Game Changer: Mental Health Strategic Communication Plan for Varsity Football Players

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Thesis submitted to the Faculty of Graduate and Postdoctoral Studies in partial fulfillment of the requirements for the MA degree in Communication

University of Ottawa

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Keywords: masculinity, mental illness stigma, varsity football players, qualitative methodology, strategic communication plan

Executive Summary

In the past two years, six National Football League players have died by suicide. Investigations into most of the deaths revealed that the players suffered from brain damage likely caused by repeated concussions. As is the case with many health issues, tragedy often precedes action; the suicides of these high profile football stars have catalyzed action on concussion policy and practice, as well as opened up the conversation about the overall mental health of athletes.

This thesis joins the conversation around mental health and athletes, specifically Canadian varsity football players. Mental health problems and illnesses are presented as especially common, affecting about 1 in 5 Canadians. That is not to underestimate the severity of mental illnesses, which can deteriorate an individual's quality of life, significantly impact friends and family and, in the most severe cases, also lead to death by suicide. That said, this thesis adopts a theoretical perspective that focuses on the promotion and protection of good mental health.

This thesis is primarily concerned with investigating the social, political, and external factors that negatively impact how football players conceptualize mental health and mental illness, and also the recommended behaviour to seek professional help if needed. The growing body of research concerning the negative impact of mental illness stigma is compelling and leaves no doubt that stigma is a significant barrier to recovery. This thesis explores the stigma process as well as its social function in groups. Next, it investigates how the already powerful stigma around mental illness is further exacerbated by gender and more specifically, how traditional masculine ideology (i.e. men should be strong and powerful) conflicts with stereotypical beliefs about mentally ill people (i.e. weak and/or incompetent). Gender and health are further linked in terms of behaviour. In other words, rejecting health behaviours becomes a

strategy some men utilize to project their masculinity, paradoxically contributing to the creation or worsening of many health problems. A health behaviour that is explored in detail is psychological help-seeking, and the psychosocial processes of help-seeking, which are also mainly regulated by masculinity. An overview of the most common mental health problems and illnesses found in male varsity athletes is provided.

All of the above components are then applied to the unique context of varsity football players. The thesis draws on the literature as well as qualitative interview data that explores the experiences of 8 varsity football players at the University of Ottawa. Regarding mental health promotion, the findings show that football players may require adapted communication approaches. To that end, the thesis transitions into an early-stage health communication plan supported by the literature and the primary data. The plan proposes overall outcomes, short term/intermediate objectives, a communication strategy, and a tactical approach. Next, a web-based health resource is suggested as a primary communication vehicle and is outlined in detail. The plan then suggests potential partnerships for extending the strategic communication plan's reach and credibility. This is followed by suggestions for evaluating both the short term/intermediate objectives as well as the strategic communication plan's overall impact.

This thesis concludes with a chapter exploring the contributions lifted from the eight qualitative interviews, as well as suggested directions for research, policy and practice.

Acknowledgements

Foremost, I would like to thank my supervisor, Dr. Jenepher Lennox Terrion, whose guidance, patience, and enthusiasm was invaluable along this journey. Her mentorship was not limited to my thesis project—Dr. Lennox Terrion was a great advisor in many other aspects of my life over the past two years, and for that I am forever grateful. Thank you for believing in me.

I would like to thank my committee members, Dr. Rukshana Ahmed and Dr. Martine Lagacé, for their helpful contributions and guidance in the early stages of my project, as well as their useful feedback and interesting comments during the defence.

To the men on the football team—the Gee-Gees are fortunate to have such a respectful and dedicated group of athletes. Thank you for sharing your stories.

Of course, my friends and family were a large part of this process and I would like to thank them individually. To Cyril—thank you for supporting me and loving me despite all my complaining. To Calais—for listening and bouncing around ideas. To Kelsey—for always encouraging me and for repeatedly making me summarize my project into one sentence.

