claimed that these posts and memes were shared by people in their interpersonal network (micro-level) and would be reshared many times by other people in the community (meso-level). The only social media application mentioned was Facebook as most participants did not appear to have other types of social media beyond Facebook. Participant 23-F discussed this in her interview,

“I think there's a lot of good that can come through Facebook with people just sharing like positivity and it's okay to ask for help. And those kinds of things through Facebook is always nice to see. And, you know, those, um, suicide prevention stuff will go around from time to time. Like don't be afraid to ask for help. And, um, so that's always encouraging to see, and I feel like the more people see that kind of stuff, the more likely they are to like, realize they're not, they're not the only one.”

Celebrities were also mentioned as sources of counternarratives (n=4), specifically men that disclosed their mental health struggles and the prioritization of their mental health care. This kind of public self-disclosure was seen as positive by several participants. Participant 11-M spoke about how much of an impression a football athlete man on him,

“I’m a huge Ohio State fan. Um, but we, we had a player this year, who, you know, retired from football and it was all around mental health...the cause he just said, “Hey, my mental health is more important than my football career. And, um, you know, here's, here's what I'm gonna do as a result of it.” And he talked openly about it. It's very powerful and it's very emotional.”

4.8 RQ9 and RQ10: Help-Seeking Perceptions and Outcomes

RQ9 and RQ10 were grouped together because these research questions are closely related, and themes/topics overlapped frequently in the analysis for these two research questions. Research Question 9 asked: *How do stigma beliefs about men’s mental health influence men’s willingness to seek help (e.g., professional treatment and/or support from interpersonal connections)?* This research question assessed men’s mental health outcomes related to stigma beliefs. While this question was intended to be answered by participants who identified as men, women also spoke to how stigma beliefs held by men in their lives have affected willingness to seek treatment. Research Question 10 asked: *How do stigma beliefs about men’s mental health influence others’ perceptions of men seeking support for their mental health?* This research question was intended to assess perceptions of men seeking support or treatment for their mental health by people who do not identify as male (all women in this study). Themes identified under these research questions were *help-seeking perceptions* and *help-seeking outcomes*.

4.8.1 Theme 1: Help-seeking Perceptions

Help-seeking perceptions were discussed at length by every participant. This theme included any comments related to men seeking support from loved ones or seeking professional help through medicine. Every man interviewed shared their experiences with seeking support or medical treatment for their mental health, and most of the women (n=8) also discussed men in

their lives who had reached out for support or had sought medical care for their mental health. Topics identified under this theme were *supportive/in favor of*, *embarrassed*, *telemedicine*, and *women seen as more accessible*.

Nearly every participant (n=23) expressed *support* for men seeking help when needed. Every man interviewed reported seeking help in some way at some point in time and felt that they understood the benefits of seeking social support and professional help for mental health. For instance, participant 13-M shared that “therapy in its own right...can be very valuable.” Participant 23-F also shared her sentiments on men seeking support for their mental health,

“I think society as a whole wants to be more open and understanding and supportive to people, men too, honestly. I think a lot of times I think it's the men who, who will oftentimes do that to themselves in a way, because they wanna be strong. They wanna be seen as strong. They wanna be seen as a man. Um, whereas if they did ask for help, I think a lot of people would be supportive and encouraging.”

However, when men discussed their own journeys of seeking help, many (n=11) reported struggling to do so for various reasons. Participant 18-M discussed his past struggles with seeking support for his mental health,

“I used to have a mindset that if you need medication, it's like a sign of, you're not, you're not close enough with God. You're not trusting him enough. You're not letting him handle this.”

Many (n=10) of the male participants seemed to internalize the stigma of mental health problems but did not seem to apply to other men in need of support or treatment. Every woman interviewed was very much in favor of mental health treatment and also felt that men should not be embarrassed to say they need help or support.

Embarrassment came up many times among participants. Most (n=11) male participants reported feeling embarrassed when they realized they needed to seek help for their mental health. Many (n=10) reported feeling more comfortable with a medical doctor than with a therapist. While some (n=4) men had found therapy useful, several (n=7) felt embarrassment over sharing their thoughts and feelings with a stranger. Participant 10-M discussed how he felt that most men would be more comfortable seeking care from a doctor than a therapist due to the embarrassment of sharing their feelings or being emotionally vulnerable,

“I think men are more, might be more accepting of...some sort of a medical, you know, or prescription sort of a solution. And again, because it spares them that, you know...the trauma of having to expose themselves, um, uh, verbally, you know, to express their fears and difficulties.”

Several male participants (n=6) also brought up feeling more comfortable with getting treatment for their mental health through *telemedicine*. Even with slow broadband, they felt that telemedicine made getting mental health care logistically easier and also made therapy feel less vulnerable. Participant 10-M discussed how he felt that telemedicine was a good way to get men to meet with a psychiatrist or try talk therapy,

“I think that that [telemedicine] might be, that might be a way for men to overcome some of the stigma associated with, um, even being seen, going into a, you know, a psychologist's office or psychiatrist's office. If the treatment, if the therapy were something that could take place in the home...then I think a lot, I think, I won't say a lot, but I think men might be a bit more comfortable with that environment than...being seen walking into the door of the local mental health center.”

When discussing other forms of help seeking such as social support, many participants (n=6) mentioned that women are often viewed as more compassionate and accessible for support. Women were regarded as more open and easier to talk to. Several men (n=6) said that they would not feel comfortable telling a male friend they are struggling with their mental health but would feel comfortable telling a woman in their life. Participant 2-M shared his thoughts on men seeking support from women,

“I mean, if that person is, is telling a female [about mental health issues], I think they're gonna respond a lot differently than a guy will. If the guy grew up in a family that, um, where men don't cry, you know, they probably would be uncomfortable and not know how to respond.”

4.8.2 Theme 2: Help-seeking Outcomes

While assessing *help-seeking outcomes* was initially intended for male participants, nearly every female (n=9) participant discussed help-seeking outcomes from men in their lives. Each man interviewed for this study discussed how they had sought help for their mental health and what led to them seeking help. Topics identified under this theme were *medication, therapy, social support, and delayed care*.

Many participants (n=10) felt that the best place to get care and support for their mental health was through their primary care physician or a specialist, primarily for a diagnosis and medication. *Medication* was discussed by many of the participants (n=16) as a viable treatment for mental health issues. Several men (n=13) reported being diagnosed with depression, anxiety, obsessive compulsive disorder, and various other mental health conditions. While most men (n=11) expressed initial reluctance to take medication for their mental health, the general attitude

toward medication was that it worked, and they were glad they tried it. Participant 17-M discussed how medication had helped him with his mental health throughout his life,

“I went back and got back on the medicine again. And it's, you know, uh, because I realized, yeah, it did, it did make a difference in my life, and it did help me.”

Several (n=5) of the men interviewed reported going to therapy for their mental health, and several women (n=5) mentioned that men in their lives were in therapy as well. However, attitudes toward therapy varied as many of the men felt uncomfortable with therapy or felt that it had not worked well for them in the past. Participants also expressed that logistically therapy was hard to access unless using telemedicine, which some found to be preferable, but others did not. Participant 17-M discussed his hesitancy to find a counselor at one time in his life, but once he started going, he found it helpful with managing his mental health,

“Um, I think that counseling helps a lot. I really do. I think that some people have trouble getting to the first. It's like going to the gym. It's that first time getting there is probably the biggest step, right. Um, but once you get in there, uh, I think talking to folks and getting it off your chest and hearing another point of view, I think sometimes it, uh, for me, I've actually been there [to therapy] for...a couple, couple things. And for me it, it validated that I was normal.”

Social support was discussed by several participants (n=17). Most men (n=12) reported seeking social support through their pastors, spouses, or other women in their lives (mothers, sisters, aunts, adult children). Many (n=9) of the men reported reaching out to a person closest to them when experiencing a mental health crisis, and many of the women (n=7) discussed how they had provided support to male employees, family members, and friends who were

experiencing mental health issues. Participant 8-F spoke to her experience with providing support to men in her life who had experienced mental health problems,

“Just in general from life, you know, personal life experiences with my father and my brother and the different things that they've dealt with through lives. My employees, which I kind of continue to hone on because they're family to me and they're the bread and butter to my business, you know, I need to make sure that they're in a good mental, stable place where they could take care of customers and deal with children. Um, friends of mine that are necessarily not, uh, able to open up to anybody else besides me. I, I wanna make sure that they know that it is an option for them at any point in time, to be able to count on someone that they can lean on.”

Delayed care was mentioned by many participants (n=18). While each male participant reported eventually seeking help in some way, many (n=12) delayed seeking care due to embarrassment or feeling as if they just needed to be stronger. Many (n=8) of the men interviewed discussed how they waited to seek professional help until their personal lives and relationships were suffering. They had not realized how bad things were until others in their lives were affected as well. Several women (n=8) reported that their male spouses and family members had also delayed care until they were in crisis. Participant 20-M felt that many men simply would delay care due to the stigma of having mental health issues,

“You know, when it comes to, um, mental health, a lot of times guys won't seek help. It's embarrassing. They don't think that there's anything to it.”

4.9 Additional Themes

Additional themes were observed during data analysis that will be beneficial to the next step in this communication intervention research project. These themes highlight trusted sources

of information on mental health, ideas from participants on reducing men's mental health stigma, and participants' thoughts on the topic of suicide.

4.9.1 Theme 1: Trusted Sources of Information on Mental Health

Trusted sources of information on mental health came up many times with participants (n=22). Assessing the types of sources community members trust the most will aid in developing a more effective stigma communication intervention program. The topics identified under this theme were *medical professionals* and *community leaders*.

Medical professionals were one of the most trusted sources of information on men's mental health. Most participants (n=17) felt that their local primary care provider was the best source of information. This highlights the importance of primary care providers in Rabun County and their possible role in reducing stigma surrounding men's mental health. Participant 17-M spoke to his trust in his family physician to treat him for his mental health,

“And sometimes you gotta ask for help and it, it needs to go beyond that. So I, I think a physician is the best for me personally. My family physician would be the best place to start.”

Community leaders were also mentioned by many participants (n=15) as trusted sources of information on men's mental health. For some, religious leaders were regarded as trusted sources of information on mental health. Some participants were pastors in the community and made a point to incorporate discussions on mental health with their congregations. Others felt that their religious leaders were people who had some training in counseling and mental health and could be trusted. Participant 13-M discussed how much he trusted his pastor to guide people in the congregation when experiencing mental health issues,

“I think, I think that our pastor is a good counsel and would do what he could to counsel the person. However, um, you know, when you got out of the realm of theology and, and all of that, um, there is that boundary line with which is not fully understood by any of us, right. Quite frankly, between, um, psychology, um, psychiatric conditions and, um, you know, evil and all that kind of thing. You start getting into the nebulous land of that. I think most pastors, I know ours would, would probably suggest seeking professional care in the medical community.”

However, other participants (n=6) reported that they had some bad experiences in church settings regarding mental health with religious leaders who did not seem to understand mental health as a medical problem but rather as a problem of faith. It really depends on the religious leader in the community and the specific church’s views on mental health.

Local political leaders, specifically male leaders, who expressed interest in mental health programs were also seen as trusted sources of information on mental health (n=6). These leaders’ efforts were seen as showing concern and care for citizens in the community and willingness to address a prevalent problem that seems to have touched most people in the community in some way. Participant 10-M discussed this in his interview,

“I think there are some, there are some local politicians, um, both at the city level Clayton and also the county level Rabun County. I think there are some, uh, political, uh, officials, elected officials who would be able to carry that off. Yes. I can think of one in particular. I think who's even possibly broached the subject of, of mental health issues. And, uh, and so I think he has the respect of most of the people in the community, and I think it [mental health education] would be taken in a positive way.”

4.9.2 Theme 2: Locals' Ideas for Reducing Stigma

Most of the participants (n=20) also provided suggestions for reducing stigma and increasing men's mental health education in the community. Some of the suggestions will aid in creating an effective intervention program specific to the needs of the community. Many suggestions by locals fall under the categories provided by Corrigan et al. (2012), which are protest, education, and contact. Topics identified under this theme were *masculine community events, hearing more from male community leaders with personal experience, informational and social media, and school programs.*

Several participants (n=5) mentioned coordinating *masculine community events* that promote men connecting with other men and potentially discussing men's mental health while engaging in "masculine activities" such as hunting or fishing. Other suggestions included coordinating game nights or other types of events where socialization and connection with other men in the community were encouraged. Participant 15-F described her idea for masculine mental health events,

"Um, well I think it, it could start with, um, your county mental health systems...creating more grassroots groups, you know, um, like, uh, setting up a mental health hunting kind of thing, you know, and involving something that's manly and that's, you know, uh, very much a part of their culture. All the guys in rural, rural north Georgia, they hunt, you know, you go out and there's tons of hunters, there's tons of fishermen, you know? And I think if it was something, uh, group oriented to where you could have open discussions about it and it not be a sissy."

Hearing more from male community leaders with personal experience was also suggested (n=5) as a way to raise awareness about men's mental health and reduce stigma. Male leaders

were seen as people who not only have credibility about men's mental health but also show that one can be a strong leader while also acknowledging that mental health is important. Participant 19-F shared,

“I think that if you could find people that are prominent community or that have good reputations that are men...the kind of the kind of type that other men might relate to, uh, that they might change their minds or want to help somebody.”

Social media was also mentioned as a good way to reach people in the community. Several participants (n=5) felt that local social media groups were a great way to spread awareness and education about men's mental health. Participant 23-F felt that Facebook was a good way to reach locals,

“I think there's a lot of good that can come through Facebook with people just sharing like positivity and it's okay to ask for help.”

Investing in *school programs* that educate on mental health and the healthy expression of emotions in boys was also mentioned several times. Many participants (n=4) felt that the stigma and negative messaging surround men with emotions and/or mental health issues start at a young age. Participant 23-F shared her thoughts on starting mental health education through school counselors,

“If we can catch 'em in school and get them in the counselor's office and get them seeing that therapy is not some scary thing, not that we do therapy in the school cause we don't, but like you're talking to a counselor when you go to a counselor outside of school, you're seeing them regularly, you're working on more intense things, but like, this is what it is. You're, you're just talking to another human and you're, and you're getting help and you're talking about skills and you're opening up, and that's okay.”

4.9.3 Theme 3: Suicide

An additional theme observed from the data was *suicide*. The topic of suicide was approached with trepidation and some discomfort but appeared to be one that many had on their minds. Topics identified under this theme were *perceptions of suicide* and *personal experience*.

Perceptions of suicide varied among participants, but most (n=19) felt that people who had died by suicide did so out of hopelessness, desperation, and lack of help/support. However, some participants (n=4) expressed not understanding why someone would take their own lives, hinting that a person who does this is “giving up” or “being selfish”. Participant 11-M expressed his views on why a person may take their own life,

“But as you know, most of the people that, uh, commit suicide have reached a point of desperation and hopelessness, and I think they have forgotten, um, the value of their own life, uh, and are purely, you know, looking at what short term seems to be a desperate situation and have lost any sense of hope or confidence that they can be a positive influence on others.”

Participant 18-M also shared his experience with a family friend who died by suicide,

“We've had some conversations here and there and just a kind of surprised like, you know, cuz when that happened, I hadn't really had much personal experience with anybody else doing that before. And it was like, how could he do that? And you know, we can understand why he was not happy, but to, to leave his grandkids and his kids. And, and it was just hard to understand and that was kind of the way the conversation went.”

Personal experience surrounding the topic of suicide was also brought up frequently by participants. Many (n=10) reported personally knowing one or more people who have died by suicide, and some (n=4) shared that they had experienced suicidal ideation at least one time in

their life. Participant 18-M discussed a common sentiment among participants, which was that suicide is a topic that most people just don't want to talk about or acknowledge, even when they know someone who has taken their own life,

“I'm good friends with two people that their father committed suicide. Um, so yeah, I mean, it, I would say the situations were different in both cases, but I've heard people talk about that. I've also heard their, their children, the ones that I'm close to talk about it some, but it's, it's certainly not something I spend a lot of time talking about. I don't think anybody's comfortable talking about it.”

Participant 20-M discussed his experience with suicidal ideation and expressed being glad he didn't take his own life. He attributed finding God to his decision to keep living,

“I mean, I'm gonna tell you the truth before I found the Lord, I had the gun to my head and the hammer pull back. I was ready to just, all it took was that was a jerk, and I would've not been here and my whole life and everything that was good. Wouldn't have actually happened in my life. The good thing is that I been through it so I can tell them there's other side. The bad part of it is, is nobody wants to give you the chance to tell it.”

Participant 23-F discussed her general observations about the suicide rates among men in the community,

“Um, we just need, we need some support around here for sure. Um, you know, when I think about the suicides that I know it's, it's almost always men. Yeah. Um, and so yeah, that's a problem.”

5 DISCUSSION & CONCLUSION

The purpose of this dissertation study was to conduct formative research for a stigma communication intervention program aimed at reducing stigma surrounding men with mental

health issues in rural America. Ultimately, this research is intended to contribute to efforts to reduce the suicide disparity of men in rural areas. This study is the first of several phases that will ultimately lead to an evidence-based intervention program tailor-made for Rabun County residents. However, this study and subsequent studies aimed at stigma communication intervention program development may also serve as a general model for additional stigma communication intervention programs in rural areas.

This chapter will discuss findings and conclusions for this research. Recommendations for the next steps in this research intervention project will be provided as well. This chapter will also introduce a theoretical contribution to stigma communication research and research on communication infrastructure theory, which is the model of stigma storytelling. Additionally, future research will be suggested along with a discussion of this study's limitations.

5.1 Considering Culture

Rabun County was chosen for this study due to the county's accessibility and sizable population in comparison to other rural areas in Appalachia. While research on Appalachian culture is robust, communities in which intervention programs are designed and implemented should be assessed for specific cultural traits within that community (Bila & Carbonatto, 2022). While this intervention study is intended to serve as a model or example of how future intervention programs can be planned and implemented, there is no one-size-fits-all model for intervention programs at the community level. Assessing specific community traits was important to this study so that the intervention design is evidence-based and tailored to the community's needs.

Data analysis showed that the Rabun County community is in many ways what one would expect of an Appalachian community. Positive core community values specific to

Appalachian culture highlighted in previous research (Deskins et al., 2006; McGarvey et al., 2011) also observed in this study were a strong sense of community (community-oriented), strong familial support systems, strong religious communities, and self-reliance. Negative or more problematic norms of the culture highlighted in previous research (Deskins et al., 2006; McGarvey et al., 2011) that were also observed in this study were fatalistic outlooks and suspicion or distrust of outsiders.

