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The Handbook of Mental Health Communication

Edited by Marco C. Yzer and Jason T. Siegel

WILEY Blackwell

The Handbook of Mental Health Communication

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Preface

In a 2023 opinion piece in *Time* magazine, Gabriel Boric (who at the time of writing is the President of the Republic of Chile) and Dr. Tedros Adhanom Ghebreyesus (who at the time of writing is Director-General of the World Health Organization) argued that mental health is a fundamental human right. Boric and Adhanom Ghebreyesus stressed that the extensive detrimental effects of mental illness and poor mental well-being on individual, public, and societal health call for a large-scale, multisectoral response from a wide array of stakeholders. There are essentially two parts to such a response. One focuses on the structural environment of mental health and mental illness and includes efforts by various stakeholders, who separately or in collaboration, improve structural conditions of people's lives, invest in mental health care capacity, and strengthen access to mental health care. The other focuses on how people think, feel, and act regarding mental health and mental illness and includes the promotion of mental health in whole populations as well as in specific priority groups such as people who currently have severe mental illness.

Purposefully planned mass communication messages are a potentially useful tool to promote mental health. Indeed, there is a long history of the use of mass media messages to promote mental health. This does not mean, however, that message-based mass communication interventions have proven to be generally effective. There are many reasons why mental health mass communication interventions may not work; for example, such interventions compete with many other media messages for an audience's attention in an increasingly cluttered media environment, there may not be sufficient funding available to ensure prolonged exposure, and social norms around mental health may not be conducive to favorable responses in some cases. Perhaps even more important, however, is the lack of an established knowledge base; the scientific domain of mental health mass communication remains in its infancy.

To enhance knowledge of how mental health mass communication can effectively be used as a tool for mental health promotion, scientific knowledge of how to create effective mental health messaging must be shared across domains. There already exists excellent work from researchers across the communication discipline who have investigated means of improving the lives of people experiencing mental health challenges. However, a lack of intellectual research space shared by mental health communication scholars among themselves and with scholars from other disciplines has minimized the potential impact of this work. Even worse,

siloed research can lead to the use of messages that can harm the very people they were meant to help—people with mental illness. This contention was the impetus for this handbook.

The *Handbook of Mental Health Communication* was designed based on the notion that optimizing mass communication messaging approaches to mental health requires the integration of insights from various disciplines relevant to communicating mental health. There exists a wealth of knowledge of the psychopathological, social, epidemiological, political, and etiological aspects of mental health and mental illness, and much is known about communication principles that can inform the development of messages on a variety of health issues. An amalgamation of this literature is a necessary and exciting next step in evolving the burgeoning mental health mass communication field.

The *Handbook of Mental Health Communication* brings together a wealth of diverse conceptual frameworks and empirical lines of research that collectively offer complementary insights for optimizing mental health mass communication. The 33 chapters in this handbook are written by 85 outstanding experts worldwide. Integrating diverse insights from various disciplines makes the handbook of interest to a broad audience. We hope that the handbook will be a resource for those who want to use messaging to improve the lives of people with mental illness.

There are seven parts to this handbook. The chapters in each part address different aspects of primary questions that need to be understood before designing mental health mass communication messages. In part I, Lisa Vos and colleagues, Elayne Ahern, Caroline Ostrand and Monica Luciana, and Fei Ying and colleagues review the causes, manifestations, and consequences of biased information processing in mental illness. In part II, Romy RW and colleagues, Brian Quick and colleagues, Seth Noar and colleagues, David Vogel and colleagues, Annie Fox and colleagues, and Anthony Jorm discuss definitional and measurement issues related to a wide array of mental health communication concepts, such as information seeking, message effectiveness perceptions, self-stigma, and mental health literacy. We next move to issues related to the global dominance of digital information platforms. In part III, Kylie Woodman and Rene Weber, Fakhra Jabeen and colleagues, Nancy Lau and colleagues, and Jolynn Dellinger unpack the dangers of digital media for mental health and how their potential can be leveraged for improving mental health. In part IV, Crystal Barksdale and colleagues, Frances Griffith and Sydney Simmons, Sabrina Menezes and Gregory Guldner, and Laura Marciano and colleagues speak to the complex question of what needs to be done to ensure that mental health messaging improves mental health outcomes in special populations, given the strong causal effects of structural factors on mental illness and well-documented evidence that health message campaigns can exacerbate mental health disparities and communication inequalities.

In part V, Xun Zhu and colleagues, Ashley Johnson and colleagues, Tara Muschetto and Jason Siegel, and Miranda Twiss and colleagues discuss various ways messages can inadvertently increase stigma of mental illness and alternative message approaches that can reduce stigma. In part VI, Christopher Falco and Benjamin Rosenberg, Thomas Niederkrotenthaler and colleagues, Tasha Straszewski and Jason Siegel, Marco Yzer and Xuan Zhu, and Jason Siegel and Cara Tan review research on message strategies that offer exciting potential for improving mental health outcomes. Part VII includes essays by Teresa Thompson, Wenhao Dai and Dolores Albarracín, Jenna Reno and colleagues, and Bill Crano in which they reflect on their prolific and essential work in domains other than mental health and advance ideas lessons learned from their work that can be applied to mental health communication. For the final chapter, we accepted the challenge of highlighting how all the chapters in the book can come together to offer a helpful path ahead for mental health communication efforts. We proudly cite every chapter in the book and provide one of many recommendations that can come from the culmination of the Handbook's chapters.