To my parents—thank you for giving me the gift of education and supporting me always.

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Chapter 1: Introduction

The World Health Organization defines mental health as, "A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (2013a, para. 4). Based on this definition it is clear that good mental health is a central component to a high-quality life.

Just like physical health, a person's mental health can be compromised with the development of problems and illnesses. Mental health problems and illnesses are very common and will affect one in five Canadians in their lifetime (Health Canada, 2002). These range from common mood disorders like depression and anxiety to the less common schizophrenia and others (Mental Health Commission of Canada, 2012). Determinants of good or poor mental health include social factors such as socio-economic pressures, rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations; psychological and personality factors; and finally, biological factors such as genetic factors and chemical imbalances in the brain (World Health Organization, 2010).

Mental health problems and illnesses left untreated can deteriorate an individual's quality of life, significantly impact friends and family and, in the most severe cases, lead to death by suicide (Mental Health Commission of Canada, 2012). In 2009 alone, 3, 890 Canadians died by suicide (Navaneelan, 2012). The economic cost of these mental health issues in Canada is projected to be over $50 billion (Smetanin, Stiff, Briante, Ahmad, & Khan, 2011).

One way to successfully recover or learn to manage mental health problem or illness is by seeking professional help for therapy and medication (Davidson & Roe, 2007); however, a

significant body of research demonstrates the stigma associated with mental health disorders is a significant barrier to accessing services (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan & Kleinlein, 2005). Moreover, recent studies have shown that people who internalize negative messages perpetuated by stigma experience low self-esteem, which contributes to unnecessary suffering (Hartman et al., 2013; Vogel, Wade, & Heckler, 2007).

Mental illness stigma, as well as stigma towards help-seeking in general, appears to be further exacerbated within the male population. Research demonstrates that men in particular hold negative attitudes towards help-seeking (Good, Dell, & Mintz, 1989; Levant, Wimer, Williams, Smalley, & Noronha, 2009), because help-seeking may be perceived as a sign of weakness and potential incompetence (Robertson & Fitzgerald, 1992). Men are less likely to seek help for problems such as depression, substance abuse and stressful life events, and therefore they underutilize professional mental health resources (Mansfield, Addis, & Courtenay, 2005).

In the sporting world, the recent suicides of high profile male athletes, notably many professional football players, have brought to light the prevalence of mental health problems and illnesses within the population and, with that, have led to calls for a closer examination of the barriers these individuals face when experiencing this highly stigmatized issue. As noted by one NFL player, “When it's a broken bone, the teams will do everything in their power to make sure it's OK. When it's a broken soul, it's like a weakness” (Wertheim, 2010, para. 4).

While the mental health issues of professional athletes is only now beginning to receive attention (Lawrence, 2012), a significant body of research demonstrates the prevalence of mental health problems and illnesses in North American male varsity athletes, or those playing at the college or university level, including football players. For the purpose of this thesis, mental

health problems and illnesses will include depression, addictive disorders and anxiety. Moreover, research demonstrates that significant percentages of male varsity athletes have increased stigmatizing attitudes towards professional help-seeking (Steinfeldt, England, Steinfeldt, & Speight, 2009), fear of being stigmatized by teammates, coaches, and fans (Brewer, Van Raalte, Petipas, Bachman, & Weinhold, 1998; Linder, Brewer, Van Raalte, & DeLange, 1991; Watson, 2005) and a general mistrust in counsellor's ability to understand the athlete lifestyle and associated problems (Watson, 2005).

This thesis draws primarily upon two theoretical perspectives: the mental health continuum theory (Keyes, 2002, 2003, 2010) and masculinity socialization in relation to health (Courtenay, 2000a,b, 2003, 2004; O'Neil, 2008; Wade, 1998). The two theoretical paradigms work well in tandem when approaching male mental health.