Perceptions of masculinity were also highlighted by many participants, supporting previous research that gender norms in Southern, rural America exacerbate the stigma of men with mental health problems (Crumb et al., 2019; Herbst et al., 2014). Participants often mentioned that men were expected to be strong, push through, show no weakness, remain stoic, and be the rock for his family, which are common gendered expectations surrounding masculinity in rural America (Crumb et al., 2019). Some participants went as far as to describe a man who has depression or anxiety as emasculating.

An unexpected finding in the community traits category was the perceived fragmentation of the community, or the subgroups identified by participants. This alone highlights why assessing community and cultural traits is essential to health intervention research. This trait is likely less common in smaller, more remote Appalachian areas, but this fragmentation was mentioned by nearly every participant. Participants who had lived in Rabun County or other parts of Appalachia their whole lives typically reported feeling as if they were part of a supportive, accessible community. However, those who considered themselves “transplants”, or people who were not from Appalachia, reported having a harder time integrating into the community, even after years of living in the county. Outsiders are generally approached with

suspicion, but they are also sometimes seen as the source of the county's economic issues, specifically the widening wealth gap.

5.2 Communication Infrastructure Theory

Using communication infrastructure theory was very useful to this study, specifically for identifying where people tend to connect the most in the storytelling system and where they tend to encounter stigma messages and counternarratives to stigma messages. This theory was also useful in identifying hotspots and comfort zones in the community; however, future research in this county should continue to assess this with a larger sample size from the community. As mentioned in Chapter 2, this theory has mostly been applied to urban areas, making this study somewhat unique. However, other studies have explored using CIT for rural intervention research studies, specifically Estrada et al. (2018) and Embry (2019). Wilkin et al. (2011) also explored in their study the concept of community comfort zones and hotspots, which was also highlighted by Embry (2019). This study assessed community comfort zones and hotspots, which will be useful information as this intervention is designed. This study has advanced the literature and application of CIT in rural areas, which has not been explored much. This study shows that CIT is useful in various community settings for designing health communication interventions, and this theory should be applied more to rural health research.

The findings from this study showed that many people felt most connected to their interpersonal networks as sources of information, especially family. Community organizations, especially religious organizations, were also seen as important sources of information and connectedness in the community. Several participants also reported using social media to stay connected in the community but tended to use social media to reinforce their interpersonal connections. News media was also mentioned several times, but most participants regarded the

news as negative and something to be avoided as a source of information. These findings are likely typical of an Appalachian community, as Appalachian culture emphasizes the important of family, community, and religion while distrusting “outsiders” (Crumb et al., 2019).

The communication action context (CAC) was also assessed in this study. Some elements of the CAC that participants highlighted that are likely to result in more open pathways of communication and connectedness were some available goods and services, some resources for residents, safety, schools, area appearance, and culture. Participants mentioned that the county had stores and quite a few options for shopping for necessities. The county also offers some resources for residents through public service institutions such as the health department and the North Georgia Food Bank. Nearly every participant spoke to how beautiful and safe the community is, regarding these two traits as some of the most appealing aspects of living in Rabun County. The county was also regarded as having great schools compared to surrounding areas, which was attributed to tax revenue from the county’s reliance on tourism to support its economy. The community-oriented culture reported by many participants is also likely where open lines of communication are most likely to occur, especially those who are involved in community organizations such as churches, Rotary Club, the Lion’s Club, etc. It’s important to note that some of these categories include elements that are also likely to contribute to a closed CAC, which will be discussed in the next paragraph.

While the county was regarded as having access to some goods and services, many participants felt that these goods and services are difficult to access if one is living in poverty or lives in more remote, mountainous areas of the county. Transportation was seen as a barrier for people who desire access to the community in some way, especially access to goods and services. Participants also expressed concerns that the cost of living in the county has become

nearly impossible. Even if one has transportation or access to a store like Wal-Mart, the cost of living has become untenable due to the wealth gap caused by the county's reliance on tourism. Access to affordable housing was voiced as a concern by many participants. Another area in which participants voiced concerns about access and affordability was healthcare resources. Nearly every participant shared that they felt the county had inadequate access to healthcare resources such as primary care providers and specialists. Also a barrier was lack of social salience. While some participants felt that they could move in and out of social groups in the community (eg: transplants vs. originals), many reported not being able to do this and feeling as if they could not penetrate certain groups, especially those who had belonged the community for most of their lives. Social saliences seemed to be the most possible in community organizations, especially those aimed at better the community in some way or in religious communities.

Also associated with communication infrastructure theory is the field of health action. Participants were asked about seeking care specifically for their mental health and what might encourage them to seek care or what might be a barrier to seeking care. Most participants felt that seeking care for their mental health would be difficult due to the lack of mental health care services available in the county. For those already undergoing mental health care, they reported receiving care in larger cities "nearby", which were Gainesville (2 hours away) or Atlanta (3.5 hours away). This type of geographical isolation, often an issue in rural areas hindering access to care (Rural Health Information Hub, 2019), was seen as a major barrier to seeking mental health care. Participants also expressed concerns about the cost of receiving specialized care for their mental health, especially therapy. Also mentioned many times by participants was the stigma of seeking mental health care and feeling that they can take care of their problems on their own.

Catalysts to seeking care included the cultural trait of community-oriented groups and the school system. Several participants spoke to how supportive the community is when someone needs help and felt that if someone was struggling with their mental health, the community would try to help get the person professional help if needed. Others felt that the school system is where mental health awareness and support should start, especially for young boys.

Overall, participants painted Rabun County as a somewhat typical Appalachian community that relies heavily on the tourism industry. Economic disparities were a concern due to this reliance on tourism and seasonal transplants, but many felt the community was helpful and supportive in various ways. Regardless of what subgroup a person reported belonging to, each person expressed an awareness of the cultural expectations of men, especially to be strong and stoic. Residents also felt that the county had a lot to offer if one was looking to become involved or connected to the community, specifically through church groups, The Rotary Club, and The Lion's Club. These groups are likely the best place to start with mental health promotion aimed at reducing the stigma of men with mental health problems.

Assessing the communication infrastructure of a community can be quite helpful in designing interventions at the community level as this theory can help assess ways to connect with and reach populations that are harder to access (Matsaganis et al., 2014). Findings from this research indicate that several participants have connections with subsets of the community that may be harder to reach. Future research for this intervention should continue to assess the storytelling system and communication infrastructure, focusing on hard-to-reach populations in the county, which would be those living in very remote areas or living in more insular Appalachian communities who are reluctant to trust outsiders.

These findings suggest that using people who are part of the community to reach populations such as this one is important as research (Matsaganis et al., 2014) shows that interpersonal channels are influential within the storytelling system and there is "outsider" mistrust. Findings of this study suggest that community leaders are important storytellers on mental health topics in the community, which supports previous research on community leaders as influential and important storytellers within a storytelling system (Literat & Chen, 2013; Matsaganis et al., 2014; Wilkin et al., 2011). These storytellers will likely be key to implementing an effective intervention program in reducing stigma surrounding men's mental health. In their study, Matsaganis et al. (2014) demonstrated that peer health advocates, who are residents in the community, can often act as interstitial actors who bridge the gap between micro- and meso-level actors, which should also be considered in the implementation of this intervention in Rabun County. In this study, several community leaders were identified that could potentially be peer health advocates for this intervention study.

5.3 The Model of Stigma Communication

The model of stigma communication was also useful to this study as this framework aided in designing a study that identified the most common stigma messages encountered in the community as well as message reactions and effects. This research demonstrated that the model of stigma communication should be used more in applied health communication research aimed at reducing stigma in specific communities. This study also contributed further to our understanding of the theory by examining various levels of stigma communication rather than focusing only on interpersonal transmission of stigma messages. While this is not completely novel, only a few studies have explored the model of stigma communication on various communication levels. Future research for this intervention in the Rabun County community

should include surveying residents to further assess stigma messages, message reactions, and message effects. Future research in general should explore how each level of stigma communication may reinforce the stigma messages. This would require examining stigma messages about a specific topic on each communication level and testing whether these messages reinforce each other.

The most commonly identified stigma messages associated with men who have mental health problems were weakness, dangerousness, and shamefulness. Personal responsibility (Smith, 2007), notably weakness, was by far the most associated stigma with men who have mental health issues. Weakness was often associated with femininity or emasculation, especially depression, which was specifically seen as a mental health problem mostly to do with weakness or not being strong enough. Several participants mentioned that a man with depression or other mental health problems was also sometimes regarded as simply not having enough trust in God and was an issue of not having enough faith that everything would be alright. This is consistent to what previous research has found. This was specific to Christian communities, and this view is commonly encountered in more conservative, Evangelical Christian communities (Lloyd et al., 2022). The prevalence of the stigma of weakness is concerning as this can be directly related to rural men's hesitancy to seek help (Crumb et al., 2019). This hesitancy has been associated in prior research with self-identifying as stoic, independent, strong, and masculine (Crumb et al., 2019; Herbst et al., 2014).

Dangerousness, which falls under Smith's (2007) categorization of peril, was also a common stigma message discussed by participants. Specifically, violence was noted by several participants as a stigma message they've encountered about men who have mental health issues. This is likely perpetuated on various levels of communication as this is a common trope in

entertainment media (Corrigan & Kosyluk, 2014) but is also depicted in news media as well (Wahl, 1995). Several participants recalled seeing some kind of negative depiction of men with mental illness in television and film. Some participants also recalled friends and family telling them to stay away from someone in their community due to them being “crazy” and dangerous. This kind of assumption can be isolating for the person with mental illness, as a person deemed dangerous to their community is often ostracized, isolated, and discriminated against by others in the community (Corrigan & Kosyluk, 2014).

Shamefulness was also a common stigma narrative observed in the data. It is simply shameful to even discuss or admit to having mental health struggles. Shame was sometimes discussed in relation to weakness or not being “tough enough”, but many participants associated shame with the label of “crazy”. Many participants discussed the shame behind being labeled as “insane” or “crazy”, expressing that they didn’t want others to think they were crazy and were resistant to seeking help in the past because they knew they weren’t “crazy”. The label of “crazy” is an example of a group label (Smith, 2007), which is often associated with dangerousness, lack of self-control, and unreliability (Corrigan & Kosyluk, 2014). These kinds of labels can lead to hesitancy to seek help and avoid being categorized as a person who belongs to the stigmatized group (Corrigan & Kosyluk, 2014; Jones & Corrigan, 2014).

Common emotional reactions discussed by participants were embarrassment and sympathy. Related to the stigma message of mental illness as shameful, many male participants reported feeling embarrassed and emotionally uncomfortable about disclosing their mental health struggles, often resulting in delaying seeking support. They were simply embarrassed to be considered part of a stigmatized group, and some male participants expressed feeling embarrassed disclosing their mental health history with the interviewer, especially those that had

experienced suicidal ideation. The feeling of shame or embarrassment is common among those who belong to or are associated with a stigmatized group as their identity can feel tainted by labels and assumptions applied to the group (Schmader & Lickel, 2006).

Sympathy was another common reaction to stigma messages. This affective reaction refers to being able to feel concern for another person by taking on that person's perspective, vicariously feeling their emotional state (Smith, 2014). According to Smith (2014), "sympathy is associated with an action tendency to alleviate the other person's reason for suffering or to provide them comfort" (p. 6). After discussing common stigma messages observed in the community, most participants expressed sympathy to those who are subjected to labels and ostracization as a result of stigma. None of the participants expressed the desire to stay away from people who are mentally ill. Every participant in this study discussed either their own mental health struggles or the struggles of men they knew, and most expressed compassion and understanding to those who experience mental health problems. Due to how common this emotional response was in this study, creating mental health promotion messages aimed at eliciting sympathy/empathy may be an effective way to reduce the stigma of mental health issues in men. Previous research has shown that there is a significant relationship between people viewing mental illness sympathetically and supporting increased allocation of funds for mental health services (Corrigan et al., 2004). However, it's important to consider how messages that elicit sympathy/empathy may have unintended consequences, especially if these messages do not also incorporate empowerment and self-determination (Corrigan, 2016). Eliciting pity may have the unintended effect of making people with mental illness seem unable to competently manage their lives and mental health, further contributing to the stigma of mental illness (Corrigan, 2016). Corrigan (2016) argues that messages of sympathy should be replaced by messages of

empowerment; however, the author of this study argues that future research should continue to test messages in intervention efforts aimed at reducing mental health stigma by combining themes of empathy/sympathy and empowerment.

Observed cognitive reactions included male participants internalizing the stigma of men with mental health issues (self-stigma) and male and female participants having the perception that men with mental health issues are personally responsible for their mental health struggles (mostly weakness or not being strong enough). Several male participants expressed how much they believed that other men with mental health problems had nothing to be ashamed of, but when they discussed their own mental health struggles, a different story emerged. Related to the emotional response of embarrassment, several expressed the shame of experiencing mental health problems throughout their life and feeling as if they were a failure due to their struggles and/or diagnoses. Others felt that it was normal for men to experience mental health issues, but they also felt that when they had experienced mental health problems themselves, they were weak or had not had enough faith. This describes self-stigma, which occurs when people internalize the stigma messages they're exposed to. This was one of the most common stigma responses among male participants. Self-stigma is quite common among those with mental illness and can result in withdrawal from one's community and avoiding seeking help (Corrigan & Kosyluk, 2014).

Weakness appeared to be the most accessed stigma narrative when discussing men with mental health issues, and embarrassment was often expressed if a male participant was discussing his own mental health struggles. Every participant mentioned the stigma narrative of weakness or personal responsibility. Cognitive reactions such as this to stigma messages can make relevant social attitudes and stereotypes associated with men who have mental health

problems more accessible (Smith et al. 2016), which is likely what is being demonstrated in this study. However, this is speculation and future research should explore the relationship between cognitive reactions and the accessibility of stereotypes using a larger sample of residents in the county.

Observed message effects as a result of stigma responses were avoidance/ostracization, label avoidance, and silence/denial. Most participants personally did not believe someone should be ostracized from the community due to mental health struggles, but many reported witnessing ostracization first-hand. Others felt that if a man shared with his community that he was depressed or having mental health problems, he would be avoided. This is a common stigma response as those who belong to the stigmatized group are often recognized by the community as “marked” and avoided by the rest of the community (Smith, 2007).

Because of the fear of being judged by people in their community, many male participants discussed not wanting to be labeled as “crazy”, even delaying mental health care until they were in crisis in order to avoid the label. This is a common outcome of label avoidance (Corrigan & Kosyluk, 2014; Jones & Corrigan, 2014). Female participants also discussed men in their lives who had waited to seek care due to not wanting to be perceived as “crazy” or “insane”. Due to how small the county is, participants felt that if they went to a support group such as AA or a mental health clinic (if available), people in town would know.

Silence/denial was also mentioned frequently. Many participants stated that people just didn’t talk about mental illness, especially in relation to men. The topic (men with mental illness) was considered taboo and rude to even discuss with others. Participants shared that this was common growing up as well as in certain church organizations within the community. This could

be considered a way in which communities avoid the stigmatized group, but this type of stigma message effect should be explored further in the study of stigma communication.

5.3.1 Exploring The Impact of Stigma Messages on Help-Seeking

Most respondents felt that men seeking help in some way for their mental health was important; however, most men also discussed how the shame and embarrassment of having mental health struggles resulted in delaying seeking support and/or professional help for themselves. Previous research has shown that adherence to rural masculine norms is a barrier to men seeking help for depression and other mental health problems (Crumb et al., 2019; Herbst et al., 2014). When discussing treatment options, there was a feeling of discomfort surrounding therapy as this was seen by many of the men as being very vulnerable in front of a stranger. Most men felt that seeking help should start either with their spouse or primary care provider. This aligns with previous research that found primary care providers are often the first clinicians sought out when people in rural areas are seeking mental health support (Moise et al., 2021).

Others felt that even if the county provided psychiatric or counseling services in town, they would be hesitant to visit a clinic in person as people they know could see them. Due to possibly being seen going into a mental health clinic, along with transportation issues, several participants mentioned that they would be open to telemedicine if they could afford it. Broadband is generally available in the area, and this mental health care option was brought up several times as a more comfortable way to engage in talk therapy. Telemedicine may not be a replacement but rather a good alternative to in-person care when a patient experiences feelings of shame or embarrassment, especially in rural areas (Hand, 2021).

Help-seeking outcomes were also discussed by most participants in this study. Men tended to discuss their own help-seeking behaviors whereas female participants discussed help-

seeking outcomes of men in their lives. Most of the male participants reported that the first place they sought care for their mental health was through their primary care provider, and nearly every man sharing that they sought medical intervention also shared that they delayed seeking care due to not wanting to seem weak or feel like a failure. The stigma of mental illness can delay recognizing the need for care as well as simply delay care due to shame (Crumb et al., 2019; Roy et al., 2013). Female participants reported the same regarding the men in their lives. The attitude toward medication to treat mental health disorders was generally favorable, but some participants expressed embarrassment when sharing that they relied on medication to manage their mental health symptoms. Participants also shared their initial hesitation to try medication for their anxiety or depression, but they tried meds because they either felt they had no other means of managing their mental health or did not feel comfortable with talk therapy.

Seeking support through family and friends was also mentioned frequently by participants. Many of the male participants reported first seeking counsel or support from the women in their lives when experiencing mental health struggles. Men often reported feeling more comfortable approaching their wives or female family members to talk about their emotions. Many men felt that women were more accessible as sources of support and simply more understanding and easier to talk to. Others felt more comfortable reaching out to their pastors as primary sources of support for their mental health, but several participants acknowledged that pastors may not have adequate training in counseling or dealing with mental health crises.

Across the board, female participants were in favor of men seeking support for their mental health in some way. Female participants reported being aware of stigma beliefs surrounding men's mental health but did not appear to hold those beliefs personally. Most

reported having men in their lives who had experienced some kind of mental health crisis, expressing that they wished the men in their lives had sought help sooner. Several women had male spouses and family members who had delayed care until they were in crisis, at times experiencing suicidal ideation.