This brief overview of the chapters in this *Handbook of Mental Health Communication* illustrates the wide range of questions that must be addressed when one considers developing mental health messages. Some questions directly ask about message aspects, whereas others ask about contextual, psychopathological, and other noncommunication issues. A comprehensive picture of the mental health communication landscape emerges when all these chapters are put together. To maximize the integration of ideas, we also asked all authors to include their thoughts on what their review meant as advice for those who want to use messaging for mental health promotion. This handbook's wealth of insights is not the final word about what we can do to optimize and safeguard mental health communication. It is a beginning. We hope this handbook will lead to a conversation among scholars, practitioners, and others for whom mental health and mental illness are essential, sparking interest in new research. This will ultimately converge in a significantly strengthened knowledge base on mental health communication.

Acknowledgments

Mental health is close to our hearts. We believe this handbook can make a real contribution to efforts that improve the lives of people with mental illness. For that reason alone, working on this project has been gratifying, humbling, and energizing. We have been similarly thrilled by the opportunity to work with and be supported by such an amazing group of people. Our collaborative work has underscored how significant an interaction effect can be.

Considerable credit goes to Nicole Allen at Wiley and Dr. Teri Thompson, founding editor of the journal *Health Communication*. Our collective paths crossed thanks to them. We are thankful to them for their reliably strong support throughout this entire project.

We are filled with gratitude for the expert contributions from all authors, who generously contributed their time and wisdom because they believed in the importance of this book's mission.

We wish to acknowledge the assistance of Zach Buttram, Yuming Fang, and Noel Perez. Their careful attention to detail and positive demeanor greatly helped the preparation of the book materials during the final stages of the project.

We owe a debt of gratitude to our departments for their support. We also are hugely thankful for the support we received from so many of our colleagues, whose helpful thoughts and patience when we made them listen to our long updates had a significant effect on the success of this project. We particularly recognize Dr. Rebekah Nagler and Dr. Jen Lueck. We also acknowledge the deep respect we have for the guidance we have received over the years from our mentors, Dr. Marty Fishbein and Dr. Bill Crano.

Dr. Siegel would also like to thank the past and present members of the Depression and Persuasion Research Lab. They believed in the importance of this scholarship and that it would make a useful contribution to the field and the plight of those with mental illness.

Dr. Yzer expresses his deep appreciation for the unwavering support and mentorship from Aaltjo and Ge Yzer.

Our families have been and are hugely important for our work. We are grateful for their inspiration, encouragement, and support as well as for their astute feedback and many other contributions. Thank you, Amanda and Satoko. Thank you, Erin, Anet, and Sven. Thank you, Maya and Shaw.

Last, we sincerely thank every person who has participated in our research studies. All of the chapters in this book are in the service of advancing understanding of how we can best develop mass communication messages that can help reduce the plight of people with mental illness.

All of the chapters ultimately also are the result of the willingness of our participants to share their personal experiences with us. An anonymous participant wrote to us after completion of one of our studies:

"Hey. I wanted to write and say I appreciate studies that cover stuff like this. As someone who as attempted suicide in the past, it's not an easy thing to talk about but I do when given the chance to help someone."

This leaves us with pride in the collective work represented in this book and a keen sense of responsibility for doing the right work and doing that work right.

Marco C. Yzer
Jason T. Siegel

Reference

Boric, G., & Adhanom Ghebreyesus, T. (2023, October 13). Mental health is a universal right. *Time*. https://time.com/collection/time100-voices/6323214/mental-health-care-delivery-who-chile/

Introduction

1

Mental Health Mass Communication: Using Messages to Relieve the Plight of People With Mental Illness

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Introduction

Mental health challenges have become one of the leading public health issues of our time, negatively affecting the well-being of millions of people globally (World Health Organization, 2022). In response, there have been significant mass communication efforts to promote mental health. Mass communication interventions "expose high proportions of large populations to messages through routine uses of existing media" (Wakefield et al., 2010, p. 1261). Mass communication interventions have been used, for example, to reduce the stigma of mental illness in the general population or to encourage seeking professional help among people with mental illness (e.g. Foulkes & Andrews, 2023; Tam et al., 2024).

The broader mental health communication field includes any scholarship and professional application of communication content, processes, and outcomes related to mental health (Aldrich & Quintero-Johnson, 2021). Subfields of mental health communication include, among others, *interpersonal communication,* such as conversations with a professional care provider to talk about one's mental illness, *media portrayals* of mental illness in entertainment media and news media, *technological features* of social media that facilitate sharing mental health information, and, the focus of this chapter, mass-communicated *messaging* that promotes mental health.