Keyes (2002, 2003, 2010) advocates for a paradigm shift to remedy the lack of progress in preventing and treating mental illness perpetuated by past risk reduction paradigms. Drawing from the domain of positive psychology, he maintains that mental health and mental illness are two separate but correlated dimensions comprising a "complete state" of mental health. Keyes (2002) argues that protecting against the loss of mental health necessitates developing symptoms of good mental health—that is, emotional, social, and psychological well-being—which, in turn, decreases the likelihood of developing mental illness.

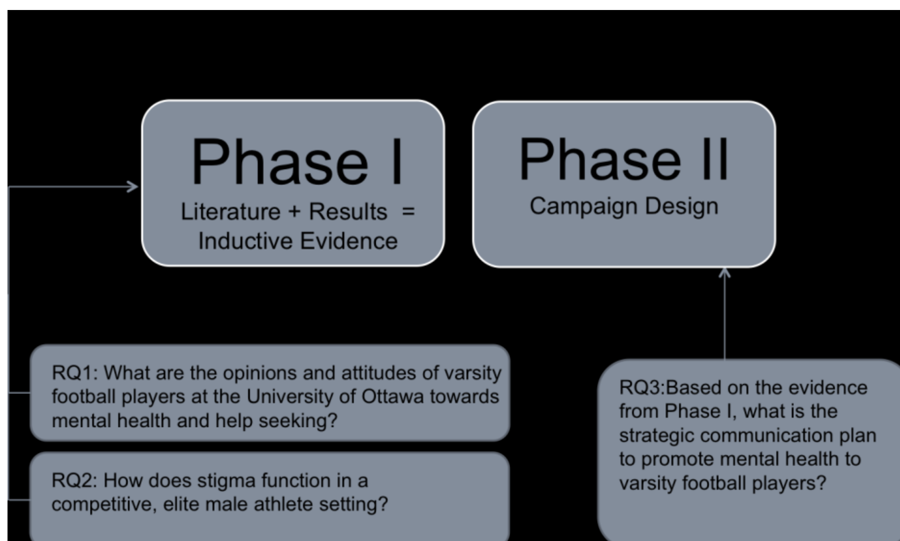
Regarding gender and health, masculinity has been repeatedly explored by researchers as playing a key role in the health of North American men. Drawing from social constructivist and feminist perspectives, researchers in this area discuss how some men—usually those with more traditional views of manhood and gender roles— actively reject health behaviours to establish their masculine identity (Courtenay, 2000a,b). The negative repercussions of adhering to these

beliefs include detrimental effects on physical health (Courtenay, 2000a), and also contribute to mental health problems including depression, anxiety and substance abuse (O'Neil, 2008). Moreover, adhering strictly to traditional masculinity inhibits professional help-seeking when it is needed (Courtenay, 2000b; O'Neil, 2008).

Purpose

Given that mental health problems and illnesses occur in varsity football players, and that stigma may be particularly salient in this population due to the competitive athlete culture and gendered beliefs about health and help-seeking, it is reasonable to suggest that this population may be in need of a specialized mental health resource. In two separate but interrelated phases, as illustrated by Figure 1, this thesis attempts to integrate the findings from a broad range of existing literature with primary data (Phase I) to provide inductive evidence for the strategic communication plan to promote mental health to varsity football players (Phase II). The literature thoroughly investigates the social, external and political factors that contribute to stigma associated with mental illness and help-seeking, while the primary data provides insight into football players' opinions and attitudes towards the thesis topic.

Figure 1: Conceptual Graph for Thesis Components



Research questions

To address Phase I, this thesis asks: “What are the opinions and attitudes of varsity football players at the University of Ottawa towards mental health and help seeking?” and “How does stigma function in a competitive elite male athlete context?” To address Phase II, this thesis asks: “Based on the evidence from Phase I, what is the strategic communication plan to promote mental health to varsity football players?”