5.4 Stigma Storytelling

This dissertation study sought to expand research in the area of stigma communication and communication infrastructure theory, which has been minimally explored (e.g., Jung & Kwesell, 2021). The concept of stigma storytelling, the multi-level transmission of stigma messages in a community, has been introduced in this dissertation as a result of combining concepts from CIT and the model of stigma communication. While this research is in its formative stages, future research in stigma communication should continue to explore the concept of stigma storytelling. In this study, assessing stigma storytelling illuminated where in the storytelling system participants tended to encounter stigma messages and who engages in stigma storytelling.

All participants were aware of common stigmas and stereotypes surrounding men with depression and other mental health problems, but most participants had a hard time remembering specific stories they had heard about mental health and men. Several remembered vague conversations with family members and friends about a man in their family or community being “crazy” or behaving bizarrely, but none could remember a specific story. Others reported seeing several television shows and films depicting mental illness in men but could not recall which shows or films. They could, however, remember the stereotypes depicted in film and television such as disheveled or dangerous. This is likely due to repeated exposure of stereotypes like this and the association made as a result of this repeated exposure (Hinton, 2017). Others reported

seeing news stories about young men who commit mass shootings being a result of mental illness, which potentially reinforces the association of dangerousness with mental illness (Beltzer et al., 2022).

The data analysis showed that the level in which stigma messages were encountered the most were on the micro-level, or through interpersonal networks. Several participants recalled stigma messages being shared as early as childhood, specifically through comments their fathers made about men being tough and not crying. The meso-level of communication was also where stigma messages were frequently encountered, especially in religious communities. While some participants mentioned that their church was perceived as supportive, many discussed how churches in the community were not supportive of people with mental health problems, attributing mental health struggles to having a lack of faith. Participants also mentioned that discussing mental health in a church setting was considered taboo.

On the macro-level, participants reported encountering stigma messages through entertainment media, news, celebrities, and social media. Most discussed specific stereotypes encountered in entertainment and news media associated with mental illness (mostly depression and anxiety), but several also brought up discussions around celebrities with mental health problems. Robin Williams was mentioned several times as an example of a celebrity generating discussion around suicide and mental illness that was perceived as negative and perpetuating negative stereotypes surrounding men's mental health. Hoffner and Cohen (2018) found in their study on media exposure of Robin Williams' suicide, that stigmatizing media exposure was related to greater depression stereotypes. Participants likely associated negative stereotypes with Williams' suicide due to the type of media they were consuming at the time and how his suicide

and mental health struggles were framed. Others reported seeing negative messages on social media, specifically through memes shared by other people in the networks.

Rabun County is very community-oriented, relying heavily on interpersonal networks for information and connection. It's no surprise that stigma messages are mostly encountered at the micro-level. Stigma messages at the meso- and macro- level likely reinforce stigma messages shared at the micro-level, which needs to be explored further in future studies, specifically how these stigma messages can be countered on each level of communication.

5.4.1 Who Is Engaging in Stigma Storytelling

Family members were reported as the most prominent source of stigma messages. Many people live with or near immediate and extended family members who are all connected to the community. Not only did participants report growing up learning about a “man’s role” as being strong and providing for the family, but they also reported that a lot of conversations surrounding the mental health of others in the community often took place at the dinner table or sitting around visiting with other family members. Friends and acquaintances were also noted as sources of stigma storytelling, but they were not mentioned as often as family. Participants identified the most influential storytellers as their family members. Many of the male participants felt that their fathers were the first and most influential sources of their stigma beliefs surrounding men’s mental health. Others reported that much of the stigma storytelling they engaged in and remembered most vividly was with family members.

Religious leaders were also reported frequently as stigma storytellers. Through sermons and private counseling sessions, stigma messages were shared, mostly implying that mental illness is the result of lack of faith. As mentioned previously, this perception of mental illness is quite common in evangelical Christian churches, which often emphasize a man’s role as being a

strong leader in his household who should have more faith and pray when experiencing any kind of internal struggle (Lloyd et al., 2019). Religious leaders were identified by participants as highly influential in the development of mental health stigma beliefs. Several participants discussed how their religious beliefs surrounding mental illness were highly impacted by their pastors/preachers, which resulted in delaying care, feeling shame, and having a crisis of faith when experiencing mental health struggles. This was especially so for male participants who had grown up in very religious households. There was some indication that some churches in the area would be more open than others to advocating for mental health education and care, but this was not discussed at length by any of the participants. Future research should explore the impact of religious organizations on mental health perceptions in small, insular communities in which religiosity is prevalent and an essential part of the community culture.

The local newspaper was also mentioned by several participants as a source of stigma storytelling, specifically reporting on arrests for drug charges or DUIs. One participant felt that this shamed people who had legitimate problems with addiction, further ostracizing them from the community they needed support from. Another participant discussed how these reports in the paper were sources of gossip among family and friends, perpetuating the stigma of addiction.

While macro-level sources of stigma were mentioned many times by participants, none of the participants regarded mass media sources as highly influential in the development of their mental health stigma beliefs. Mass media can reinforce stigma messages and beliefs regarding mental illness (Arboleda-Flórez, 2003; Wahl, 1995); therefore, some of the media examples provided by participants have likely reinforced some stigma messages encountered on the micro- and meso-level, which future research should explore further. It's also highly likely that

participants are simply not aware how much the media influence their attitudes toward men's mental health, which might be better measured through a quantitative approach.

5.4.2 Counternarratives

For this intervention study, counternarratives were essential to investigate. Assessing counternarratives allows for understanding where stigma communication intervention efforts are best placed or where some may already be happening in the community. Messages that challenge stigma narratives were encountered through significant others, community organizations, and mass media.

Several male participants mentioned that their spouses were the reason they changed their perceptions on having mental health issues and seeking help. Their significant others encouraged them to learn more about mental health and how treatment works. Men were also encouraged by their spouses to seek help for the sake of their family's wellbeing. This supports research showing that interpersonal connections can reduce stigmatizing views on mental illness (Couture & Penn, 2003); however, this study also showed that most people encountered stigma messages from their interpersonal network and specifically found family to be the most influential source of stigma beliefs. This suggests that intervention efforts should target interpersonal networks when aiming to reduce stigma surrounding men's mental health.

Community organizations were where most participants reported encountering messages that challenge stigma narratives. The Rotary Club, The Lion's Club, and The Mental Health Task Force were mentioned by several participants. According to participants, the Rotary Club and The Lion's Club have existing efforts aimed at addressing mental health needs in the community, and these organizations promote seeking mental health support. These two organizations would likely be great resources for implementing an intervention program aimed at men's mental health

as they have the means to disseminate mental health education materials as well as implement programs that encourage discussion surrounding men's mental health and seeking help. The Mental Health Task Force was also discussed at length by several participants. This is a newer organization in the early stages of development, but their main focus is to address mental health disparities in the county and the lack of mental health care services. This organization is also a good place to work with community leaders invested in improving mental health care in the region. These findings suggest that community organizations such as these are great places to connect people and have those well connected in the community engage in outreach to those less connected to the infrastructure. This also supports Jung and Kwezell's (2021) research on CIT and stigma, which found that participation in community organizations can moderate stigma beliefs. For this health communication intervention, reliance on community organizations will likely be essential to the successful implantation of the intervention as well as sustainability of the program.

Participants also discussed mass media messages that discussed men's mental health in a positive manner. Celebrity disclosures of mental health struggles and seeking care for mental health appeared to have quite an impact on several participants, this was especially so when the celebrity was a well-known athlete. Prior research has shown that celebrity disclosures can support mental health stigma-reduction efforts by creating more awareness on the issue and appealing to those who have parasocial relationships with the celebrities engaging in disclosure (Gronholm & Thornicroft, 2022; Hoffner, 2019). Others reported seeing positive messaging on social media through memes, mostly through Facebook. Facebook seemed to be the most used social networking site among users and may be a good way to disseminate mental health promotion materials in the community.

5.5 Additional Findings to Inform Intervention Research Design

Additional themes were identified outside the scope of the research questions and the assessment of the community's traits. These findings are important to acknowledge as they give further insight into the community as well as provide additional data that will aid in forming an evidence-based approach to intervention design. These additional findings included trusted sources of information on mental health, locals' ideas for reducing stigma, and suicide.

Many participants discussed trusted sources of information on mental health, and most felt that either medical professionals or community leaders were the best sources of information. These are important figures within the storytelling system that will likely be essential to the successful implementation of a stigma communication intervention program. Participants felt that their primary care providers were the best place to go for information on mental health, which is where most medical care for mental health occurs (Moise et al., 2021). They felt the environment was safe, neutral, and that clinicians knew more about the topic than most other sources of information on mental health care. Others felt that community leaders leading mental health awareness efforts were also good sources of information, especially those who were men. Intervention efforts may be best promoted through sources such as local clinicians and prominent male leaders who are considered role models in the community. For instance, the mayor and sheriff were considered reliable and invested in the community, regarded as voices of authority in the community.

Participants also offered ideas for reducing the stigma of men with mental health problems. This came up in most interviews because participants were eager to share what they thought may help improve mental health awareness and suicide rates in the area. By providing this information, participants gave insight into what may work well for this community to reduce

the stigma surrounding men's mental health. Several people suggested masculine events in which men could connect with one another, form community, and potentially discuss men's mental health in some way. Examples of masculine events provided by participants were fishing and/or hunting excursions and game nights with darts or cornhole. Others suggested that male community leaders who have personal experience with mental health struggles should speak out and assume leadership positions in the community. If there are men in the community willing to do this, having them speak at or promote these "masculine" events could be a way to promote men's mental health awareness while building community. Additionally, several participants mentioned Facebook as a good way to reach people in the community. There are several community pages and community bulletins on Facebook where people connect. This may be a good way to disseminate positive message but also promote mental health awareness events such as those suggested above. Some participants also believed that intervention efforts for normalizing men's mental health should start in the schools through mental health awareness programs. Participants mentioned that normalizing seeking support and/or professional help needed to start early on, especially for boys. Participants were not aware of existing efforts in K-12 schools in Rabun County but felt it was important to consider.

An additional theme observed in the data was suicide. While participants were not explicitly asked about their thoughts and experiences related to the topic of suicide, the subject came up in nearly every interview. This is likely due to the title of the study and ultimate goals of the study detailed in the informed consent form. Many participants were curious about the county's suicide rates and were keenly aware that suicide was a problem among men in the area. Participants typically brought up the topic in interviews when discussing their personal

experiences with mental health problems or when discussing other people in their lives who had died by suicide.

This topic needs to be explored more in future studies for this intervention as the conversations surround suicide were quite different than conversations surrounding men with mental health problems. While the topic of men with mental health issues seemed to be acknowledged as a stigmatized issue, most participants did not have much hesitancy talking about it. However, the topic of suicide was met with trepidation but the desire to discuss the topic, with several expressing they did not understand why others would take their own lives and leave their loved ones behind. Several male participants also shared that they had experience suicidal ideation before but had not been able to talk about it with others openly for fear of what the ramifications would be. While not measurable through the data collected, the stigma of suicide appeared to be much stronger than the stigma of men who have mental health disorders such as depression or anxiety, though suicide is often the worst outcome of these mental health issues. This supports prior research examining the stigma of suicide. There appears to have been some reduction in the stigmatization of mental illness, but little to no reduction in the stigma associated with suicide and suicide-survivorship (Corrigan et al., 2017; Mayer et al., 2020; Sudak & Carpenter, 2008). Others expressed how suicide had “tainted” their family or other families they knew in the community. For future studies informing the development of this intervention, the stigma of suicide and suicidal ideation should be examined as this topic seems to be perceived much differently than mental health problems in general.

5.6 Stigma Communication Intervention Program Recommendations

While this stigma communication intervention research is in the beginning stages, intervention program recommendations are necessary to determine the direction intervention

development will eventually go in. These recommendations should be considered and refined as more formative research is collected and as intervention efforts are gradually implemented:

- Provide educational resources on men's mental health such as flyers, social media posts, and resource lists. Participants frequently mentioned not knowing what mental health resources existed in the community. Flyers, brochures, and resource lists may be best placed in community centers such as the food bank, the health department, schools, libraries, and local primary care clinics. These educational resources, specifically a resource list including information where people can find support in the community or in nearby communities, may also be effective when shared in community Facebook groups. Additionally, because participants reported Facebook as being the most used social media app in the community, community organizations such as The Rotary Club, The Lion's Club, or the Mental Health Task Force should consider posting in community groups on Facebook regularly to promote men's mental health awareness as well as community efforts to address men's mental health. Positive messaging surrounding men's mental health will create visibility and normalize conversations surrounding men's mental health, potentially normalizing the issue.
- Connect further with community leaders such as local political figures, medical professionals, law enforcement, business owners, and other active members of community organizations who are willing to promote mental health education surrounding men as well as other efforts aimed at reducing stigma. These community members are likely the best links to the rest of the community as they are very connected to the communication infrastructure, often acting as interstitial actors between community organizations and Rabun County residents. Having the confidence and buy-in

from community leaders will likely make developing and implementing intervention efforts more successful in the future.

- Consider piloting “masculine” events that promote men’s mental health awareness in some way. These events can be small and simply involve games, watching sports events, or a day of fishing. The goal is to encourage connection and conversation. Having the endorsement and attendance of prominent community leaders would likely make these events successful. This would also be an appropriate initiative for an organization such as the Rotary Club or the Mental Health Task Force. These events could be promoted through local meeting spaces (churches, community center, library, etc.) and through Facebook groups such as the Rabun County Bulletin.

5.7 Theoretical Contribution: The Model of Stigma Storytelling

This dissertation research proposes a theoretical contribution to stigma communication research, which will be used going forward in future studies in Rabun County for the development of a stigma communication intervention program. Because the model of stigma communication was complementary to communication infrastructure theory in this intervention research, this study proposes to integrate the model of stigma communication with communication infrastructure theory to better assess stigma messages and their effects in rural communities. Stigma is a social process that often involves storytelling, and this integrated model will assist in understanding how stigma storytelling occurs throughout multi-level actors, where stigma storytelling tends to take place, and where stigma messages may be reinforced due to connections to various storytellers within the communication infrastructure. This model will also aid in assessing the outcomes or effects of these stigma messages. More research needs to explore various types of storytelling that take place within a communication infrastructure,

specifically stigma storytelling or the transmission negative messages about particular conditions. The model of stigma communication has not adequately explored stigma message transmission on various levels and how each level of stigma messaging may reinforce the other, which the model of stigma storytelling attempts to address.

Stigma storytelling, defined in Chapter 2, is the multi-level transmission of stigma messages in a community. This model is intended to be a tool that aids in better understanding how the transmission of stigma occurs in communities through macro-, meso-, and micro-level communication. The model emphasizes the stigma message choices on each level as well as the message reactions and message effects on a micro-level. This model is intended to assess the following:

- What specific stigma narratives exist in a community
- Where these stigmas are encountered and learned
- What parts of a community's communication infrastructure are enabling the spread of stigma messages (communication action context features: e.g., comfort zones and communication hotspots)
- How stigma messages shared on a macro-, meso-, and micro-level affect community members' perceptions of mental illness in others and in themselves
- Where the most effective interventions to reduce stigma messaging and increase education and awareness can take place.

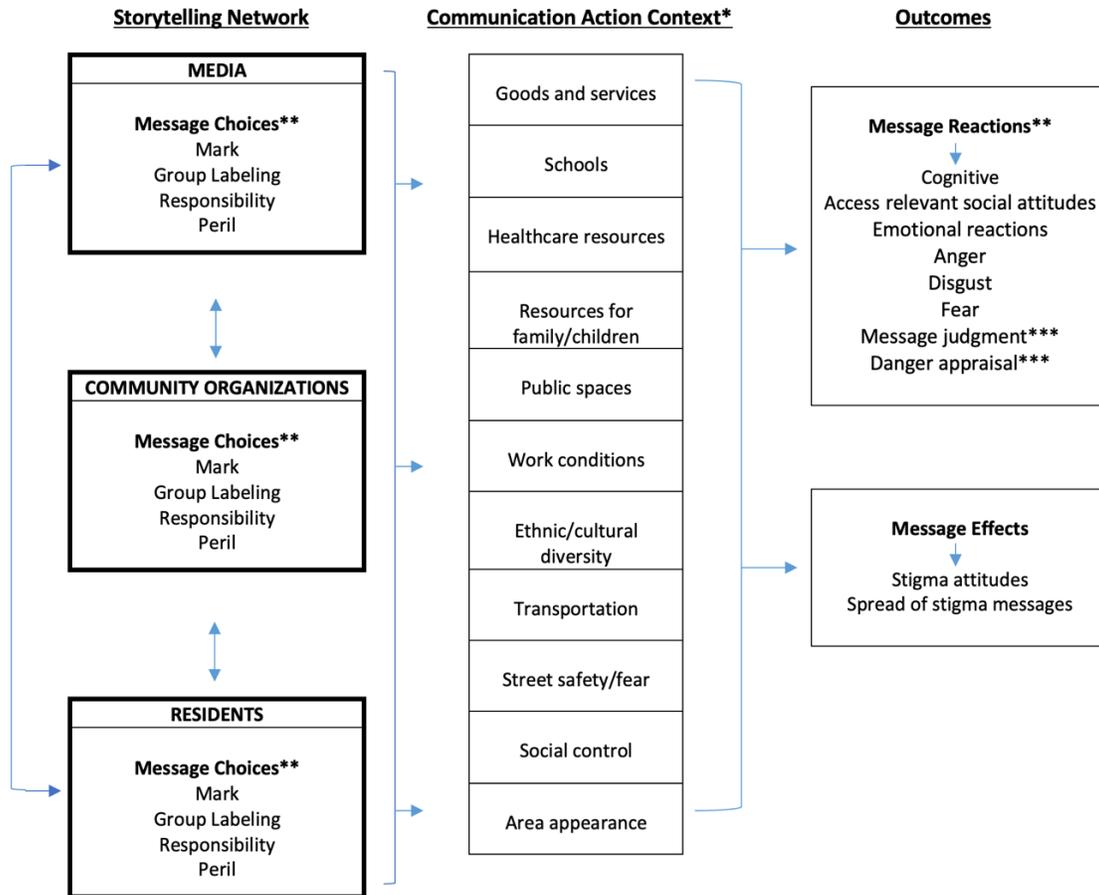


Figure 2. The Model of Stigma Storytelling

*Ball-Rokeach et al. (2006); ** Smith (2007); *** Smith et al. (2019)

5.8 Future Studies

Interviews modeled after the one in this study (see Appendix B) as well as scales can be used to assess the community’s storytelling network and where the communication action contexts are open in the community. The variables measured in surveys can also be used for experiments similar to Smith’s work on the model of stigma communication. As this dissertation research has shown, interviews are particularly helpful in assessing who the main storytellers/sources of stigma are in the communication network. Interviews and/or a survey instrument can be used to assess what stigma narratives exist in the community and where in the

community's communication infrastructure these stigma narratives are accessed and passed on to others in the community. Using a mixed-methods approach is suggested when applying this model to stigma communication intervention research.