Mental health mass communication shares a focus on how communication content, processes, and outcomes affect mental health with other subfields of mental health communication but is uniquely different in the approach to those communication factors. We define mental health mass communication as *the academic study and practice of purposefully planned mass communication messages designed to improve the plight of people with mental illness by, for example, promoting mental health awareness, reducing stigma, or encouraging help-seeking behaviors.*

In this chapter we discuss various aspects of mental health mass communication. We put forth a set of principles that offer actionable guidance for optimizing and safeguarding mental health messaging. We begin with a discussion of the significance of mental illness as a global public health issue to contextualize the need for effective mental health mass communication.

The Handbook of Mental Health Communication, First Edition.
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The Need for Mental Health Mass Communication: The Global Burden of Mental Illness

Prevalence data make clear that mental illness is a massive global public health issue. Several sources of global mental illness prevalence data support this contention. For example, the World Health Organization's world mental health surveys (Harvard Medical School, 2023; Kessler et al., 2006) collect prevalence data on anxiety disorders, mood disorders, impulse control disorders, and substance disorders from over 30 countries. In one analysis of world mental health survey data collected between 2001 and 2021, the lifetime prevalence of any mental disorder was about 29%; the morbid risk of any mental disorder by age 75 was 46% for males and 53% for females; and major depression (both males and females), alcohol use disorder (males), and phobia disorders (females) were the most prevalent mental disorders (McGrath et al., 2023).

The Global Burden of Diseases, Injuries, and Risk Factors study (GBD) collects data on over 350 causes of adverse health outcomes (Murray, 2020). In an analysis of 2019 data on 369 diseases and injuries across 294 countries, depression and anxiety were the 13th and 24th leading causes of loss of life years (Vos et al., 2020). The GBD database suggests that in 2019, the global prevalence of mental illness was as high as 970 million people or one in eight people. Anxiety (301 million) and depression disorders (280 million) were most prevalent. Among other mental disorders, the prevalence of alcohol use disorder was estimated to be 108 million; attention deficit or hyperactivity disorder 85 million; drug use disorder 58 million; conduct disorder 40 million; bipolar disorder 40 million; schizophrenia 24 million; and eating disorders 13 million (Institute of Health Metrics and Evaluation, 2024). These prevalence estimates may differ between regions in the world. For example, an analysis of world health surveys between 2001 and 2012 suggested that the prevalence of posttraumatic stress disorder (PTSD) was 3.9% across 24 mostly upper- to high-income countries (Koenen et al., 2017). In contrast, the prevalence of PTSD in 2019 was as high as 27% in 12 countries affected by war (Hoppen et al., 2021).

Whether global prevalence rates of mental illness are rising is a debated question, partly because of methodological issues in studies that may have led to an interpretation of demographic changes in the past decades as increasing prevalence trends (Baxter et al., 2013; Richter et al., 2019). What is less debated is that the COVID-19 pandemic has contributed to an increase in mental illness. For example, a recent initiative has examined the impact of the COVID-19 pandemic on depression and anxiety disorders (COVID-19 Mental Disorders Collaborators, 2021). Estimates from a meta-analysis of 48 data sources that represented 204 countries suggested that global prevalence rates of depression increased from 193 million to 246 million people during the COVID-19 pandemic, and prevalence rates of anxiety increased from 298 million to 374 million. For both depression and anxiety disorders, both prevalence and increase in prevalence were higher for females than for males and higher for younger age groups than older age groups (COVID-19 Mental Disorders Collaborators, 2021).

Most epidemiological research reports the prevalence of mental illnesses either as prevalence estimates based on survey participants' self-reported disorder severity or self-reported diagnoses (Kessler et al., 2006) or as counts of medical health data, such as treatment data or insurance claims (Global Burden of Disease Collaborative Network, 2020). However, people can have poor mental health even if they do not meet the criteria for a formal mental illness diagnosis. In addition, many people who may meet the diagnosis criteria for mental illness are not able to see a health professional for their symptoms and are therefore not formally diagnosed. This means that most published prevalence data underestimate the number of people who suffer from mental illness symptoms. In addition, mental illness prevalence data are not available for many countries or suffer from methodological problems, which makes an accurate estimate of the global burden of mental illness difficult (Baxter et al., 2013). This underscores that mental illness is common, which makes it even more tragic that mental illness continues to be stigmatized and that people with mental illness often feel alone in their predicament.

The Role of Mass Communication in Reducing the Burden of Mental Illness

Mass communication messaging interventions have a demonstrated potential for producing positive health outcomes, ranging from health knowledge and beliefs to health behaviors (Noar, 2006; Wakefield et al., 2010). Whereas competing factors such as cluttered media environments and firmly rooted social norms, among many others, certainly challenge the success of mass communication interventions, the likelihood of producing positive changes demonstrably improves when principles of mass communication intervention effectiveness are adhered to. These include the use of mechanisms of effects theories as a basis for message design, careful pretesting of messages, and the use of intervention design and dissemination tools that maximize exposure, among others (Noar, 2006; Wakefield et al., 2010; Willoughby & Noar, 2022).