Approach

Based on an exploratory qualitative approach (Creswell, 2009, 2013), this thesis will use a combination of primary data and a critical review of the literature to answer the research questions. The use of literature aids in gaining a more thorough understanding of the audience and the major factors contributing to the situation. Secondly, it aids in guiding the interview questions and the data analysis. Finally, it provides support for elements of the strategic communication plan proposed in chapter five.

Procedures for collecting primary data followed general qualitative methodology in collaboration with an approach called *stimulus text* (Törrönen, 2002). The use of stimulus text, which is defined as a “description, narrative, story fragment, picture continuum or collage that is more extensive than a question, sentence or proposition” (p. 344), fits well with the subject matter at hand because it is intended to facilitate discussion around sensitive, or in this case, stigmatized topics. Data analysis procedures will follow a blending of general qualitative approaches recommended by Creswell (2009, 2013) and phenomenological approaches used by Moustakas (1994).

Definitions

Mental health is defined as "a syndrome of symptoms of positive feelings and positive functioning in life" (Keyes, 2002, p. 208). Mental health encompasses social, psychological and emotional well-being. These will be described more fully in chapter two.

For the purposes of this thesis, *mental illness* is defined as "persistent and substantial deviation from normal functioning that impairs an individual's ability to execute their social roles […] and generates emotional suffering (Keyes, 2003, p. 293). Mental illness will be limited to depression, anxiety and addictive disorders. Each issue is explored in chapter two.

Masculinity is represented as a not a "certain type of man, but rather, a way men position themselves through discursive practices" (Connell & Messerschmidt, 2005, p. 841). It is not conceptualized as "patriarchy" or "the long-term structure of the subordination of women" (p. 839).

Finally, in this thesis, *inductive evidence* is defined as a set of arguments drawn from "the data to generate ideas" (Thorne, 2000, p. 68) for the strategic communication plan. The suggestions made are not deductive; that is, they were not "confirmed or negated using data" (p.68).

Overview of Thesis

The remainder of this thesis will be organized as follows:

Chapter 2: Review of literature. This chapter includes a review of the literature in three major areas: stigma, group dynamics, and masculinity as it operates in a health, football and help-seeking context. The chapter concludes with a closer examination of the key theoretical mental health protection and promotion paradigm, and a brief prevalence-focused review of mental health problems and illnesses in male varsity athletes.

Chapter 3: Methodology. This chapter outlines the steps taken in conducting the primary including a description of the sample, data collection procedures and data analysis approach.

Chapter 4: Findings. This chapter highlights the key findings that emerge from the literature review and the qualitative interviews. The researcher draws conclusions based on the findings, which contribute to both the development of the strategic communication plan, and the research, policy and practice directions.

Chapter 5: Game Changer Strategic Communication Plan. This chapter outlines the proposed strategic communication plan, called *Game Changer*. It provides arguments for the adoption of certain guiding theories, justifies framing choices, and describes the tactical elements. It concludes with evaluation directions necessary to measure success and contribute to strategic communication plan improvements.

Chapter 6: Conclusion. This chapter highlights the significance of the research and provides future areas for research, and implications for policy and practice.

Chapter 2: Review of Literature

The purpose of this chapter is to give the reader a more thorough understanding of the relevant literature associated with male mental health in an elite football context. The chapter begins by exploring stigma; its elements and effect on help-seeking, and its function in social contexts. The next section explores elements of group membership and the benefits of social capital for psychological health. What follows is a large section devoted to masculinity and health. It begins with a look at two interrelated theories on gender and health, and how masculinity functions in help-seeking processes. Sport and its role in the masculine socialization of North American men will then be explored in detail, followed by an overview of the research exploring athletes' help-seeking attitudes and behaviours. The chapter concludes with a closer examination of the guiding mental health theoretical framework introduced in chapter one and a brief overview of common mental health problems and illnesses associated with college-aged male athletes.