Corrigan et al. (2012) have categorized existing efforts to reduce stigma as protest, education, and contact, which some stigma intervention programs have attempted to address. However, more intervention programs that use empirically based approaches are needed. This model of stigma storytelling would be appropriate to use as a formative research tool in the development of programs or campaigns seeking to reduce the stigma surround a particular health condition. This model is also useful in simply assessing which stigma narratives are more prevalent on each level of communication and where stigma messages are reinforced.

The model of stigma storytelling will likely prove to be a useful tool in developing and implementing evidence-based health communication interventions for stigma. This tool will not only advance theory in stigma communication, but it can also be used to help communities in need. Stigma is often a barrier to people seeking the care or support they need, and campaigns aimed at reducing stigma can aid in breaking those barriers. This model will be used going forward when conducting additional research for this intervention program. Future research on stigma communication should use this model to understand how a community's communication infrastructure enables the transmission of stigma messages surrounding a particular condition. By better understanding where the stigma messages are coming from and where they are reinforced, more effective approaches can be taken to reduce stigma surrounding particular conditions.

In general, future research needs to further explore the stigma of men with mental health issues in rural areas, specifically how stigma messages are spread and how these messages affect help-seeking behaviors. Unique cultural traits of rural communities, namely perceptions of

masculinity, make these communities challenging when attempting to reduce stigma (Crumb et al., 2019). It will take multiple studies in several rural communities to better understand how stigma narratives contribute to larger issues such as suicide disparities in specific rural populations and what types of stigma reduction intervention programs work best in these communities.

Future research should also examine how stigma narratives are reinforced at various levels on the communication infrastructure. The findings from this research hint at stigma messages being mostly spread at the micro- and meso-level and reinforced at the macro-level. The model of stigma storytelling is designed to address reinforcement but requires more testing and development.

Future studies should also examine the stigma of suicide among men in rural areas, which appeared to have a stronger stigma attached to it than the general topics of men with mental health problems or men with depression. More studies should explore this specific stigma in rural areas as it will likely highlight why some men do not seek help. The stigma of suicide and suicidal ideation likely contributes to men not seeking help when experiencing suicidal ideation.

5.9 Limitations

This study has several limitations. Perhaps the biggest limitation is the population sample. Though many participants were Appalachian or from surrounding Southern areas, several of the participants were not originally from Appalachia and could only speak to their experiences of trying to assimilate to Appalachian culture. Most transplants could provide observations of Appalachian culture and Southern culture, but future studies should try to focus on smaller, more insular Appalachian communities to gain a clearer understanding of the unique

challenges and perspectives of Appalachian people. This will be one of the goals of the next phase of research for this multi-phase intervention research.

Additionally, most participants appeared to volunteer for the study because they were passionate about making mental health awareness and mental health care services better in their community. This provided quite a few contacts for the promotion of future studies in the community and the possible implementation of intervention efforts later on, but their outlooks on men's mental health were potentially more positive than some other residents in the county who may be more isolated or who may not have volunteered due to the stigma associated with the health topic. The participants were mostly well connected to the community, providing valuable observations of the people in the county. However, future studies should attempt to reach people who are less connected to the communication infrastructure, assessing their perspectives on men's mental health as well as their perceptions on access to care and information. This will also be a goal of the next phase of research for this intervention program in Rabun County.

Another limitation was the lack of exploration of the stigma of suicide and suicidal ideation. How this stigma can contribute to a delay in seeking care or support when experiencing a mental health crisis and/or suicidal ideation was not considered as much as it should have been. Many participants discussed suicide in some way, but by design this study did not explore this specific stigma adequately. Suicide stigma was clearly different than the stigma of mental illness or specific conditions such as anxiety and depression.

While not necessarily a limitation but rather a trait of qualitative research, it is important to note that the data generated by this study is not generalizable. While the data were robust, the sample size was small. While intercoder reliability was established for the thematic analysis, interpretation of the data was subjective in nature due to the methodology of the study. This

study and subsequent studies related to the development of this intervention serve as examples to follow in other stigma communication intervention research in rural populations, but it should be noted that findings may vary depending on the community's culture. This is while a multi-pronged approach to intervention development is necessary, and next steps will include a quantitative approach.

5.10 Conclusion

This formative research is the first phase (Phase 1-prephase) of research for the development and implementation of a stigma communication intervention program in a rural, Appalachian community. Additional research is required in the development phase for the Rabun County community, specifically more prephase research needs to be implemented along with feasibility studies for the implementation of a stigma communication intervention program. However, this study generated valuable data, highlighting community traits unique to Rabun County, emphasizing the communication infrastructure along with prominent stigma narratives encountered on various communication levels. Stigma storytelling appeared to take place the most at the micro-level through family and friends; however, meso-level communication was also considered a source of stigma narratives, especially in religious organizations. Stigma storytelling surrounding men's mental health was often associated with emasculation and weakness, which can generate shame when living in communities that heavily emphasize traditional gendered roles and traditional perceptions of masculinity.

While stigma is not the only contributing factor to the suicide rate disparity of rural men, research such as this dissertation study may ultimately be able to aid in the reduction of stigma, resulting in the reduction of suicide rates in rural communities. However, stigma reduction programs should be implemented in tandem with other efforts aimed at reducing suicide rates in

rural America. This is a complex public health problem that requires a multi-faceted, multi-disciplinary approach.

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APPENDICES

Appendix A

Informed Consent
Georgia State University
Department of Communication

Please fill out your name here:

Title: Addressing Rural America's Suicide Disparity Among Men: How Mental Health Stigma Is Communicated and Learned Through Storytelling Networks

Principle Investigator: Holley Wilkin, Ph.D.

Student Principle Investigator: Lindsey Jo Hand

Instructions and Key Information

You are invited to take part in a research study. It is up to you to decide if you would like to take part in the study.

The purpose of this study is to better understand how the stigma of mental health problems in spread in a community.

Your role in the study will last about one hour, and we will only meet once.

You will be asked to:

- Review this consent form and verbally consent to participating in this study before participating in the interview,
- Participate in a one-on-one interview through Zoom or a phone call.

Participating in this study will not expose you to any more risks than you would experience in a typical day.

This study is not designed to directly benefit you. Overall, we hope to know how negative messages about mental illness in men can be addressed. We hope that this research will help us develop programs that lessen stigma and inspire people to seek help when they need it.

Purpose

The purpose of this study is to understand how the stigmas of mental health problems in men are shared in a rural community. You are invited to take part in this research study because you live in Rabun County and are over the age of 18. Between 30 to 40 people will be invited to take part in this study.

Procedures

If you decide to be a part of this study, you will be interviewed for about one hour over Zoom or over a phone call. Please know that you may choose to skip questions or end the interview at any time. The interview will be audio recorded for the purpose of making sure the interviewer has an accurate record of the interview, but audio recordings will not be shared with anyone outside of the research team.

What to expect:

- You will only interact with the interviewer, Lindsey Jo Hand, for this study.
- After reaching out to Lindsey Jo Hand to let her know you would like to be interviewed, you will receive a consent form (this form) to review before meeting for the interview.
- You may choose to meet on Zoom or through a phone call. If the meeting is on Zoom, Lindsey will email you a password protected Zoom link for the meeting. If you choose to meet through a phone call, Lindsey will call you using the phone number you have given her.
- You will be asked to verbally agree to participating in this study before the interview begins.
- The interview will be several questions about your views on mental health and men. It will last up to one hour.
- The interview will be audio recorded. There will be no video recording.
- When the interview is done, you will be emailed a \$25 Amazon gift card along with the study website link so you may explore resources on men's mental health.

Future Research

We will remove any information that may identify you and may use information from interviews for future research. If we do this, we will not ask for any further consent from you.

Risks

In this study, you will not have any more risks than you would in a normal day of life. No injury is expected from this study, but if you believe you have been harmed, contact the research team as soon as you can. Georgia State University and the research team have not set aside funds to pay for any injury.

Benefits

This study is not designed to benefit you on a personal level. However, there may be direct benefits to you. In better understanding the stigma of mental health issues in men, this study will help us know a little more about how to lessen suicide rates among men in rural areas. Overall, we hope to gain information about the stigma of mental health issues in men so we can design community health programs that encourage people to get help for their mental health when needed.

Alternatives

The alternative to taking part in this study is to not take part in the study.

Compensation

For participating in an interview, you will be awarded a \$25 Amazon gift card. The gift card will be emailed to you right after the interview is finished.

Voluntary Participation and Withdrawal

You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time.

This will not cause you to lose any benefits to which you are otherwise entitled.

Confidentiality

We will keep your records private to the extent allowed by law. The following people and entities will have access to the information you provide:

- Dr. Holley Wilkin and Lindsey Jo Hand (research team)
- GSU Institutional Review Board
- Office for Human Research Protection (OHRP)

We will use a code name of your choosing rather than your legal name on study records. The information you provide will be stored on a firewall and password protected computer in a password protected zip file. When we present or publish the results of this study, we will not use your name or other information that may identify you.

Audio recordings of interviews will be stored on one computer, which is firewall- and password-protected. Audio recordings will be transcribed using automated transcription services through MediaSpace, but they will not be stored in MediaSpace. Audio recordings of the interviews will be deleted once this study is done, which will take no longer than six months.

Email addresses provided to receive the gift cards will not be kept in our records or shared with other parties. Please understand that data sent over the Internet may not be secure, but we will take every precaution.

Contact Information

Contact Lindsey Jo Hand at 706-302-3748 or at lhand1@student.gsu.edu or Dr. Holley Wilkin at 404-413-5657 or at hwilkin@gsu.edu if you:

- Have questions about the study or your part in it
- Have questions, concerns or complaints about the study

The IRB at Georgia State University reviews all research that involves human participants. You can contact the IRB if you would like to speak to someone who is not involved directly with the study. You can contact the IRB for questions, concerns, problems, information, input, or questions about your rights as a research participant. Contact the IRB at 404-413-3500 or irb@gsu.edu.

Consent

Please keep this digital copy of the consent form for your records. If you agree to participate in this research and complete an interview, please indicate this verbally at the start of the interview.

Appendix B

Semi-Structured Interview Guide

The script below is meant to be followed in a semi-structured manner and delivered extemporaneously. These questions are intended to provide a general guideline and some questions will differ based on the interaction with the participant and the participant's willingness to share information. The interviewer should ask probe questions as necessary.

Interview Script and Questions

[DIRECTIONS TO INTERVIEWER]

Before you start the interview, get verbal confirmation from the participant that they have reviewed the consent form and if they consent to being interviewed. Then ask if they have any questions about the study.

Please note: Some of the questions in the guide should be modified based on whether the participant identifies as male.

Interviewer: Thank you for agreeing to meet with me and answer a few questions for our study. Before we get started, I would like to make sure you were able to sign the consent form that was emailed to you. Do you have any questions about the consent form or the study before we begin?

Again, thank you for being here. As I indicated in the consent form, some of the questions I ask you will be of a personal nature. There will be no judgment about anything you say, but if you are uncomfortable with a question or wish not to answer, please let me know and we will move along. Please know that everything you share with me is confidential. I will keep your information private. I won't use your name when discussing my research findings or discuss what you've said with anyone you know. I am also asking that you do not share any identifiable information about others with me (like first and last names of friends and family). If you haven't already, I suggest moving to a private room where you can speak freely with me. Please keep in mind that I will be recording this interview, and the only reason I need to record is so I don't miss any details for the study I am conducting. Once the study is completed, the recordings will be destroyed.

Interview Script

Interviewer: Today we're talking about life and health of people living in rural communities, and we'll be focusing on mental health. As I mentioned earlier, I am not going to identify you or your responses by name, but I do need to record some basic information about each participant. Doing this helps me understand potential differences in responses based on things like age or gender. Can you state for the record your gender, age, race/ethnicity, religious affiliation, and education? Thank you!

Before we get started, I would like to tell you a little more about myself. I'm Lindsey Jo, and I'm from rural Georgia. My brother and I are the first in my family to go to college and I am the first to get my Ph.D. I have chosen this topic for my Ph.D. because I know there are unique struggles people face in rural areas that need to be recognized and explored more and I do not think it gets enough attention. Before we get started on the interview questions, is there anything else you'd like to know about me or my background?

1. To begin, can you tell me a little about yourself and your community?

- **Sample probe:** How long have you and your family lived here?
- **Sample probe:** What do you do for a living?

This study is about men and their mental health. So, I would like to ask you a little bit about your personal views on men and mental health as well as your perception of others in your community.

2. What do you think about men who have mental health problems?

- **Sample probe:** What are some phrases or terms that come to mind?
- **Sample probe:** Where do you think these associations have come from?
- **Sample probe:** Who do you think has had the most influence on these thoughts?

3. What types of stories do you hear about men who are experiencing mental health problems?

- **Sample probe:** Where have you heard these stories? The movies? The news? Family or friends?

4. What specific stereotypes have you heard about men who are mentally ill or have conditions such as depression?

- **Sample probe:** What stereotypes have you heard from others in your community about men who have mental health problems?
- **Sample probe:** What stereotypes have you heard from others in your community about men with depression?
- **Sample probe:** Have you come across any stereotypes from other sources such as your church or the media?

5. How do you think most people in your community would react if a man shared with them that he was depressed? What do you think the most common reaction to a man with depression would be?

- **Sample probe:** How do you think people would react if he cried?
- **Sample probe:** How do you think people would react if a man shared that he was mentally ill?
- **Sample probe:** How do you think people would react to a man they knew saying he was in therapy?

6. Who do you think has been the most influential in forming your views surrounding mental illness, specifically men who have mental illness? For example, do you tend to listen more to your friends, your family (parents or siblings), your preacher (if you have one), the media, or someone else?

- **Sample probe:** Who in your community seems to be the most influential when it comes to the topic of mental illness and men?

- **Sample probe:** Who in your community seems to be the most influential when it comes to the topic of men seeking help for depression?
7. **Can you think of where you have you encountered stereotypes about men and depression (or men and mental illness)?**
- **Sample probe:** Are there any kinds of media sources you can think of?
 - **Sample probe:** What about community leaders or people you know well?
8. **Who in your community has ever mentioned something negative about mental illness? This could be anyone from a parent to a sibling to a friend to a community or religious leader.**
- **Sample probe:** Have they ever mentioned anything specific about men and mental health? If so, do you mind telling me?
 - **Sample probe:** What do you think the people around you think about men who are depressed or are in therapy? Why?
9. **Have you encountered any messages about men’s mental health that you consider to be more positive? Messages that might encourage seeking help or support for mental health? If so, where?**
- **Sample probe:** Are there any kind of media sources you can think of?
 - **Sample probe:** What about a community leader or people you know well?
 - **Sample probe:** What about messages that encourage seeking help or support? Do you hear these types of messages? If so, where?
10. ***ONLY FOR MEN*—If you were struggling with your mental health, would you seek help? Why or why not?**
- **Sample probe:** Where would you start? Who would you go to?
 - **Sample probe:** Would you worry about what people would think if they found out you were trying to get help for your mental health? Why or why not?
 - **Sample probe (if yes):** Would you be more comfortable with talking to your family or friends? If so, which family members or friends?
 - **Sample probe (if yes):** Would you be more comfortable seeking professional help such as therapy or seeing a psychiatrist? Why or why not?
 - **Sample probe (if no):** Would you be ashamed to seek help? Why?
11. ***ONLY FOR PEOPLE WHO AREN’T MEN*—What would you think if a man in your life told you he was struggling with his mental health? Would you encourage him to seek treatment or find help in some way? If so, in what way?**
- **Sample probe:** What would you think if he told you he was in therapy or seeing a psychiatrist?
 - **Sample probe:** Would you think differently of him? Why or why not?
 - **Sample probe:** Would you want to be a part of his support system as he addressed his mental health problems? Why or why not?
12. **What are your thoughts on therapy or other kinds of treatment for men’s mental health? Please explain your answers.**
- **Sample probe for men:** Would you ever seek professional help for your mental health? Why or why not?
 - **Sample probe for other genders:** Would you encourage a male in your life to seek professional help for their mental health? Why or why not?

13. Is there anything else that you would like to share with me about men and mental health in your community?

Additional Questions to Ask if You Have Time

Mental Health Knowledge/Experience

1. Have you ever experienced mental health issues or been diagnosed with a mental health condition? If so, what was your experience like? Did you seek support or professional help? Did you share with others in your family? Why or why not?
2. Where have you learned about mental health and mental health illnesses, and what have you learned? Please try to think of specific media, community organizations, and friends/family. [PROBE: Which of these sources do you think have had the most influence on your beliefs about mental illness?]
3. How often do people around here share their mental health struggles? Why do you think that is? [PROBE: How often to you think men share their mental health struggles?]
4. Should men tell others they are sad or are having thoughts of self-harm? [IF NECESSARY: Why/Why not?]

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5. What sorts of resources are available in the community where people can get support for their mental health struggles? For instance, are there organizations that provide individual or group therapy? Healthcare providers? Or do people seek support at churches? [FOLLOW-UP: What have you heard about these resources?]
6. What types of things impact your health and well-being? For instance, any personal barriers? Any barriers in your community?
7. How do you feel about your access to goods and services?

Manliness

8. What do you think makes a man strong OR what makes a man “manly”? What do you think makes a man weak?
9. How do you think men should express their emotions?
10. Do you think it’s okay for a man to cry? Is it okay to cry in front of others?

Thank you so much for your time today. I will email your \$25 Amazon gift card to you right after we are done.

Before we end the interview, would you be willing to agree to share my contact information with up to three people willing to do this interview with me? They would be awarded a \$25 Amazon gift card as well. Thanks again for taking the time to speak with me!