With great power comes great responsibility. Mental health mass communication exists in a complex system of multilevel factors that interact and reciprocally influence mental health (Allen et al., 2014). These factors are outlined in social determinants of mental health frameworks, which explain the causal role of a range of structural and malleable factors such as economic opportunities, racism, educational attainment, access to media, and many others (Alegría et al., 2018; Marciano et al., 2025). Social determinants of mental health frameworks imply that the use of mental health mass communication to improve mental health is not a decision that should be made without considering other factors that influence mental health. For example, messages that promote self-care activities to cope with mental illness will not be optimally effective or even ethically suspect if structural factors that cause mental illness are not addressed in other interventions. As another example, when designing a message intervention to encourage people to seek help for mental illness, one must ensure that there are sufficient professional care options and that people have access to these. An important implication is that communication must be matched to what is feasible. For example, a campaign that encourages help-seeking may not be appropriate if there are insufficient treatment resources. However, if that is the case, messages that increase social support for people with mental illness would be helpful. Particular communication campaigns might be inappropriate for some goals, but there are always ways to use alternative communication for the betterment of people with mental illness.

Mental Health Mass Communication: Objectives, Messages, and Audiences

When it is clear that mass communication is an appropriate tool to consider in a particular setting for improving the plight of people with mental illness, decisions need to be made to develop mass communication messages. Central to these decisions are three interrelated factors: the objectives of mental health mass communication, the messages that are used to reach those objectives, and the audiences for whom the messages are intended.

Objectives

Whereas intuitively, mental health mass communication may be expected to primarily focus on reducing mental illness symptomatology and reducing stigma toward people with mental illness, prevention efforts that focus on maintaining mental health, interventions that seek to strengthen well-being, and efforts to convince policymakers to implement mental health-related system changes also are the province of mental health mass communication. Thus, the ultimate objective of mental health mass communication to relieve the plight of people with mental illness can be achieved by a wide array of interventions. This means that those who want to use messaging to strengthen mental health and reduce mental illness must think imaginatively about all the different ways that mental health can be improved.

Messages

Mental health mass communication messages can be thought of as content about mental health or mental illness that is presented in various formats, disseminated through many channel types, and conveyed using a wide range of strategies. For a discussion of theory-based, systematic ways to determine mental health message content, see Yzer and Zhu (2025).

Message Format and Channel Types

Mass communication messages come in various formats that relate to embodiment (e.g. a printed brochure, a 30-second video advertisement, billboards, and bumper stickers) and dissemination channels (e.g. print, broadcast, and digital media). Mental health mass communication uses the full spectrum of message formats. Large-scale campaigns typically use different formats and channels to reach multiple audiences over an extended period (for an illustrative review, see Foster, 2018).

Message Strategies

Message strategies pertain to the types of appeal and message features used to express the content of the message. An essential focus of mental health mass communication scholarship is on testing these strategies for mental health promotion purposes. For example, Lueck (2017) tested the effects of framing information about help-seeking for depression in terms of positive outcomes of help-seeking and adverse outcomes of not seeking help. Straszewski and Siegel (2018) tested the effects of message-induced savoring (i.e. focusing attention on positive feelings and experiences) on help-seeking for depression. Quintero Johnson et al. (2021) tested the effects of narrative perspective (i.e. that of a bystander, first person, or third person) on recall of mental illness information and attitudinal beliefs about mental illness. For an overview of mental health message components and strategies, see RW et al. (2025) and Siegel and Yzer (2025).

Given the multitude of message formats and strategies, the number of possible message configurations is infinitely large (Cappella, 2006). This requires systematic, theory-based research to identify those message configurations that maximize the match between the message and audience characteristics relevant to message attention and processing. For example, which dissemination channel should be selected is a function of how much members of an intended audience rely on various channels as part of their media diet, and which format and strategy should be selected is a function of how cognitive characteristics of intended audience members challenge or facilitate message engagement and processing. We return to this contention in greater detail when we present principles of effective mental health mass communication.

Audiences

There are two primary questions when considering audiences of mental health mass communication efforts. The first question pertains to audience segmentation: Who needs to be addressed? A second question asks: What needs to be known about these audiences, that is, which audience characteristics have meaningful implications for messaging?

Concerning the question of who needs to be reached, it is helpful to consider that messages can improve conditions for people with mental illness through direct and indirect pathways (Hornik & Yanovitzky, 2003). A direct pathway means that people with mental illness are the target audience of a message intervention. In direct pathway interventions, messages aim to educate or persuade people with mental illness by directly speaking to them. The mechanism of effects is that when people with mental illness engage with a message themselves, learning processes are induced that can lead to awareness, knowledge, belief change, and action. In contrast, an indirect pathway means that people with mental illness are *not* the target audience of a message intervention, even if the ultimate objective is to relieve the plight of people with mental illness.

Two types of audiences exist in indirect pathway interventions. First, messages can aim to persuade institutions such as news media and policymakers of the importance of mental health and, in doing so, rely on institutional change processes. Second, messages can aim to encourage the public or social

network members to support others who have mental illness and, in doing so, rely on interpersonal influence processes. In indirect pathway interventions, the mechanism of effects is that, for example, more frequent and more accurate reporting on mental illness in news media, implementation of policies that improve mental health care, and strengthened motivation and skills to support social network members with mental illness create a supportive environment that improves conditions for people with mental illness (Herrman, 2001; Woodman & Weber, 2025).

Principles of Effective Mental Health Mass Communication

Considerations of objectives, messages, and audiences are essential for developing mass communication interventions across all health domains. Communicating mental health additionally faces several challenges that are unique to the mental health domain. Those who want to use mass communication for mental health must be cognizant of these challenges in order to optimize and safeguard mental health messaging. This section presents several principles of effective mental health mass communication that can guide the research and development of mental health messages. Four principles pertain to message development research, and three to message testing research.

Message Development Principles

Principle 1: Develop Systematic Research Programs

We highlighted that mental health mass communication involves a complex set of interacting factors, analogous to a 5,000-piece jigsaw puzzle where each piece is essential but must be considered in the context of the entire picture. This requires a systematic, programmatic approach to mental health mass communication research. A wealth of research insights are available for developing those research programs. First, one can lean upon the existing communication literature, which offers much guidance (Quick et al., 2025; RW et al., 2025). In addition, consider contributions from other disciplines, given that many questions that mental health message scientists must address originate outside the realm of communication (e.g. what are the pathological characteristics of particular mental disorders? Which structural factors that cause mental illness are malleable?). Research across all subdomains of psychology, communication, sociology, medicine, public health, anthropology, and likely others we failed to mention have insights that must be applied.

We rely on basic science as the foundation of our work. There is a need for basic researchers to be the masters of their domain, but given the goal of improving the lives of people with mental illness, those accepting this mission do not have the luxury of being field-specific. All contributions must be considered and utilized regardless of the field in which they are published. Note that this has implications for research funding. Whereas many basic science grant opportunities exist in the mental health domain, grant mechanisms for communication-centered projects on mental health are sparse. Researchers must use their grantsmanship to explain the significance of mass communication research on particular mental disorders to grant reviewers who may not be very familiar with mental health mass communication science. An integrative, interdisciplinary approach is central to successful mental health communication grant applications.

Further Recommendation: Continue the Trend of Research Transparency. The integrity of research programs is imperative for safeguarding mental health communication messaging (see John et al. 2012 for a foundational piece on this topic). Research practices that must be adhered to include reporting all the dependent measures collected as part of a study, reporting studies that do not support hypotheses, and acknowledging that unexpected findings go against a priori hypotheses.

In this spirit, we caution against perhaps understandable practices given the publication pressure many academic researchers feel, but that are never acceptable from a research integrity perspective. These include slicing single data collections into multiple studies and presenting new terms for existing concepts. These practices lead to a disjointed literature and the loss of relevant findings, which hinders scientific progress. Overstating the success of a messaging approach by failing to report nonsignificant dependent measures or reporting only studies that support hypotheses can lead to the selection of

messaging approaches that, in actuality, are not very successful. These behaviors are problematic in all research, but such behaviors in mental health communication research can risk lives.

Principle 2: Consider Cognitive Characteristics of Message Recipients

When designing messages for people with mental illness, the cognitive characteristics of the particular mental disorder must be thoroughly understood, as these can significantly bias how people process information. Biased information processing in mental illness has been widely documented across a wide variety of mental disorders (MacLeod, 2012). The implication of biased information processing for mental health communication is that a mental health promotional message will be perceived through the lens of the particular mental disorder, which may not be the same as the message designer intended.

The implications of biased information processing in mental disorders must be considered when designing messages for people with a particular mental disorder (Yzer & Siegel, in press). For example, schizophrenia is associated with an impaired ability to focus on salient information and an increased sensitivity to distraction. This means that people with schizophrenia may be more easily overwhelmed by messages and focus on peripheral rather than focal message elements (Braff, 1993). Borderline personality disorder (BPD) is associated with a reduced ability to recognize other people's emotions accurately. This implies that people with BPD may incorrectly interpret messages that use images and language that portray emotional expressions (Niedtfeld et al., 2016). PTSD is associated with a heightened interpretation of ambiguous situations as threatening to oneself. This means that people with PTSD may feel at increased risk for harm if they see a message that uses ambiguous imagery or language (Bomyea et al., 2017). As a last example, negative self-knowledge schemas in depression lead to an expectation of negative experiences and outcomes as well as a reappraisal of positive, disconfirming information (Kube et al., 2020). This implies that messages that emphasize positive information, such as the notion that depression is not one's fault, may inadvertently reinforce existing negative self-information among people with depression (Lienemann et al., 2013).

Whereas the idea that in order to effectively communicate mental health, one must understand mental health science seems self-evidently true, integrating psychopathology and communication principles is not yet the norm in mental health mass communication scholarship, although promising exceptions certainly exist (for review, see Siegel et al., 2017; Yzer & Siegel, in press). We implore researchers and practitioners to begin their intervention projects with a thorough analysis of the nature and extent of biased information processing in their audience. Next, translate these to implications for message design. Partnerships with psychopathology experts are recommended for ensuring that cognitive aspects of mental illness are respected in message design.