Appendix C

Codebook

Themes	Topics & Subtopics	Description	Example Quotes
<p>Storytelling System and Communication Infrastructure</p>	<ul style="list-style-type: none"> • Interpersonal networks • Community organizations • Media 	<p>Anything pertaining to the person’s connectedness to the communication infrastructure/expression of reliance on parts of the communication infrastructure.</p>	<p>“I really like to go on Facebook to see what’s going on with people in the community.”</p>
<p>Communication Action Context</p>	<ul style="list-style-type: none"> • Goods and services • Resources for residents • Healthcare resources • Safety • Transportation • Schools • Work conditions • Area appearance • Social salience (<i>ability to move in and out of social groups in the community</i>) • Culture 	<p>Resources in the area that promote communication between residents.</p> <p style="text-align: center;">OR</p> <p>Lack of resources in the area that hinder communication between residents.</p>	<p>“We have a really great school system here in Rabun County.”</p> <p>“There aren’t many places where people can congregate and meet in public. It’s kind of isolated.”</p> <p>“Some homes in the county are in very rural areas, and transportation is hard. Some homes won’t have a car or will have one that everyone is sharing.”</p>

			Getting around can be hard.”
Perceptions of Access to Mental Health Resources	<ul style="list-style-type: none"> • Access • Lack of Access • Community support (<i>belief people in the community will provide support in some way</i>) 	Any comments related to perceptions of access to mental health support—interpersonally and through community organization.	<p>“We just really don’t have much here. I don’t know that I can think of where you’d even get mental health care here.”</p> <p>“A lot of people here are very kind and welcoming. They offer support when needed.”</p>
Field of Health Action	<ul style="list-style-type: none"> • Hinderances to seeking care • Catalysts for seeking care 	The meaning people attach to CAC elements based on whether residents may be more or less inclined to seek particular health-care services and respond favorably to a health-promotion intervention.	<p>“I have to drive really far just to see my primary care doctor for mental health care. It’s hard to make consistent trips due to how far away the office is.”</p> <p>“I think telemedicine has helped me a lot. I am able to see a therapist regularly and not have to drive over an hour to</p>

			an in-office visit.”
Cultural Traits	<ul style="list-style-type: none"> • Self-sufficient (<i>does not ask for help</i>) • Community oriented • Isolated • Perceptions of masculinity • Religious/Christian • Subgroups <ul style="list-style-type: none"> ○ Hispanic ○ Old Appalachia ○ New Appalachia ○ Transplants ○ Originals 	Any comments made about cultural traits of people in the community.	<p>“A lot of people here are big on self-reliance. They don’t ask for help and you just take care of your own.”</p> <p>“A lot of people here are religious, mostly Christian folks.”</p> <p>“There are a lot of transplants here, and they are received differently than people who have been here for their whole lives.”</p>
Trusted Sources of Information on Mental Health	<ul style="list-style-type: none"> • Medical professionals • Community leaders 	Any of expression of trust in people or organizations as sources of information on mental health.	<p>“I think my doctor is probably the best source of information on mental health.”</p> <p>“I really trust my pastor for information on issues like this. He has a lot of experience.”</p>

<p>Personal Experience with Mental Health Issues</p>	<ul style="list-style-type: none"> • Self • Family • Friends/Acquaintances 	<p>Refers to any diagnosis of a mental health condition of self or personally knowing a person with a diagnosed mental health issue. Can also refer to personally experiencing mental health problems that aren't diagnosed or knowing a person seen as mentally unhealthy but does not have a specific diagnosis.</p>	<p>“Growing up, my mom had a lot of mental health issues. She was in and out of hospitals for most of my childhood.”</p> <p>“I’ve been treated for depression before and still take medication.”</p>
<p>Suicide</p>	<ul style="list-style-type: none"> • Perceptions of suicide • Personal experience 	<p>Any reference to suicide or suicidal ideation.</p>	<p>“I have a few friends I’ve lost to suicide throughout my life.”</p> <p>“A guy I went to high school with recently took his own life.”</p> <p>“I sometimes think about it [suicide], and I’ve had to seek out care for this in the past few years.”</p>
<p>Stories (RQ1, RQ4)</p>	<ul style="list-style-type: none"> • Interpersonal Network • Family • Friends • Media • News media • Entertainment (film and television) 	<p>Any comments related to the types of stories people have encountered about men with mental health issues and where they have encountered these stories.</p>	<p>“You know how family will just sit around the table and gossip about so-and-so having some kind of breakdown.”</p>

			<p>“I see on the news all the time how these young men are doing these shootings and need mental help.”</p>
<p>Mental Health Perceptions (RQ2)</p>	<ul style="list-style-type: none"> • General perceptions • Perceptions of men • Neutral/Normal 	<p>Any comments related to perceptions of men with mental health problems. This can include perceptions in general and perceptions of self.</p>	<p>“I think men experiencing mental health issues is totally normal.”</p> <p>“Everybody gets a little sad sometimes, even men.”</p> <p>“There’s nothing wrong with men expressing that they’re sad, but I probably wouldn’t reach out to my friends about it. It’s a little embarrassing.”</p>
<p>Stigma Narratives (RQ2)</p>	<ul style="list-style-type: none"> • Weakness (personally responsibility) <ul style="list-style-type: none"> ○ Disease/disorder related ○ Perceptions of masculinity/emasculati on ○ Sin/lack of faith • Dangerous <ul style="list-style-type: none"> ○ Violent • Shameful <ul style="list-style-type: none"> ○ Labeled as crazy 	<p>The types of stigmas commonly heard about men with depression or mental illness among community members. These would be message choices such as marks, peril, labels, and responsibility. This can also include remarks about specific issues such as depression or suicide.</p>	<p>“Men with depression are often considered weak.”</p> <p>“I have to be strong for my family, and I can’t let them see my mental health</p>

	<ul style="list-style-type: none"> ○ Self-stigma 		<p>struggles. They need me to be strong.”</p> <p>“So many people have very little willpower when it comes to pills and alcohol.”</p>
<p>Stigma Responses (RQ3)</p>	<ul style="list-style-type: none"> ● Emotional Reactions ● Embarrassment/discomfort (self or person they know) ● Sympathy ● Cognitive Reactions ● Personal responsibility ● Self-stigma ● Message Effects ● Avoidance/Ostracization of person ● Label avoidance ● Silence/denial 	<p>How people react to the stigmatized phenomenon. This would include emotional reactions, cognitive reactions, and accessing common stereotypes. Message effects can also be included in this category.</p>	<p>“Men with depression make me very uncomfortable.”</p> <p>“I usually try to stay away from people like that.”</p> <p>“I normally don’t talk about it [mental health problems] because I don’t want to be seen as crazy.”</p>
<p>Stigma Storytelling (RQ4, RQ5, RQ6)</p>	<ul style="list-style-type: none"> ● Micro-level <ul style="list-style-type: none"> ○ Family ○ Friends ● Meso-level <ul style="list-style-type: none"> ○ Religious communities ○ Local media (newspaper) ● Macro-level <ul style="list-style-type: none"> ○ Film and television ○ News ○ Celebrities ○ Social media 	<p>Any comments noting the spread of stigma messages, where stigma messages have been accessed, and who is most influential in spreading stigma messages.</p>	<p>“I grew up learning from my father that men didn’t cry.”</p> <p>“I’ve heard from pastors in the past that if you’re still depressed, you just are</p>

			<p>praying hard enough.”</p> <p>“Yeah, I’ve seen a lot of stuff in movies where men just aren’t supposed to be soft and just tough out the hard things.”</p>
<p>Reducing Stigma (RQ 7)</p>	<ul style="list-style-type: none"> • Interpersonal connections <ul style="list-style-type: none"> ○ Significant others ○ Family • Existing efforts <ul style="list-style-type: none"> ○ Community leaders and organizations ○ Positive messaging from community leaders ○ Positive messaging from celebrities/media • Suggestions from locals <ul style="list-style-type: none"> ○ Masculine community events promoting mental health ○ Male community leaders with personal experience ○ Social media ○ School/youth programs 	<p>Any comments made by participants expressing ideas about how to address mental health stigma among men in their community</p> <p style="text-align: center;">OR</p> <p>Current efforts in the community aimed at mental health awareness.</p>	<p>“I think schools are a good place to start educating people about mental health, especially boys.”</p> <p>“Having male leaders who share their experience openly and advocate for mental health awareness among men would be extremely helpful.”</p>
<p>Help-seeking Perceptions (RQ8, RQ9)</p>	<ul style="list-style-type: none"> • Supportive/In favor of • Embarrassed (<i>worried people will know</i>) • Telemedicine • Women seen as more accessible 	<p>Any comments related to perceptions of self and other men seeking help for their mental health. This can include seeking support from interpersonal connections, online support groups, and clinical care.</p>	<p>“I would never tell anyone that I’m in therapy. I just feel uncomfortable with them knowing.”</p> <p>“I think people are</p>

			<p>generally very supportive and wouldn't judge someone for getting care for their mental health."</p> <p>"I'd rather do telemedicine than go to an office. Everybody knows everybody here, and when we had that one place, you always knew who was there."</p>
<p>Help-Seeking Outcomes (RQ8, RQ9)</p>	<ul style="list-style-type: none"> • Medication • Therapy • Social Support • Delayed care 	<p>Any comments related to men's experiences seeking help for their own mental health. This can also include women reporting men in their life seeking or not seeking care.</p>	<p>"Yes, I've sought out care for my mental health before. I was having some issues with anxiety and saw my doctor. He put me on a really low dose of medication."</p> <p>"I had a friend who was having a lot of problems, and he waited until everything</p>

			was out of hand. He was embarrassed .”
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Appendix D

Recruitment Message and Website

The recruitment message is as follows:

Hello!

My name is Lindsey Jo Hand, and I am working on my Ph.D. at Georgia State University. I am from Franklin, Georgia in Heard County, which is about 3 hours southwest of Rabun County. Being from a rural community in Georgia, I am very passionate about health in our rural communities. The study I am doing is about health and wellness of people living in rural areas, including mental health.

If you have at least one hour to spare, I would love to interview you and get your perspective on mental health. Your responses in interviews will be completely confidential.

For participating, you will be awarded a **\$25 Amazon gift card**.

If you would like to learn more about the study or me, please visit my website at this link: <https://lindseyjohand.wixsite.com/researchinfo>. If you would like to participate in the study, please email me at lhand1@student.gsu.edu.

I hope to hear from you!

Sincerely,

Lindsey Jo

Appendix E**Recruitment Flyer**

The Department of Communication at Georgia State University seeks Rabun County residents over the age of 18 to participate in an interview.

Time Required: 1 hour

Compensation: \$25 Amazon Gift Card



For more information, please contact **Lindsey Jo Hand**:

- e: lhand1@student.gsu.edu
- p: 706-302-3748
- w: <https://lindseyjohand.wixsite.com/researchinfo>

Principal Investigator:

Dr. Holley Wilkin

IRB #:

000000000000



Appendix F

Exemplary Quotes from Transcripts

*Quotes Frequently Overlap with Themes.

Storytelling System/Communication Infrastructure

- Interpersonal networks
- Community organizations
- Media

P2-M: I really do think that just, um, again, distancing myself from news and other stuff like that kind of, kind of makes me miss what everybody else is thinking about and talking about.

P6-M: Just through business connections, that's how I have, basically have connections in the community. I'm kind of like an outsider though, I guess.

P8-F: I'm a very active individual, uh, very connected to the community. Uh, I love living in Clayton, Georgia.

P8-F: Um, I mean, we do, we do share and we try to help, like I said, this is a pretty tight community, so no matter who's going through something we're all gonna find out.

P11-M: Probably the most prominent activity that we've undertaken is, um, to, uh, do a series of videos, uh, interviews features if you will, whatever your, your preference is, but we have gone out to, um, local businesses, governmental offices, not-for-profits, um, organizations like the chamber and on videos, uh, where we typically interview one or a few people to talk about the mission of that given organization. And, and that's just an attempt to meet the market demand for video content, certainly the fastest growing segment of social media, right. And, um, so that has, um, sort of introduced us more readily to our community on a personal level.

P11-M: Um, there, there's a pretty, I think, close knit community up here. Um, there's, uh, a lot of, you know, really wonderful people that live up here.

P13-F: I do volunteer with the animal shelter. I do things with the historical [society], with the church, with the...Special Olympics, Boy Scouts, and um, a couple of other different things.

P16-F: A lot of the families that are here live on like communes. So, they all live in the same property. Um, you know, you'll have like five or six houses on the same plot of land mm-hmm. Um, and so taking care of your family might include extended family, also, um, aunts, uncles, parents, children, grandchildren, that kind of thing.

P17-M: It seems like everyone still uses community. They, they have these little community groups on Facebook. They use a lot of Facebook, um, some Instagram, um, but it looks like they, they resort to Facebook a lot and they have community groups and they put community information out there.

P18-M: I feel like it's my home, but it's, you can tell the difference between somebody like me and, and somebody that's been here for generations and, and how they know everybody and all that... it's hard to keep up with all the connections because it's a small town because people have been here for so long. It seems like everybody is cousins with everybody in some way, shape or form.

P20-M: I don't even watch news in the United States anymore. I watch BBC 'cause they don't have two different sides blaring at your head day and night.

P23-F: Most of my information comes through, uh, Facebook, you know, I have small children at home. I don't turn the news on a lot.

Communication Action Context

- Goods and services
- Resources for residents
- Healthcare resources
- Safety
- Transportation
- Schools
- Work conditions
- Area appearance
- Social salience (*ability to move in and out of social groups in the community*)
- Culture

P2-M: Yeah, so yeah, we love, we love the area. We've got streams, we've got lakes, we've got mountains, we've got everything that you can enjoy from God's creation here. We, we get snow. Sometimes we have beautiful weather in the summer, so it's a great mixture of everything. We're a great community.

P2-M: What's crazy about where we live is there's a, there's not really a middle class here...So, you know, we've got millionaires, and then my wife teaches in the the elementary school and saying that she's got students that have no running water and no electricity in their house. So, you've got people that have second and third homes here that, that maybe visit once a year if they've ever visited their house. Uh, and we've got people that are literally living without running water and electricity.

P2-M: Um, so that we're in a big kind of crisis here of providing homes for people to, to live in. But yet there's no jobs here because the industry here is tourism and there's no, there's no big money from tourism.

P3-M: When I talk about the pressure... nowadays we are having a challenge of maybe someone had a family and his work is not well paid. And, you know, you need to provide the whole basic one for the family, right?

P6-M: So, like I found this house and it was a good deal, very rural, just got internet. So it was like, I could work here actually from home, you know, doing my web stuff and like stuff like that. So that's why I chose Rabun county. They have really good schools...I'd they still have some of the top schools.

P7-M: Wages for this area, uh, are not compatible with the cost of living ...I'm 70 years old working two jobs.. just to pay the bills. 'Cause cost of living is so much higher here.

P8-F: Yeah, so the soccer players, they're all Mexican descent and they all mess with each other. And of course they deal with customer abuse. They work a lot in construction, so they have to deal with those kind of stressors and they just, their way to relieve it is by playing soccer.

P9-M: Um, and then you got family connections that can help you, uh, get some assistance. And then, you know, the health department, American Legion, and, um, and actually I even have a store

here that you can bring your clothes to and they clean 'em dry, clean them and whatever, and people can go there and get clothes for free.

P11-M: Um, so we've got, you know, lower crime rates and things of that nature.

P13-F: Pretty much everything you need, you have to go to Gainesville for unless it's just the small medical issue.

P13-M: Uh, Atlanta has discovered all the mountain communities [Rabun County] during COVID-- those with money and those without money.

P16-F: Um, it's a very closed system. So, um, my partner was born and raised here, but in general, they're really not open to outsiders like me.

P16-F: Rabun County actually has pretty high education levels, but there's a lot of, um, there's a lot of people that didn't finish school and, um, like even in the generation before mine, a lot of them dropped outta school in elementary school to help work the farms or whatever. So, there's kind of, there's not really a lot of, um, value put on education. There are a couple of really, um, prestigious, um, private schools in Rabun County, but a lot of the people who go there are not from Rabun County.

P16-F: We just don't have any transportation. Most of the folks don't have cars, and typically will just like walk if they can...Um, so a lot of the families have like one vehicle for the whole family. And when I say the whole family, I meant extended family, too. And the area itself is just really rural. So, you know, like it, it's just really wide, so it's not something, you know, it's mountainous and the hills are rough. The driveways, sometimes you can't even get a vehicle up them. So that's part of it too. But in general, a lot of people don't have transportation.

P16-F: There's such a stark divide between the wealthy and the poor, right. Um, middle class is actually probably the smallest population in Rabun County.

P18-M: It seems like the businesses and our little downtown area kinda doing well and more popping up. And it just seems like it's, I would say revitalized a little bit in terms of its popularity. Um, but it's still small town and everybody, a lot of, most people that are here have been here for generations.

P19-F: I was born and raised here. Okay. So, I've lived here all my life. Um, good place to grow up.

P19-F: Well. There is a, there is a lot of depression, um, people that need grief counseling, depression, mental health, and anxiety issues. That's all through this county.

P19-F: Locally in this county, um, there's lots of opportunities for people and there's lots of help out there for people. We have, um, the local health department. We have the Lion's Club, which sponsors the dental clinic, which helps low income, uh, people. Um, there's lots of things such as the Food Bank, uh, different food services. Um, there are, um, different vouchers that people can get that are, that if they're low income from City Hall, from an office that operates out of city hall out there. Um, just different opportunities for people to actually help them, you know, with things, if they're having a hard time.

P20-M: There's a lot of churches out there. A lot of Christian people that don't even believe that a psychiatrist is an actual doctor

P20-M: Um, trying to put food on the table, especially right now they have no time to do anything? And the stress that builds up is enough to destroy you. I mean, truthfully, sometimes I look at my own life and I think, I don't know how I'm gonna make it... the act of daily survival is slowly killing me.

P21-M: Um, we, um, love the mountains. Um, I'm an outdoors person, so I like, you know, I like the streams to go trout fishing in and, um, we like to hunt and fish and boat and everything else.

P22-F: Um, it's really nice. It's a great place for kids to go to school.

P22-F: The downside to living in this community is that there's very limited amounts of outside services.

P23-F: So a small community, small schools, um, we honestly, we are kind of in a bubble, I feel like.

P23-F: Right now we're working with the Rotary [Club]. Um, you know, so yeah, we have a lot of like community events from time to time, like little, um, you know, like the farmer's market or we'll have like an event with like booth set up, um, where people, especially an older group goes and walks around and there's like local, you know, people who sell, um, crafts or things like that.