This can be an exciting part of the research process, as message developers must find synergy between the clinical psychology literature on processing and the persuasion literature. For example, the idea that people with depression process self-relevant information in a particularly negatively biased fashion (Bargh & Tota, 1988) led Siegel and colleagues to use Walster and Festinger's (1962) overheard communication technique to reduce self-focus and maximize message success (Siegel et al., 2015). This also led Hollar and Siegel (2020) to explore the utility of self-distancing. Beck's theorizing on how the depressogenic schema can be temporarily thwarted (Beck, 2002) led Siegel and Thomson (2017) to test the positive emotion infusion technique.

Further Recommendation: Expand the Knowledge Base to All Mental Illnesses. Extant research in the mental health mass communication literature primarily focuses on depression disorders, anxiety disorders, or nonspecified mental health or mental illness. Collectively, these studies have importantly advanced knowledge of help-seeking beliefs, intentions, and behavior as a function of particular message configurations (e.g. Quintero Johnson et al., 2021; Siegel et al., 2017) and of positive and negative effects of messaging on the stigma of mental illnesses (e.g. Corrigan, 2016; Foster, 2018). At the same time, the primary attention to depression and anxiety disorders and on nonspecified mental illness makes clear that mental health communication principles regarding other mental disorders largely remain uncharted territory. Exceptions exist; Woodman and Weber (2025), for example, connect the cognitive basis of gaming disorder with the effectiveness of immersive messaging strategies for people with gaming disorder. Nevertheless, it is safe to say that many other mental

disorders have received little or no research attention in the mental health mass communication literature. It is exciting that the knowledge base of mental health mass communication is growing, yet it is concerning that this is primarily true for depression and anxiety disorders only.

The paucity of mental health mass communication research on mental disorders other than depression and anxiety would not be a concern if it can be assumed that findings about message effects on depression and anxiety or nonspecified mental health and mental illness outcomes can be generalized to all mental disorders. This, however, is unlikely to be accurate, as biased information processing manifests itself in uniquely different ways in different mental disorders. Each mental disorder has unique cognitive characteristics that must be understood to decide whether messaging is a viable option and, if so, what the implications of these specific cognitive features of the particular illness are for how particular message configurations are processed. Further complicating matters is the high prevalence of comorbidity in mental illness (McGrath et al., 2020). For example, the implications of depression symptoms for information processing for someone who is afflicted with major depression may well be different than the implications for information processing for someone whose depression symptoms co-occur with BPD.

Thus, we call for mental health mass communication research on all mental disorders, including their comorbidities. This may require significant effort. For example, the nature of some disorders may make it very difficult to find research volunteers who are severely affected.

Principle 3: Anticipate Unintended Message Effects

It is imperative to realize that a message can backfire, that is, have unintended adverse effects. For example, it is not uncommon for those creating mental health promotion messages to underestimate how individual differences in message receivers (e.g. the presence of mental illness symptomatology) affect message processing. This can be a costly mistake. For example, research findings suggest that directly addressing depressed individuals in help-seeking messaging may lead those individuals to be even less inclined to seek help for their depression than they would have been without seeing those messages (Lienemann et al., 2013).

Relatedly, one must consider that unintended effects are possible when a message is seen by people not in the intended audience. A mass communication message that is created for people with mental illness will also be seen by people without mental illness. Similarly, if a mass communication message is created to change perceptions of the public, people with mental illness will see these messages as well. There is good evidence that well-intended large-scale campaigns that aim to reduce mental illness stigma in the general population can inadvertently lead to *increased* self-stigma among people with mental illness (Corrigan, 2016), for example, because antistigma messages can make the negative self-perceptions that people with certain mental disorders have more accessible (Siegel et al., 2017).

The possibility of unintended adverse message effects implies that in contrast to the saying that something is better than nothing, in mental health mass communication, something is *not always* better than nothing. However, when researchers are mindful that their interventions can have unintended effects, steps can be taken to prevent adverse effects. For example, many unintended negative research participation effects on people with mental illness can be prevented by matching a message to the cognitive characteristics of mental illness so that biased processing of the message will be less likely. In addition, studies can be designed to ensure that participants leave the study in a better place than when they came in. For example, Siegel adds a positive emotion infusion task to the end of his studies. In a positive emotion infusion task, participants reflect on a positive experience and how they felt during that experience, which has been shown to elevate positive feelings and even help-seeking intentions (e.g. Straszewski & Siegel, 2018).

Principle 4: Match Messages to Cultural Meanings of Mental Health and Illness

Our discussion of the interrelatedness of objectives, messages, and audiences spoke to the contention that the effectiveness of a mental health message is a function of the match between the message and audience characteristics that are relevant for message attention and processing. In addition to cognitive characteristics of mental illness (see Principle 2), cultural factors deserve particular attention as an audience characteristic that must be considered in message design. The language that is used to talk

about mental illness reflects cultural values that should be respected in messaging. For example, because of a history of gendered racism and oppression, many African American women have developed what has been named a superwoman schema that dictates the need to always be strong. In addition to existing disparities in access to mental health care, the superwoman schema negatively affects professional help-seeking as that violates the normative expectation to be strong, suppress emotions, and prioritize caring for others over self-care (Woods-Giscombe et al., 2016). This means that messaging for African American women may need to avoid language about formal treatment and, more generally, should avoid any language or imagery that may inadvertently reinforce stigma. Barksdale et al. (2025) argue that mental health communication messages that focus on culturally diverse populations should focus on health equity through fairness, inclusivity, and justice by using messages that include accessibility, representation, and community engagement and that use culturally and linguistically appropriate information.

Message Testing Principles

Principle 5: Test Messages Meant for People with Mental Illness Among Participants With Mental Illness

The discussion thus far has made clear that researchers should anticipate the likelihood that people with mental illness will attend to, interpret, and remember messages that are directed to them in a biased manner. This means that research conducted to assess messages that are meant to be beneficial for people with mental illness should include participants with mental illness.

As the extent of biased information processing increases as a function of mental illness severity, samples that include a relatively even distribution of participants along a mental illness' symptom severity continuum will be best able to demonstrate at which level of severity particular message strategies will produce diverging effects. Alternatively, when researchers are interested only in the question of whether a particular message configuration works for people with heightened mental illness (and not in the question of whether people with varying mental illness severity respond differently to the same message), they should recruit only participants with heightened levels of mental illness. Both of these situations require purposive sampling strategies. See Bell et al. (2010) and Lienemann and Siegel (2019) for excellent examples.

Purposive sampling of people with mental illness is essential for research that aims to speak to the question of which message configurations and strategies are beneficial for people with mental illness. Of course, having the right sampling strategy does not guarantee an optimal actual sample. For example, participants with heightened mental illness may not be representative of the population of people who have the particular illness, as the very same psychiatric symptoms that are the impetus for the research may make participation in a study very hard or undesirable (Kanuch et al., 2016; Lally et al., 2018). Conversely, mental health severity may also be a motivator for research participation. For example, Pfeiffer et al. (2010) found in a sample of patients at a mental health care organization that patients with relatively more severe mental illness and more extended treatment history were more likely to volunteer for mental health outpatient research. These examples underscore that researchers must give painstaking attention to their participant recruitment to be confident that their sample allows them to draw conclusions about which messages are most promising for those people for whom these messages are supposed to be beneficial. Online participant-sourcing platforms, available in many but unfortunately not yet in all regions of the world, offer avenues for finding research participants that were near impossible prior to online data collection. For example, Yzer and Zhu (2025) recruited participants from the Prolific platform. They used background data that Prolific had collected from their panel members about depression diagnoses for purposively sampling people with depression.

Principle 6: Recognize Your Implicit Assumptions About Mental Health

The proposition to develop systematic mental health communication research programs by integrating contributions from multiple disciplines implies the need for careful conceptualization of primary variables. By definition, a conceptualization of a variable implies a set of assumptions about that variable, and often these assumptions are unrecognized. This may be particularly consequential for mental

health. Consider, for example, the core concepts of mental health and mental illness. Mental health and mental illness have been conceptualized as semantic opposites on a single bipolar continuum (Zhao & Tay, 2023), which means that mental health is the absence of mental illness, and alternatively as two distinct concepts that can correlate but do not necessarily always do (the dual continua model; Iasiello et al., 2024; Keyes, 2005; Manderscheid et al., 2010), which implies that a person may not have a mental illness yet may not have positive mental health. A bipolar interpretation of mental health as the absence of mental illness implies that assessment of symptoms can be sufficient to measure mental health, whereas the dual continua model implies that mental health and mental illness can be and should be measured separately (Keyes, 2005; Westerhof & Keyes, 2010). Beyond measurement implications, a conceptualization of mental health and mental illness as distinct broadens the scope of mental health mass communication from reducing symptoms of mental illness to strengthening mental health among people who may or may not have mental illness (Marciano et al., 2025).

In addition, in the psychopathology literature, mental illness has been conceptualized as categorical or dimensional (Ostrand & Luciana, 2025). A categorical approach conceptualizes mental illness as a syndrome of symptoms, which produces descriptive categories of distinct mental disorders. This is the basis of the widely used *Diagnostic and Statistical Manual of Mental Disorders*, currently in its fifth edition (DSM-5; American Psychiatric Association [APA], 2022). DSM-5 describes each specific mental disorder in terms of symptoms. The presence and duration of these symptoms are the diagnostic criteria for mental disorders. For example, a person is diagnosed with major depression when they report that they experienced at least five of nine symptoms (e.g. trouble concentrating, feeling worthless) in a 2-week period, and when one of those symptoms is depressed mood or loss of interest in activities (APA, 2022). Alternatively, a dimensional conceptualization of mental illness proposes various aspects or dimensions of mental illness. It describes those as continuums, moving away from a threshold-based interpretation of mental illness and allowing for individualized descriptions that cut across categorical disorders (Cuthbert, 2022; Krueger & Bezdjian, 2009).

Different conceptualizations of mental illness have measurement implications. Categorical measures tend to ask about the presence and duration of symptoms specific to a disorder, whereas dimensional measures assess task performance, physiological responses, and digital phenotyping, among others (Cuthbert, 2022). Measurement variability also exists within the same conceptualizations. For example, Newson et al. (2020) reviewed 126 categorical assessment instruments for 10 mental disorders. They found that the consistency of symptom assessments within disorders was as low as 29% (for bipolar disorder and schizophrenia) and no higher than 58% (for obsessive-compulsive disorder).