P24-F: Um, I love Rabun County. I think that it is, I haven't traveled everywhere, but it's a very special place, you know? Um, it's one of the most beautiful places I've seen in the entire world. There's a lot of changing demographics up here pretty rapidly in the years recently that people have been allowed to have more remote work opportunities and internet, right. Twenty years ago it wouldn't have been as possible to have like a remote job up here, but um, those kind of infrastructure things have improved as well. But it's, it's everything, you know, we would've hoped for. So yeah, education's great. Um, love our little growing downtown area. You know, you got some places to eat, some little places to shop.

P24-F: You know, a lot of people who've been up here for generations and generations and um, just hardworking, um, good folks, you know?

P24-F: So, the library is a really important resource for people. We also have the, the biggest food bank in the Northeast part of Georgia. Okay. So, I don't know, um, if they do any of that kind, other community outreach, other than very important feeding of people, but it's a very central location.

Perceptions of Access to Mental Health Resources

- Access
- Lack of Access
- Community support (*belief people in the community will or will not provide support in some way*)

P1-F: The male was not the dad, but the male had been the caregiver, um, was in a very tough situation trying to find housing, different things like that. Definitely had, um, some mental health issues and did not know where to turn, you know, um, needing resources. And we were limited because a lot of that requires insurance or, you know, out of pocket type stuff. And it's just, it's not something that's easily accessible, but, um, it's hard to see somebody who has a need and not be able to give 'em a resource or some avenue for help.

P2-M: Somebody started a center here that, that helped with the mental health thing and now, and she had to shut down for some reason.

P4-M: We have people like church leaders. Uh, I can say I trust church leaders because, uh, there are people who really understand how you are...there are people whom when you, when you tell anything they understand.

P4-M: I can say access to this services, sometimes a challenge, uh, maybe because of racial, like people like us, Black Americans, you know, when you go to hospital, right? Sometimes you, you feel, uh, so isolated, you know...sometimes you can find people, doctors who are, who are willing to assist you, like you are fellow American.

P5-M: And the other thing I tell you is the, uh, therapist, the psychiatrist that I work with now, um, who is a town away is probably gonna retire at any time.

P6-M: That's more so of an economic thing. I don't really know anywhere that [mental health services] would be, unless it's just like some random free calling therapist kind of thing. There's nowhere around here for like a free therapist that you could see on a regular basis that I know of.

P8-F: And in Clayton, per se, there is not a whole lot of outlets for males or females in general to go to. There's nothing here that could be affordable or perhaps subsidized by the government where they can actually have therapy and do it unless they're doing it by FaceTime or doing it from the computer with different people from outside the area.

P8-F: This is a very, uh, Christian, Catholic, Methodist, Lutheran town--all sorts of different churches. So, no matter which god they follow, they're all going to be very sympathetic to anyone suffering, whether male or female. So, I feel like they will be very supportive.

P10-M: There are not enough mental health facilities available to people in Rabun County.

P10-M: It's a very conservative area. And I don't know, there tends to, I think there's a tendency among, um, conservatives to, to downplay the need for, um, mental healthcare and facilities, and especially in government funding of those sorts of, of facilities.

P11-M: That's, you know, one of the things we talked about here in Rabun County was there's the general, um, agreement that there's a shortage of therapists.

P11-M: Rabun County, for all the wonderful things, it still has a shortage of high-speed internet. Um, you know, not the legacy definition of high speed as 25 megabytes per second, you know, download speeds. But really we, we talk about high speed. We're talking about, you know, at least a hundred, right. But, you know, or up to, and over a gig, well, if you wanna do telemedicine, if you wanna do telehealth, teletherapy, uh, work remotely, uh, all those sorts of things, you really need that.

P12-F: I believe that systemic change is needed, um, that allocation of funds to mental health care is needed, especially substance abuse. Substance abuse isn't just a behavioral health issue that it's a whole other kind of thing. Mental health care is very siloed.

P13-M: I'm not a professional clearly, and I wouldn't pretend to be a professional, but as neighbors and as just people of faith, I think we'd wanna listen to the person's problem, hear them out. And if you know, there's anything we could do for them, pray with them, whatever the case may be, we

would probably do so. I know I would if they welcomed it. I think getting a guy to welcome that is difficult too.

P14-F: If you need...a psychiatrist, you need to a psychologist, you need a Parkinson's doctor, you need anything, you have to go to Gainesville.

P17-M: I think, I think in today's atmosphere in this community, um, people would be more apt to offer assistance or look for ways to help if someone was struggling with their mental health.

P19-F: We see a big problem with people that have, that need mental care that are not receiving what they need... I feel like a lot of 'em are falling through the cracks.

P19-F: The parents. I think if the parents here, if they have a problem, if they would go to their counselors, I'm not saying the school's always the answer, but for the kids that are school age, if they would go to the counselors and worked together, there are, there are options out there.

P20-M: But the problem again is when you're in the religious groups, um, they're really mean. I'm just telling you the truth. I'm not from here. I don't, I don't buy that stuff that they put out, but they were just so mean to people. If they were to come to say, for instance, if you were to go to some of these people up here and say you were depressed, they try to cast a demon outta you or something.

P20-M: I don't know of any mental health people up here at all to tell the truth. I don't know one. And even if there was one, I don't know if they'd have a big enough practice that they could actually support themselves. And that's, that's crazy. I don't know a psychiatrist, a psychologist, anyone that's in mental health. The only people I know of are, are the pastors...and a lot of 'em have no training whatsoever.

P21-M: And I think like at church, I think, um, most people in our church would, uh, would take that person to the side and, uh, maybe try to befriend them, uh, maybe, you know, share, share their, share their faith with 'em, um, and try to be there with 'em.

P22-F: Uh, we need to have more outside services available for, um, for children and adults, as it stands. We have, um, you know, most families have to drive, you know, 30, 40 miles in order to get any type of, um, to be able to see a licensed therapist for the most part. Um, we've got, I think there's two or three different people here in town, but if those are people that either the family didn't feel like they had a connection with, or if they don't have their insurance doesn't get covered through that, then that just limits their options.

P22-F: Um, I mean, I think that there are lots of people and organizations that might have, um, the best of intentions and I'm thinking mostly like in their regard, in, in regards to things, um, places such as like church groups and that type of thing. They may be able to provide some type of support, but depending on the severity of whatever it is that may be going on or whatever crisis it may be, they, they themselves may be very limited.

P22-F: We have fewer services in order to, um, fewer services, fewer resources in order to, um, to serve those people [who need mental health support].

P23-F: You know, they're [Rotary Club] definitely, um, they're getting groups of people together. We're having meetings monthly. Um, it's not specifically towards men's mental health, but just mental health in general and, um, making it more accessible, bringing more providers in. We've had a lot of conversations around, um, you know, how difficult it is just to access the resources, because

there are so many hoops to jump through with, you know, you gotta get your insurance provider to, you know, find out what they are gonna cover and who takes this insurance and, and where you have to go and you have to have a referral from this person to do, you know, all those processes that like some people just aren't capable of jumping through all those hoops.

Field of Health Action

- Hinderances to seeking care
- Catalysts for seeking care

P4-M: Yes. I can say when men say they have depression, is that, uh, they're emotionally or they are feeling, we, we, we have things like stigma also discrimination. Sometimes men from a minority group...they really feel isolated from the other people because they are minority. They are not getting their services, enough services like other people.

P7-M: I think the people who need it [mental health care] the most here in the mountains can afford it the least.

P7-M: And, uh, he classified me as a pretty serious case and put me on medication and doubled it yesterday. 'Cause it's not working and, and reaching out for counseling. Uh, I've got to go out of the area and I'm working to do that now, but it's hard to find someone out of the area, uh, that you can go to that.

P10-M: There have been times when I thought, geez, I wish I, I wish there was somebody or, you know, some organization, group practitioner who was close by that, that I could connect with. I can't think of any. I don't know that I have ever passed a, maybe one office with maybe a psychologist or something on the door, but I just, you know, I feel that there have been times in the last few years when I could have gotten back into therapy and, and, and I would've definitely benefited from it.

P14-F: The mental health here is not very much. Yep. Although we have some great opportunities for people from Atlanta come up here for mental health. We have like the, um, outdoor adventures, like a mental health adventure. Therapeutic wilderness, therapeutic wilderness survival. There's an art therapy thing that people come up to enjoy our mountains. Right. From Atlanta. Like \$3,000 per week. It's too expensive for the people who actually live here.

P16-F: Um, like if somebody needed to go to regular counseling or something the chances of them being able to get there would be really slim.

P20-M: But it's hard not to mention the fact you got no money, especially right now, right? I mean, my insurance is like, I got a \$5,000 deductible. I mean, I can't go see anybody, even if I really wanted to.

Cultural Traits

- Self-sufficient (*does not ask for help*)
- Community oriented
- Isolated
- Perceptions of masculinity
- Religious/Christian
- Subgroups
 - Hispanic
 - Old Appalachia/Old Timers
 - New Appalachia

- Transplants
- Originals

P2-M: So I think, I think the majority of people I talk to are in a church situation to where hopefully they're taught that, you know, we care for people. We love people. And, and it's not just the, you know, it's that, um, you know, when we see somebody, we say, "Hey, how are you?" But we really don't want to know how they are.

P7-M: And here in Rabun County, Georgia, we have a mixture of, uh, people. Uh, I think it's the best way to put it. We have Old Appalachians. Uh, they are, uh, anti-government uh, they prefer staying at home. They don't like outsiders....and the New (Appalachians) are, uh, usually related to the Old Appalachians, but they're people who do yoga on the side of the mountain. They like the internet. They'll shop at Walmart or Food Lion by Lowes. They often are, are better educated and, uh, they, uh, work to make change through the system. Then it's people that have moved here from other parts of the country, uh, from Connecticut, Massachusetts, New York, Rhode Island, they have moved here from California. A lot of them have, uh, moved to Florida upon retirement found it was too hot then they moved into the mountains of Northeast Georgia. They're called "half backers". We have, uh, a good number of those here in the area or people that are just wanting to retreat from society itself. Uh, then the other part of the group that is here that make up a large part of it are, uh, the people that are the doctors, lawyers, uh, wealthy business, people from major cities around here who have, uh, weekend homes and summer homes. So you have a lot of tourism here and people that are part-timers, some of those stay full time.

P8-F: People are very helpful with any kind of need when there's anything that the community needs. Everyone really pulls towards helping no matter their age, relationship, religion, demographics, political views. It doesn't matter. Everybody here is very community minded. Um, I will say as far as connectivity, we have a very large Hispanic community here that plays soccer a lot. It's very active and that I have been able to connect with other people around the area because of activity in this community.

P9-M: Uh, I think a men's role is, is that, you know, you need to get a job. Um, either I always say this is what was told to me from my parents is that either, you know, go to college or go to the military and defend your country. And if you get married, um, you, uh, take care of your wife. Uh, you take care of your kids, no matter what you have to do. If you gotta get two jobs, make ends meet, then make ends meet. And I guess I've learned from my dad. My dad, he always, we always have food on the table and you know, and you see now these days and times, um, nobody wants to work. Guys don't wanna work.

P10-M: I've participated in a few, uh, get togethers with people who tend to be more representative the native population. And so I, I can <laugh>, for example, when I first came here, I went to a barber shop downtown, and this is a, this is an old boy's--I hate to use that term too, but it's an old boy's gathering spot with guns and animal heads all over the walls and, uh, mixed in with, you know, religious iconography. So I thought, well, I didn't go there, you know, very often after that, but, um, you know, they, they have a whole different kind of, I think, way of, way of relating to one another than the kinds of people that, that I'm, you know, more comfortable and more familiar with. Um, the conversations tend to be, you know, um, surface. You know, nobody gets into discussions about, well, how are you feeling?

P10-M: Yeah. The masculine tropes, you know, are important among, I think among the folks in this community.

P13-M: And it's so easy here to become a hermit and not deal... But I, I guarantee you, if you dig deep and you don't have to go too far into some of the local attitudes, that would, would be that we're an Appalachian community. We take care of our own. We don't go outside for help. We don't even ask each other for help unless we're desperate. And you know, I can't get outta my driveway and I had to pull neighbors to help me cut trees down so I could escape or even get a, even get an EMT up here if I needed. Um, but those, those situations, you have to be pretty desperate to ask for help here. Right. Um, there's a self-reliant attitude here--very, very much an Appalachian.

P17-F: Most everybody wants to be self-sufficient right. So, um, in fact, most of the time they won't even call like a professional to do stuff. They'll just call a family member or somebody else. So, if you've got a tree falling on your property, then you just deal with it yourself. If you've got, um, you know, plumbing or electric is like, you just deal with it all yourself. You don't really call for help at all.

P20-M: And the problem is, is the people up here don't ask for help. It's just the way it is.

P23-F: I know a lot of the Old Timers, you know, we call 'em and the people there are Rabun Count. They have a bad rap for being, you know, narrow minded and, um, you know, country town.

P23-F: Like people are always in your business. People are in your business and people know what you're doing because everybody knows everybody. But that also means when somebody needs help our community rallies, like nothing else you can imagine, um, to support people.

Trusted Sources of Information on Mental Health

- Medical professionals
- Community leaders

P10-M: Hmm, yes. I think there are some, there are some local politicians, um, both at the city level Clayton and also the county level Rabun County. I think there are some, uh, political, uh, officials, elected officials who would be able to carry that off. Yes. I can think of one in particular. I think who's even possibly broached the subject of, of mental health issues. And, uh, and so I think he has the respect of most of the people in the community, and I think it [mental health education] would be taken in a positive way.

P13-M: I think, I think that our pastor is a good counsel and would do what he could to counsel the person. However, um, you know, when you got out of the realm of theology and, and all of that, um, there is that boundary line with which is not fully understood by any of us, right. Quite frankly, between, um, psychology, um, psychiatric conditions and, um, you know, evil and all that kind of thing. You start getting into the nebulous land of that. I think most pastors, I know ours would, would probably suggest seeking professional care in the medical community.

P16-F: So they [mountain people] have like these medicine people who just have these gifts, who can do certain things and I don't know all the ins and outs of it and it's very secretive.

P17-M: And sometimes you gotta ask for help and it, it needs to go beyond that. So I, I think a physician is the best for me personally. My family physician would be the best place to start.

Personal Experience with Mental Health Issues

- Self

- Family
- Friends/Acquaintances

P2-M: And even for me personally, with stuff, I have struggled with OCD.

P2-M: So my wife's actually been the person that's really changed my perspective [on mental health] because I've had to walk with her through process of helping in specific areas of her life that she can't control that, that wasn't, uh, that was based on childhood trauma.

P7-M: Uh, I grew with a mother who had been sexually abused and a sister who was raped when she was about the same age by a neighbor boy...I had family members who, uh, had mental issues and I grew up understanding the stigma.

P8-F: Just in general from life, you know, personal life experiences with my father and my brother and the different things that they've dealt with through lives. My employees, which I kind of continue to hone on because they're family to me and they're the bread and butter to my business, you know, I need to make sure that they're in a good mental, stable place where they could take care of customers and deal with children. Um, friends of mine that are necessarily not, uh, able to open up to anybody else besides me. I, I wanna make sure that they know that it is an option for them at any point in time, to be able to count on someone that they can lean on.

P10-M: I was exposed to, to mental health difficulties from a very early age... I might have been a junior or senior, and one of my stepfathers, um, actually had a mental breakdown and had to, and went to one of the veterans, a veteran's hospital, where he spent some time. And I remember that there wasn't a whole lot of conversation about it. Nobody, nobody really talked about what his problem was, but it was obvious that he was in the ward at the veteran's hospital where, you know they treated people with emotional illness.

P10-M: I early, very early in my life suffered from depression and anxiety and went into treatment, you know, when I was 16, 17, something like that.

P15-F: My father, he, um, suffered from PTSD when he came out of the Korean conflict and there just wasn't a lot of help for him. Uh, it was difficult to get into the VA. Um, so it was just, you know, he suffered a lot, uh, even long after, you know, I was, um, even long before I was born. It was just, you know, still flashbacks. Wow. Even when he died at 73. So, it was just, um, yeah, I guess he influenced me and my perspective.

Suicide

- Perceptions of suicide
- Personal Experience

P6-M: I've known a few people that died from suicide from mental health issues.

P7-M: I became suicidal. That's the reason I went in for help. And, it wasn't, uh, you know, I just contemplated suicide for about eight hours when I pulled out on the other side of it. I've done a couple things. One is I got rid of all weapons in the house, and I don't have any to this day. And the second thing I did was I called for, uh, and went for counseling for two years, uh, out of that I saw from the other side.

P11-M: I have struggled with depression, um, really for my whole life that I can really remember, uh, you know, from a pretty early age was, uh, definitely suicidal when I was a teenager. And so mental health, uh, is more than just a, a cause, you know, to me, uh, it's something that I've got a good bit experience with and certainly empathize with people that are struggling in some way, shape or form.

P10-M: I felt suicidal at times in the past couple of years.

P11-M: But as you know, most of the people that, uh, commit suicide have reached a point of desperation and hopelessness, and I think they have forgotten, um, the value of their own life, uh, and are purely, you know, looking at what short term seems to be a desperate situation and have lost any sense of hope or confidence that they can be a positive influence on others.

P18-M: I'm good friends with two people that their father committed suicide. Um, so yeah, I mean, it, I would say the situations were different in both cases, but I've heard people talk about that. I've also heard their, their children, the ones that I'm close to talk about it some, but it's, it's certainly not something I spend a lot of time talking about. I don't think anybody's comfortable talking about it.

P18-M: We've had some conversations here and there and just a kind of surprised like, you know, cuz when that happened, I hadn't really had much personal experience with anybody else doing that before. And it was like, how could he do that? And you know, we can understand why he was not happy, but to, to leave his grandkids and his kids. And, and it was just hard to understand and that was kind of the way the conversation went.

P20-M: He, he committed suicide. And the reason why he did was he was going through some mental health issues. I was working with him, and it just took one person to be mean to him. And it actually was the sheriff of his county, um, was just disrespectful to him, thought he was crazy called him such.

P20-M: I mean, I'm gonna tell you the truth before I found the Lord, I had the gun to my head and the hammer pull back. I was ready to just, all it took was that was a jerk, and I would've not been here and my whole life and everything that was good. Wouldn't have actually happened in my life. The good thing is that I been through it so I can tell them there's other side. The bad part of it is, is nobody wants to give you the chance to tell it.