Principle 7: First, Do No Harm

Research on mental health mass communication has several ethical implications. To begin, before inviting people with mental illness to a research study on mental illness, one must ask whether it is possible that participating in the study worsens symptoms. For example, Boothroyd (2000) reported results from exit interviews with 668 adults with severe mental illness who had been part of a 12-month study on the effects of two mental health managed care plans. He found that whereas most participants did not report adverse outcomes, some did; 9% reported that participating in the study made them anxious, 17% feared that their responses could be disclosed, and 17% thought the questions were invasive. A comparative analysis showed that these proportions were much higher than those obtained in community samples of participants who did not have mental illness. Jorm et al. (2007) reported more encouraging findings. They reviewed 46 studies that assessed the association between mental disorder symptoms and emotional responses to research participation. They found that less than 10% of participants reported distress across settings. In studies that focused on traumatic or otherwise adverse experiences, distress rates were higher. Findings from studies that included markers of longer-term effects showed no indications of persistent effects. Notwithstanding these encouraging findings, Jorm et al. (2007) cautioned that care must be given to ensure that research protocols are maximally protective against untoward effects of research participation on people with mental illness. We fully support this contention.

A second set of ethical questions concerns the outcomes of mental health mass communication interventions. Consider, for example, that a common goal of many mental health mass communication interventions is to encourage people to seek help if they have mental illness. What if such interventions

are successful? Counterintuitively, there may be reasons for concern if an intervention successfully encourages people to seek help. Typically, help-seeking interventions do not include a second arm that supports people when the intervention helps them take the step to seek help. At the very least, researchers need to determine whether there, in fact, are treatment or care options available for their participants. These can be included at the end of research instruments, for example, as a list of resources.

As a last example, implementing new media technologies before the implications of those technologies are fully understood can produce unexpected outcomes. Artificial intelligence (AI) technologies present a particularly relevant case at the time of writing. AI is increasingly used for easily accessible online mental health support. However, it may offer less appropriate feedback than human counselors (Morris et al., 2018) and result in unethical sharing of personal information because data privacy regulation has not been fully established (Dellinger, 2025).

Conclusions

Mental health mass communication has compelling potential for relieving the plight of people who have mental illness. It is one of many tools that will be maximally effective when used together with other intervention tools, particularly those that ensure concurrent availability of treatment options (Wakefield et al., 2010). Indeed, whereas mental health mass communication has significant potential, it is not a tool that is advisable under all circumstances. For example, if environmental factors do not facilitate or even obstruct mental health care, mental health mass communication that encourages seeking treatment is not effective or even appropriate.

Once it has been determined that mental health mass communication is appropriate in a particular setting, several issues must be considered to optimize and safeguard mental health messaging. In this chapter, we discussed those issues and proposed several principles of effective mental health mass communication messaging. We hope these principles will catalyze interest among scholars, lead to conversations that refine the principles, and spur exciting new research on mental health communication. This will ultimately converge in a significantly strengthened mental health mass communication messaging that can improve the lives of people with mental illness.

References

Aldrich, R. S., & Quintero-Johnson, J. M. (2021). Mental health, mental illness, and suicide. In T. L. Thompson & N. G. Harrington (Eds.), *The Routledge handbook of health communication* (3rd ed., pp. 63–76). Routledge.

Alegría, M., NeMoyer, A., Bagué, I. F., Wang, Y., & Alvarez, K. (2018). Social determinants of mental health: Where we are and where we need to go. *Current Psychiatry Reports*, *20*(11), 95. https://doi.org/10.1007/s11920-018-0969-9

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (3rd ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bargh, J. A., & Tota, M. E. (1988). Context-dependent automatic processing in depression: Accessibility of negative constructs with regard to self but not others. *Journal of Personality and Social Psychology*, *54*(6), 925–939. https://doi.org/10.1037//0022-3514.54.6.925

Barksdale, C. L., Lawhorn, C., Alvidrez, J., & Schwartz, K. (2025). Considerations for optimizing mental health communication to advance mental health equity. In M. C. Yzer & J. T. Siegel (Eds.), *Handbook of mental health communication*. Wiley.

Baxter, A. J., Patton, G., Scott, K. M., Degenhardt, L., & Whiteford, H. A. (2013). Global epidemiology of mental disorders: What are we missing? *PLoS One*, *8*(6), e65514. https://doi.org/10.1371/journal.pone.0065514

Beck, A. T. (2002). Cognitive models of depression. In L. Robert & E. T. Dowd (Eds.), *Clinical advances in cognitive psychotherapy: Theory and application* (pp. 29–61). Springer.

Bell, R. A., Paterniti, D. A., Azari, R., Duberstein, P. R., Epstein, R. M., Rochlen, A. B., & Kravitz, R. L. (2010). Encouraging patients with depressive symptoms to seek care: A mixed methods approach to message development. *Patient Education and Counseling*, *78*, 198–205. https://doi.org/10.1016/j.pec2009.07.007