P23-F: Um, we just need, we need some support around here for sure. Um, you know, when I think about the suicides that I know it's, it's almost always men. Yeah. Um, and so yeah, that's a problem.

Stories (RQ1, RQ4)

- Interpersonal Network
 - Family
 - Friends
- Media
 - News media
 - Entertainment (film and television)

P1-F: I mean, you do, you do hear a lot of times, I think in the small towns, um, you know, some of the things that I have heard from people I know, um, like he or she is crazy, he or she, you know, that kind of thing. Um, and that's unfortunate because I think sometimes that's just, that's kind of judging.

P2-M: My grandfather and my uncles all struggled with mental health. Um, and it became more heightened after my uncle's, um, being in the war. Um, and so that's kind of stuff that I've known and have talked with my mom about for, for years.

P9-M: It's the news people. I mean, all, all they wanna show is negative stuff. Everything that you, if you turn the TV on, there's always something negative. Uh, somebody getting shot, you know, or, or it just, it's scaring a lot of people and, and it affects, it affects a lot of people like, you know, kids going back to school now. I mean that shooting in Texas, um, there's a lot of kids that are scared to go back. I mean, and that's gonna affect a lot of kids.

P17-M: I think that's where a lot of the stereotypes came from originally was from, uh, television and the media. I mean, just in general movies, TV shows and stuff like that.

P21-M: I mean, just from on the news, I hear, uh, you know, we, we watch Fox news a lot, and I hear a lot about, um, men who maybe have served in the military. Um, just stuff that I've heard on the news. I mean, it stems from, like I said, drugs and alcohol politics, uh, men who served in the military maybe have, you know, post traumatic syndrome, things like that.

Mental Health Perceptions (RQ2)

- General perceptions
- Perceptions of men
- Neutral/Normal

P1-F: Um, I personally, you know, I think everybody after the last two years with COVID, um, has some sort of mental health issue.

P3-M: I think men have a lot of stress, okay. And stress needs to be sorted well, because it'll lead you to, uh, destruction, if you don't have, if you don't have any good way of handling it.

P6-M: I think it's human, human nature. Everybody has some kind of [mental health] issue they have to deal with at some point.

P8-F: Um, it's a serious problem that they [men] avoid, that they don't take care of.

P10-M: I think men can, are just as susceptible to mental health problems as women.

P11-M: It is not weakness...it is a necessary ingredient of dealing with a world that in addition to all of its beautiful things, has some very terrible and awful things that we have to experience, witness and deal with and any given day, um, that is the paradox of our existence.

P11-M: And so I, I would say that I think men in general are simply not as well adjusted and the, um, failure to reflect, to have a support network of friends, family, or others that you can openly discuss issues without any judgment or stigma.

P13-M: I think the general, you know, attitude here would be tough it out, you know? Yeah. Um, tough it out, suck it up, you know, um, you know, we all have problems, so don't complain, you know, that would be the, the general attitude.

P13-M: Um, to some extent, I think we all have those moments, uh, whether they rise to the occasion of, uh, becoming a nonfunctioning man in society, considering taking your own life...if you go on the, on the right side of that perspective, you go, okay, maybe, maybe I want to take your guns away. You know, everybody has a degree of depression without being bipolar. Right. Everybody has depressing moments, but they, but they pull out of it. It's those that don't pull out of it.

P15-F: Well, broadly, I feel like there are more men, um, who have mental health issues and they mask it, uh, and they use coping skills, like, uh, coping tactics mechanisms, whatever you wanna call them, um, to cover it up, like even drinking. Um, I, I see a lot of that even in the older population. Um, so I think it's, it's more prominent than what statistics say, because they won't go to the doctor. They won't get help for it, but, you know, they try to cope. Yeah, they try to cope. Um, I mean, I think, you know, drugs, alcohol, you know, those kind of things... yeah, they try to cope.

P15-F: It's, you know, it's the lack of education and on behavioral health. And of course it stems from, you know, uh, there's just not a lot of education on, uh, the importance of behavioral health when you're young.

P16-F: Um, for sure when it comes to veterans and PTSD, that seems to be something that everybody's kind of accepting of and oh, of course they have PTSD. And like that seems to be kind of a pretty common, um, like commonly accepted form of mental health. Um, let's see, of course substance abuse in general is very common...um, whether it's alcohol or harder drugs, um, and probably the main way that people are dealing with mental health, uh, truthfully around here anyway. Um, as far as, yeah, I don't think people really talk about it.

P23-F: I think society as a whole wants to be more open and understanding and supportive to people, men too, honestly. I think a lot of times I think it's the men who, who will oftentimes do that to themselves in a way, because they wanna be strong. They wanna be seen as strong. They wanna be seen as a man. Um, whereas if they did ask for help, I think a lot of people would be supportive and encouraging.

P24-F: Oh, um, I think, I think it's really common and normal.

Stigma Narratives (RQ2)

- Weakness (personal responsibility)
 - Disease/disorder related
 - Perceptions of masculinity/emasculatation
 - Sin/lack of faith
- Dangerous
 - Violent
- Shameful
 - Labeled as crazy
 - Self-stigma

P1-F: Men I think are primarily that role model where they should have everything together, you know what I'm saying? And it's like, if, if they don't, they're not as manly or, you know, it's a, it's a feminine or weakness kind of thing, you know?

P2-M: The same mentality that I think a lot of people have..it's a weakness and you just kind, um, you don't talk about it. You, you, you push that and get over it.

P2-M: I think usually the stereotype is they have mental health issues, so they're dangerous.

P4-M: They're expressing their feelings...men fear because, uh, people, when you speak the problem to other people, people see you as a, you are nothing; you are expressing your weakness.

P6-M: I mean, it's basically emasculation, basically for the most part. So, whether it's like a weakness and, and for the most part, that's like masculinity, right. Is like how strong you are, I guess...one way or another, I guess, either called weak or called feminine.

P7-M: They keep it quiet, uh, in the old Appalachian culture. And that's the culture that I grew up in. Uh, it's considered a weakness.. suck it up, man. Just get over it. Uh, you know, you, you just gotta deal with life, uh, grow up. Uh, it it's, it's the mentality that if you've got a mental health issue, uh, if you're in the church, it's because of a sin in your life. If you're outta the church, it's maybe the cause of, uh, your parents or your own behavior, but it's, it's, it's always a stigma.

P8-F: I feel that because they are males, they have this stereotype that they are not allowed to have feelings. And that's just kind of how the community views it here. You know, you just have to suck it up and deal with it...so it's the fact that the men are not allowed to have feelings; they're not allowed to cry.

P10-M: Particularly gender expectations are such that men tend to feel that mental health problems are, are, are female problems and that therefore...they're reluctant to seek help. They're even reluctant to even admit that possibly they have a mental health problem.

P11-M: I would say that I think that to some degree for men, um, there's a tendency to, uh, even, uh, in, in terms of, um, self-actualization, if that's the right term think that, uh, depression and things of that nature are signs of weakness and that, you know, we are supposed to be strong, uh, creatures and, uh, be able to overcome, uh, things that, that happen to us. And, and I think to some degree, uh, because of that, uh, we tend to either try to sweep things under the rug, which accumulate. And then at some point, uh, you gotta pile of dust so large that you, you know, you can't vacuum anymore.

P13-M: Uh, I'm expected to be the strong guy, you know? Yeah. Make the money, manage things, take care of two homes, et cetera, et cetera. So, I think it [mental health problems and seeking care] would be, um, perceived as a negative.

P15-F: I think it's considered, uh, demeaning for men. And if they're looked at as the leader of their home, of course, in the South. But if they're looked at as the leader of their home and the provider and, you know, and those kind of stereotypical roles are, are prominent here in rural areas.

P15-F: It's a cultural educational kind of thing. Um, it's not talked about it. It's not, it's not allowed, um, really, especially in the male population. So, I mean, you know, so you, you just don't have it. You don't have depression and anxiety, you don't do that. It's not, you know, it's not accepted. It's not talked about, and it's just not something that, you know, you get help for.

P15-F: The stereotypes are weakness, you know, they can't handle their crap, they can't handle their life. Um, and it makes them up here weak, um, you know, and their egos are, are, and that, you know, it's big and tough. You know, I don't wanna look bad in front of my buddies and, and that's really the way it is.

P16-F: I think there's a sense of like mental health is a weakness, probably, um, definitely a lack of understanding or education in general about mental health. Um, not just here, but especially here.

P16-F: Um, I think there's a general stereotype that people with mental health are dangerous. I've had conversations with judges about like gun control rights, and their theory is basically that all of the major, um, like shootings are caused by mental health issues.

P16-F: I think that's the majority of the people that I know who have a hard time even going to treatment, even when it's required. They're like, well, I'm not crazy.

P16-F: A lot of the clergy would, um, say, you know, just needed to be prayed out of you or you needed to believe stronger.

P17-M: So they don't wanna ask for help because it's a, it's seen as a sign of weakness. Well, with older men, I would say. Um, so, uh, I think that's the biggest issue with men and, uh, seeking out help and asking for help, um, is just a huge issue for them. So, they tend to, to basically let it, I guess you would say let it stew and, and, um, it ends up turning into something bigger.

P17-M: They're seen as, as crazy. They're seen as, uh, schizophrenic, um, maybe they, they just don't tend to, um, they don't tend to, to engage with the public as much because of, um, the fear of being seen is crazy.

P17-M: They see it as a weakness, especially depression.

P18-M: I think it's, there might be a shameful, um, side of it, I guess it it's shameful. People are embarrassed, um, that, you know, men are supposed to be tough.

P18-M: And a lot of times when you think you're strong in your faith, then you're trusting God all the time and something like this wouldn't [happen], that mental health is, is, is a lack of trust in God that he's in control and that you can trust him with, with things that are, that cause you anxiety or cause you to feel down and depressed.

P19-F: You're supposed to be strong, and you're supposed to not show any weakness and you're supposed to, you know, be all these things.

P19-F: I think in his case, at least a lot of things of what his dad said to him, I think made a big difference. Like that's [counseling] for sissies or that's, that's crazy. That's not, you know, that's for crazy people. That's for, you know, that kind of thing.

P20-M: The minute you say that, they think you're crazy and they call you crazy.

P20-M: It's just the way it is, especially for men. Men think they're supposed to be invulnerable.

P20-M: But for men, a lot of times it's a fear of failure, right? Um, and they do, they, they have this idea that they have to do everything, right. That to be the strongest person in the room, um, they don't cry. They can't cry. I mean, I was taught that my whole like men don't cry.

P21-M: I think men tend to wanna hold things in a lot more than women. Um, and so again, I think that's really just more of a pride thing. Uh, we don't wanna seem like we we're weak. Um, maybe we think a lot of times, uh, you know, if we open up say stuff like that, we kind of put on this. We think that we're gonna look weak in people's eyes.

P22-F: I do think that men are perceived that they need to be the strong one. They need to be the one that can figure their stuff out. So, I think oftentimes if they are having depression or any type of mental illnesses, they're, they're perceived as being weak.

P23-F: I think there's still that stigma around men are supposed to be strong and, you know, um, very prideful. Yeah, no, I definitely think that, you know, society makes them feel like, um, they're weak or they can't handle it. They're not, um, the strong men that they should be.

Stigma Responses (RQ3)

- Emotional Reactions
 - Embarrassment/discomfort (self or person they know)
 - Sympathy
- Cognitive Reactions
 - Personal responsibility
 - Self-stigma
- Message Effects
 - Avoidance/Ostracization of person
 - Label avoidance
 - Silence/denial

P1-F: Um, the most common reaction would probably, I would say just be like surprised and then it probably would just kind of be laughed off, you know what I'm saying?

P1-F: Cause it's just kind of hush, hush and you know, they, they keep a lot of that to themselves because they are afraid that they're gonna be laughed at, or they're gonna be perceived as weak, or they're gonna be perceived as crazy, or they're gonna be perceived as, you know, whatever, you know, and, and they keep those guards up.

P1-F: I feel like most men probably wouldn't even say that they [have mental health problems] They would keep it to themselves.

P1-F: Like, it's just, you know, what's the old saying, you might be able to help me with this, but, um, if you don't talk about it, doesn't exist.

P2-M: The best thing to do is just say, stay away from them because we don't know what's gonna happen.

P3-M: You know we say it's better dead than to cry in front of someone. We fear embarrassment. We don't want to be embarrassed.

P5-M: I would say most of the people, I know the men wouldn't say anything or want anybody to know.

P6-M: Yeah. Uh, I mean, for the most part, I think our society kind of sees men's mental health is kind of like, um, in the background for the most part. I guess generally most people in our society, even locally kind of see men's mental health is, you know, the last thing that is kind of being dealt with, you know. If a woman is going through issues, it's kind of like very easy to generally kind of recommend, you know, a therapist or something like that. Men usually don't even speak out their issues, because they've kind of learned that like, I mean, I hate to say it, but there's some, if you speak out your issues in a lot of general populations, you're kind of seen as weak, I guess, basically from, um, you know, a masculine perspective.

P6-M: Generally I think like a majority of people don't want to hear, uh, you know, that's a man is going through this or that or dealing with this or that.

P7-M: Uh, across the board is going to be the word denial...it's you just don't talk about it. Uh, it can affect, uh, your ability to get a job. If, uh, your, uh, working for someone and they're provided health insurance, you go for mental health, you suddenly find your job's eliminated. Uh, you're considered a risk.

P7-M: I realized that I had a church full of, uh, men who were struggling with alcoholism and some women, but primarily men. Being the bright, uh, young pastor that I was, we needed AA. So, we start AA and suddenly these men start disappearing and they, they do not attend. And so I sat down with a couple of 'em said, "Hey, you know, just, we're just trying to help. What's going on?" They said, "Well, word's out that everybody comes on Thursday nights is an alcoholic. Uh, cause we got certain people driving by the church, looking at cars and knowing who own, what car they're going out."

P10-M: Um, and even, I remember, I remember at the funeral, he had a son who died in a car crash at a very young age. And so my brother stood at the funeral and showed no emotion whatsoever, never shed a tear. And <laugh>, I'm getting emotional just talking about it. But, um, I was struck by, you know, the fact that he felt he was not allowed to show how he felt.

P11-M: If you have someone that gives you an indication, you know, they might be thinking about suicide. You go ahead and embarrass them and say, "Hey, are you thinking about hurting yourself?" And that's a hard thing for people to ask, cuz it's socially awkward and, and all those things.

P15-F: They're the leaders of the home, you shake it off and you go on and you just tough it out, you know...you don't ever want to be defined as crazy.

P16-F: So, I go to Gainesville for mine [mental health care]. Um, and that's because I don't wanna go somewhere where anybody else knows me...I don't want to go anywhere in this small town where people are gonna find out that I'm getting treatment.

P17-M: They don't, they wanna bring up, they don't wanna, you know, mention it. And you just were taught at a young age. Don't ask Uncle John about the war. That's just the way it goes, you know.

P19-F: There's certain people [in the community]...that would, would, would show sympathy, and then there's others that would say, well, you know, I don't wanna be around somebody that's depressed.

P19-F: There's a lot of churches that won't talk about a lot of things anymore. Yeah. Um, avoid certain subjects. Well, that's, you know, we don't do that. We don't handle that [mental health] here.

P20-M: And I mean to take a gun and blow the top of your head off, I mean, that takes a lot of pain. Instead of looking at it as taking a lot of pain, they look at it, there's something wrong with them. I don't know what's going on. I mean, the pain that you have to go through to do that is just unbelievable.

P20-M: And they just, and then you, you break out crying. Everybody looks at you like something's wrong with you because you actually felt something.

Stigma Storytelling (RQ4, RQ5, RQ6)

- Micro-level
 - Family
 - Friends
- Meso-level
 - Religious communities
 - Local media (newspaper)
- Macro-level
 - Film and television
 - News
 - Celebrities
 - Social media

P1-F: Yeah, my, my family has said some of that for sure. Okay. Um, you know, just, um, saying like they're crazy, their family's crazy, you know, that kind of thing for sure. Um, it's not easy to admit that I don't think, but you know, I have heard that for sure.

P2-M: I mean, you know, reading news about what's happening in, in the Senate right now with, with gun laws being passed, but also seeing some of the, the stuff that's happening with, uh, violence in schools and seeing that some of it may be related to mental health issues. Um, some just may be that people are just lunatics...because what they're not wanting to do is put guns into the hands of people that have mental health problems.

P2-M: I see stuff about it [gun violence] on maybe Facebook pages and stuff like that regarding people that have specifically mental health issues.

P2-M: I can't speak for other people and what their, their, uh, upbringing is, but just, uh, from, from, you know, what you see in movies and, and other stuff growing up, men are supposed to be strong. Men are the hunter gatherers and, and the women stay at home and they be emotional and, and they take care of the kids and, and it's okay if they cry because that's normal for a woman, you know? Well, men don't cry, you know? Um, but I think we've just been conditioned to think that men just don't cry. And so it makes it uncomfortable for men if other men cry, cuz they probably see it as a sign of weakness, you know? And I think that is displayed a lot in movies and other stuff like that.

P6-M: I don't really watch a lot of news and stuff and like movies and things like that. I guess like, generally it is kind of shown in movies that, you know, men's mental health is kind of secondary to most people. I think that my perspective is really just a personal from just seeing like, just experience experiencing life as a man.

P7-M: Uh, well it's "just suck it up" is a common expression. Okay. Hey, you're just, that's a hand God dealt, you just live with. And that's as common among the unchurched as the church...It, it, it doesn't come outta the media. It comes from family, friends, relatives. And, and, and it comes out the church.

P12-F: I mean, the newspaper publishes when people are arrested on drug charges and other related things. They, uh, basically publicly shame people who have problems with addiction and it does have an effect.

P13-M: I'm gonna have to say media for the most part. Cause I don't encounter people that I would identify in that area necessarily. So my attitudes are driven by media, which is kind of scary... broadcast media or, uh, internet, um, you know, the big, the big companies, uh, CNN and all that.

P15-F: I think they, they probably learn about it from their dads, from, I mean, you know, from their family and also from, you know, uh, movies. For instance, Robin Williams, and this is, I guess, I don't know, other than, than these examples, but for Robin Williams, he was dealing with dementia for the longest time. And you didn't really hear of it until after his suicide.

P15-F: I know like at the dinner table at my house, my dad was a school bus driver, and then he worked at the plain mill, the, the wood mill, and, you know, at dinner table around the dinner table, it was like, "Oh my goodness, Mr. Burns lost his mind and that there chicken house back there." Lord, you know, stuff like that. And my grandma used to say, "He just needs to go to church and get right. You know what, devil's just on his back." I mean, you know, that's the kind of things that you hear.

P15-F: Mine's just been, just around folks, you know, at church, even at, you know, when we're out with friends, "You know, so and so they've been in their bedroom for four days, you know, what's Jesse gonna do with, with Jim, you know, he's, he's laid up in the bed, you know, he's just, well, he's just gotta change the way he thinks about things, you know?" And, and it just seems like a lot of that.

P16-F: I've heard a lot of things about like Robin Williams when he committed suicide and, um, what's that guy's name? Kim Kardashian's husband, Kanye um, you know, and his mental health issues. I don't know. I think, um, the general consensus is just like, well, people just use that stuff to like benefit themselves or change the narrative to gain sympathy or, you know, know that kind of thing rather than it being a legitimate issue that people need help.

P17-M: In law enforcement, we tend, we tend to label folks too. And I think we're really working hard not to do that. I think there's a, there's been a huge change, um, in the time that I've been in law enforcement, but I think there's, there's always been those stereotypes of, uh, that guy's crazy. Um, you know, um, and just word of mouth. I mean, it just gets around that you don't deal with that guy, you know.

P20-M: And when, if you say something like you're going to see a therapist, oh my gosh, they have a complete fit. I mean, they can't even get a vaccination. Can you imagine what they say about a psychiatrist or a psychologist? Um, they just look at you like, okay, and they'll just give you a face or a little "Ooh." You know, or something like that. And they'll walk away and you know, the next thing you know, everybody in the world knows about it. That's the one thing about being up here. They, they, they don't keep anything private. Everything's gotta be sent out to everybody in the, the world and really hurts relationships. Cause people don't wanna reach out cuz they know if they do everybody in the world's gonna know about it.

P20-M: My father would say, "You need to be a man at all... costs, you can't show emotion. You have to, you have to be the rock in your family... you're not allowed to show weakness in any way."

P21-M: I have just heard through Facebook, uh, and social media that he had had problems.

P24-F: Yeah, I think on television, there's definitely more of a depiction of, um, a man with mental illness as far as being outwardly disheveled.

Reducing Stigma (RQ 7)

- Interpersonal connections
 - Significant others
 - Family
- Existing efforts
 - Community leaders and organizations
 - Positive messaging from community leaders
 - Positive messaging from celebrities/media
- Suggestions from locals
 - Masculine community events promoting mental health
 - Male community leaders with personal experience
 - Social media
 - School/youth programs

P1-F: I do know we have one county commissioner that is, um, big into mental health right now, and really trying to push that and, and be involved.

P1-F: Most of that is going to be, um, like social media, you know, just, just that's that seems to be the best avenue to, to kind of get everything [mental health education] out there.

P3-M: Two months ago we [congregation] were...we engaged in a, uh, a leadership of, uh, young people, the youth. We were discussing on how we can handle or how we can help our young generation with, uh, with this stress management. So, our pastor has given us the opportunity to have some programs so that we can help to go and share our experiences in life.

P6-M: Um, but like, for example, to, to go in on that a little bit though, it's like my grandfather, he was raised in Georgia. He was picking cotton at like 11 years old, you know what I'm saying? But he was still an emotional person. He was still willing to share his emotional side. Like he didn't go to therapy or anything like that, but he was, he definitely shared emotion with me. And maybe that gave me a little bit of like, of a different view worldview than some other people.

P6-M: Like vague Facebook posts or things like that, you know, that are generally talking about, you know, men's mental health, things like that. Um, I ran a Facebook group that was like, you know, a masculine group basically. And we would talk about stuff like that between each other sometimes. Um, and talk about ways that, you know, that helped us, like, you know, my big thing was drumming and making something, growing something, doing something, create something, you know, create music, create art, create something. Um, so yeah, just, I guess that's the only thing that I could think of is like just general Facebook groups or some or general Facebook posts from friends.

P9M: Um, there is, um, Lake Rabun Association. They really want to help people in the community. Um, and also, uh, you know, Rotary I'm in Rotary, too. Um, they wanna do whatever they can do to help people in the community.

P9M: "I, uh, definitely had some support and understanding from my family, especially my aunt and mom. They helped me a lot with understanding that what I was experiencing was normal."

P11-M: I'm a huge Ohio State fan. Um, but we, we had a player this year, who, you know, retired from football and it was all around mental health...the cause he just said, "Hey, my mental health is

more important than my football career. And, um, you know, here's, here's what I'm gonna do as a result of it." And he talked openly about it. It's very powerful and it's very emotional.

P11-M: And I think you see that in things like the fact that we're trying to start a task force, that we do have organizations that their mission is to address mental health issues and mental health at large and, and things of that nature.

P12-F: We have these events where people in recovery can gather and just have fellowship in a supportive environment. We did this for the Super Bowl, and it was great.

P15-F: Every church needs to, you know, have some type of like we do, um, you know, we do programs to help educate the support groups for folks with mental health.

P15-F: Um, well I think it, it could start with, um, your county mental health systems...creating more grassroots groups, you know, um, like, uh, setting up a mental health hunting kind of thing, you know, and involving something that's manly and that's, you know, uh, very much a part of their culture. All the guys in rural, rural north Georgia, they hunt, you know, you go out and there's tons of hunters, there's tons of fishermen, you know? And I think if it was something, uh, group oriented to where you could have open discussions about it and it not be a sissy.

P16-F: Um, the sheriff, um, he has actually done a good bit for substance, for reducing stigma of substance abuse and kind of helping with that.

P17-M: I think the best way to do that [reduce stigma] would be more to continue to educate the public, to let 'em know that it's, it's normal, um, to, to do more community events.

P19-F: I think that if you could find people that are prominent community or that have good reputations that are men...the kind of the kind of type that other men might relate to, uh, that they might change their minds or want to help somebody.

P20-M: But really the truth is, is if you reach the men, when they're younger right now to tell them, "Hey, this is okay, it's okay to feel this way...You know, here's how you get help. This is, you know, it's okay to feel that you don't have to worry about being weak. We're all weak." Those are things that if you got 'em now, imagine what they'd be like when they grew up, you know. It took me years of pain to find the answers and the answers that fit for me.

P23-F: Um, like the Rotary Club is kind of taking on mental health as their current, like focus area of just trying to offer some resources to get something off the ground. Um, so it's definitely getting some attention right now.

P23-F: I mean, I think, especially when you're talking about small town where everybody does know everybody, it, it does matter who it's coming from. Um, you know, because if you see somebody who has a good reputation and who has some kind of, I don't wanna use the word authority, but like, um, just a presence, you know? Yeah. Known for positive things in our community and they were to, you know, speak out and lead then. Yeah. I think that would definitely make a difference.

P23-F: I think there's a lot of good that can come through Facebook with people just sharing like positivity and it's okay to ask for help. And those kinds of things through Facebook is always nice to see. And, you know, those, um, suicide prevention stuff will go around from time to time. Like don't be afraid to ask for help. And, um, so that's always encouraging to see, and I feel like the more

people see that kind of stuff, the more likely they are to like, realize they're not, they're not the only one.

P23-F: If we can catch 'em in school and get them in the counselor's office and get them seeing that therapy is not some scary thing, not that we do therapy in the school cause we don't, but like you're talking to a counselor when you go to a counselor outside of school, you're seeing them regularly, you're working on more intense things, but like, this is what it is. You're, you're just talking to another human and you're, and you're getting help and you're talking about skills and you're opening up, and that's okay.

Help-seeking Perceptions (RQ8, RQ9)

- Supportive/In favor of
- Embarrassed (*worried people will know*)
- Telemedicine
- Women seen as more accessible

P1-F: Um, I feel like if somebody's opening up to you enough to tell you that they suffer with depression, um, then that's enough for you to sit down and give them 30 minutes of your time, um, to listen to what they have to say.

P2-M: I don't like medicine. I don't like taking that kind of stuff. Um, and I don't know, there may be that it, in me, a part of me is sees that as weakness. I just don't like doing it.

P2-M: Hey, prayer's not always the answer. Um, you can't just throw dirt on it and suck it up and get better. Sometimes it takes finding other resources that are available and people that have specific knowledge and skill to be able to help it.

P2-M: I mean, if that person is, is telling a female, I think they're gonna respond a lot differently than a guy will. If the guy grew up in a family that, um, where men don't cry, you know, they probably would be uncomfortable and not know how to respond.

P2-M: So now I don't wanna go get medicine because then the realization is, yes, you have a problem and you need something for it. I'm like, no, that means I'm a failure. I'm weak.

P6-M: I'm a naturalist for the most part. Like I don't really, even, I haven't taken a prescription drug in 20 something years. Maybe take a Tylenol every once in a while. So, if it was anything unnatural, I'd probably go against it. But like, you know, basic therapy, things like that, I'm cool with, you know. I've known people that did crazy stuff like hypnotherapy and stuff like that.

P10-M: Maybe it's because I there's this lingering idea that people don't really wanna hear about your problems. Um, and...in many cases though, you, you make them uncomfortable. So, you know, I, and maybe, I, I don't know if I'm just using that as an excuse, but I do tend to be more, you know, self-reliant and, and keep, and keep my problems to myself... I'm not gonna go to one of my friends and, you know, try to, you know, to help me through a difficult situation.

P10-M: I think men are more, might be more accepting of...some sort of a medical, you know, or prescription sort of a solution. And again, because it spares them that, you know...the trauma of having to expose themselves, um, uh, verbally, you know, to express their fears and difficulties.

P10-M: I think that that [telemedicine] might be, that might be a way for men to overcome some of the stigma associated with, um, even being seen, going into a, you know, a psychologist's office or

psychiatrist's office. If the treatment, if the therapy were something that could take place in the home...then I think a lot, I think, I won't say a lot, but I think men might be a bit more comfortable with that environment than...being seen walking into the door of the local mental health center.

P11-M: I think in rural communities, that's where, um, some of the teletherapy, if that's even a word, becomes very exciting, uh, because you don't have to have someone that is physically local. I, I understand, you know, again, it's a little bit harder, um, from a privacy standpoint, to open up to someone that's on the other end of a computer, and you know, there's probably not, um, a hundred percent substitute, but when you have smaller communities and you don't need, you know, a full-time person in Rabun County who specializes in, you know...it's a whole lot better than nothing.

P13-M: I think it'd be very rare for a, a, you know, a man to approach another man with that [mental health issues]. I don't know why I say that, but maybe women talk to each other about that stuff, but I think it'd be very rare... we go camping and guys talk about a lot of things, but not that.

P13-M: Well, I'd say, you know, a therapy in its own right; I think it can be very valuable.

P16-F: I think everybody kind of thinks that anybody who works in the psychiatric field at all is kind of just a quack who's taking advantage of people. And I don't think they understand like mental health is a legitimate health issue. I think they just think, oh, it's something we all go through at some point or another, like, just get over it.

P17-M: I think that the biggest issue for men with mental health problems is that they're afraid to ask for help.

P17-M: When I was in church, I would go to, to the pastor. But again, it was, it was not talked about...they would say, well, turn to God. Well, I am, you know? Yeah. But God gives us intelligence and he gives us thing tools to use.

P17-M: Um, I think that counseling helps a lot. I really do. I think that some people have trouble getting to the first. It's like going to the gym. It's that first time getting there is probably the biggest step, right. Um, but once you get in there, uh, I think talking to folks and getting it off your chest and hearing another point of view, I think sometimes it, uh, for me, I've actually been there [to therapy] for...a couple, couple things. And for me it, it validated that I was normal.

P18-M: I used to have a mindset that if you need medication, it's like a sign of, you're not, you're not close enough with God. You're not trusting him enough. You're not letting him handle this. There's no reason you should need that if you have a, a good walk with him. But I have, since through my wife's experience and through this other leader, in my church's experience, I've realized that's not something I believe anymore. Um, I think sometimes there's something chemically in the brain that needs to be corrected to allow you to even consider God's word or to trust him.

P20-M: I personally believe that...everybody needs help sometimes.

P20-M: I think, I really believe if they would've got help, that [suicide] wouldn't have happened, but they, they suffer and suffer and they suffer in silence and nobody knows what's going on until it's too late.

P21-M: Um, I think that if, if someone's, uh, brave enough to step up and say that they have, you know, the problem that I think counseling and therapy is much needed; I think that it would be something great.

P22-F: I just think that oftentimes men see their issues, their problems with things, as something that they should be able to fix on their own.

P23-F: Everyone can benefit from therapy. Even when things are good, it's not, it's not a bad thing.

P24-F: I don't think, and this may just be a Southern thing too--I don't, I don't think, um, men are as open a about needing that kind of help, uh, in the South.

Help-Seeking Outcomes (RQ8, RQ9)

- Medication
- Therapy
- Social Support
- Delayed care

P2-M: And it wasn't until it, it affected, it was affecting my life. It was affecting my marriage, my family, that I realized crap, I need to do something. And, uh, you know, and that was this year, but I've known with other stuff like the depression and anxiety and, and other issues like that. It's, I'm like, yeah, no, those are problems that, that need to be addressed in some way. And you can't really overlook them for me. I, I didn't see what I was struggling with...I'm a huge advocate now that I'm on medicine and how it's helped me. I'm like, "Hey, listen, you know, medicine's not always bad."

P2-M: I have a problem that I won't take care of it because of my pride and because I think it'll be alright. You know, and, and it was affecting a lot of people and the... the reality is that probably a lot of other people were thinking that and just weren't brave enough to tell me, right. And my wife did. And she's like, you know, she got tired of saying, Hey, there's stuff to help with that. And she finally just said, you're just miserable to be around. So, um, that was a catalyst [for seeking mental health care].

P6-M: I've been such a self-sufficient person. I've managed to kind of do a fairly okay job of dealing with my own kind of mental health for the most part. Like, I still deal with my own depression, things like that, you know, but, uh, I think that that unique self-reliant thing has kind of given me an advantage compared to some people, right.

P7-M: The men I know usually have gone to get help--usually go through their private physician to get help, not through a counseling service.

P7-M: And, uh, I, I normally could pull through, I've never had a problem pulling through issues like that in the past, but this time I couldn't. And I went to my doctor about.

P10-M: I've done that [therapy]. You know, I've done that several times throughout my lifetime.

P17-M: I went back and got back on the medicine again. And it's, you know, uh, because I realized, yeah, it did, it did make a difference in my life, and it did help me.

P19-F: My oldest son is now, he's uh, he's an alcoholic. And it's because he didn't get the help that he should have gotten back then, and he refused it, and he wants to ignore it, and he thinks that therapy or counseling is a waste of time. And so that's what he lives with now.

P20-M: You know, when it comes to, um, mental health, a lot of times guys won't seek help. They don't think that there's anything to it.

P21-M: Um, so I would probably first probably, um, maybe sit with, uh, some of our, our pastors at our church, but also my wife where she works with our doctor. He's also our, um, family physician. So, um, I would probably...look into getting some help, uh, from him and honestly, and I'll just let you know, uh, you know, I, I have, I don't have really depression, but I've had anxiety issues. I'm on a very low dose of, of that myself...for anxiety medicine, and that's who I went to, um, you know, to get some medicine for that.

P23-F: Um, I think they're more likely to try to hide them [mental health issues], um, as opposed to women. I mean, I see this with students all the time. Um, my office is frequently full of girls, um, but the boys are less often willing to show up and say they need help.

Appendix G

Data Analysis Grid

Category	Themes	Topics
Community Traits	Cultural Traits	<ul style="list-style-type: none"> • Self-sufficiency • Community oriented • Isolated • Perceptions of masculinity • Religious/Christian • Subgroups
RQ1: Storytelling System	Communication Infrastructure	<ul style="list-style-type: none"> • Interpersonal networks • Community organizations • Media
	Communication Action Context	<ul style="list-style-type: none"> • Goods and services • Resources for residents • Healthcare resources • Safety • Transportation • Schools • Work conditions • Area appearance • Social salience • Culture
	Field of Health Action	<ul style="list-style-type: none"> • Hinderances to seeking care • Catalysts to seeking care
RQ2: Stories	Interpersonal Network	<ul style="list-style-type: none"> • Family • Friends

	Media	<ul style="list-style-type: none"> • News media • Entertainment (film and television)
RQ3: Stigma Narratives	Weakness	<ul style="list-style-type: none"> • Disease/disorder related • Perceptions of masculinity/emasculatation • Sin/lack of faith
	Dangerousness	<ul style="list-style-type: none"> • Violent
	Shamefulness	<ul style="list-style-type: none"> • Labeled as crazy • Self-Stigma
RQ4: Stigma Responses	Emotional Reactions	<ul style="list-style-type: none"> • Embarrassment/discomfort (self or person they know) • Sympathy
	Cognitive Reactions	<ul style="list-style-type: none"> • Personal responsibility • Self-stigma
	Message Effects	<ul style="list-style-type: none"> • Avoidance/ostracization of person • Label avoidance • Silence/denial
RQ5, RQ6, RQ7: Stigma Storytelling	Micro-level	<ul style="list-style-type: none"> • Family • Friends
	Meso-level	<ul style="list-style-type: none"> • Religious communities • Local media (newspapers)
	Macro-level	<ul style="list-style-type: none"> • Film and television • News • Celebrities • Social media
RQ8: Counternarratives and Reducing Stigma	Interpersonal Connections	<ul style="list-style-type: none"> • Significant others • Family
	Community Leaders/Community Organizations	<ul style="list-style-type: none"> • Existing efforts • Positive messaging from community leaders

	Mass Media	<ul style="list-style-type: none"> • Social media • Celebrities
RQ9 & RQ10: Help-Seeking Perceptions and Outcomes	Help-Seeking Perceptions	<ul style="list-style-type: none"> • Supportive/in favor of • Embarrassed • Telemedicine • Women seen as more accessible
	Help-Seeking Outcomes	<ul style="list-style-type: none"> • Medication • Therapy • Social support • Delayed care
Additional Themes	Trusted Sources of Information on Mental Health	<ul style="list-style-type: none"> • Medical professionals • Community leaders
	Locals' Ideas for Reducing Stigma	<ul style="list-style-type: none"> • Masculine community events • Hearing more from male community leaders with personal experience • Social media • School programs
	Suicide	<ul style="list-style-type: none"> • Perceptions of suicide • Personal experience