Stigma

The stigma that individuals with mental health problems or illnesses face is acknowledged as one of the greatest barriers to seeking help, despite the fact that proper diagnosis and treatment can greatly reduce unnecessary suffering (Health Canada, 2002; Mental Health Commission of Canada, 2012). More recently, it has been discussed that when individuals internalize negative perceptions surrounding people with mental illness, they can experience significant decreases in self-esteem (Hartman et al., 2013). Therefore, understanding the concept of stigma, its social functions, and effects on help-seeking is critical to designing strategies to mitigate stigma.

Link and Phelan (2001) revisited Goffman's (1986) concept of stigma, stating that stigma is propelled by "elements of labeling, stereotyping, separation, status loss, and discrimination" working together in a "power situation that allows them" (p. 377). The first element, *labelling*, is a process whereby groups are created as a result of gross oversimplification based on single characteristics, and subsequently, these groups are linked to stereotypes (Link & Phelan, 2001). *Stereotypes* are defined as "beliefs about the characteristics, attributes, and behaviours of people who are categorizable as a member of a particular social group" (Corrigan & Shapiro, 2010, p. 908-09). Some of the negative stereotypes associated with the labeled group "mentally ill" are that they are dangerous, incompetent and/or have a weak character (Brockington, Hall, & Levings, 1993; Taylor & Dear, 1980), are violent or criminal (Cutcliffe & Hannigan, 2001), and simple-minded and childlike (Wilson, Nairn, Coverdale, & Panapa, 1999).

The third component that propels stigma is the *separation* of "us" from "them", whereby "they"—the group that shares the label and its negative associations—are defined as essentially different from "us" (Link & Phelan, 2001). Goffman (1963) noted that this reduces the labeled individual "from a whole and usual person, to a tainted, discounted one" (p. 3), eventually resulting in status loss and discriminatory behaviour (Link & Phelan, 2001). Ottati, Bodenhausen, and Neuman (2005) provided the following example illustrating the pathway between stereotype, prejudice and discrimination in the workplace: "An individual who believes that persons with mental illness are incompetent (stereotype) might consequently evaluate an individual with mental illness in a negative fashion (prejudice), and therefore refuse to hire that person (discrimination)" (p. 100). Notice in this example that the stigma process includes a power element whereby the employer (the stigmatizer) controls employment opportunities of the person with a mental illness (the stigmatized). In fact, Link and Phelan (2001) stated that

stigmatization is “entirely contingent on access to social, economic, and political power that allows […] the components of stigma to unfold” (p. 367). This means that groups holding significant power over the lives of individuals – including landlords, employers, healthcare providers, criminal justice professionals, policy makers, and the media – should be priority target groups for reducing mental illness stigma (Corrigan, 2004).

The importance of reducing *public stigma*—which refers to the societal perception that an individual is socially unacceptable—cannot be understated given its direct influence on other levels of stigma (Corrigan, Watson, & Barr, 2006). Public stigma has a particularly strong influence on *self-stigma*, which has been linked to help-seeking behaviours (Barney et al., 2006; Corrigan & Kleinlein, 2005; Hartman et al., 2013; Vogel et al., 2007). Research has found that when individuals with mental health problems or illnesses internalize the public’s negative stereotypes and attitudes about mental illness, self-stigma occurs, subsequently diminishing self-esteem and self-efficacy (Corrigan & Kleinlein, 2005) and reducing willingness to seek professional help (Vogel et al., 2007). Vogel et al. found the relationship between self-stigma and *perceived public stigma* was stronger in men than in women, suggesting that men may internalize negative stereotypes more thoroughly. Self-stigma may also produce negative and limiting thoughts such as, “Yes, I am dangerous, blameworthy, incompetent, and childlike…hence I am not worthy of a normal life, so why should I try to get nice job?” (Corrigan & Shapiro, 2010, Table 1). However, Corrigan and Watson (2002) caution that self-stigma should also be considered as a catalyst to change because individuals who recognize the injustice of such prejudices and stereotypes may actively speak out. Lastly, other levels of stigma include *personal stigma*, which refers to people’s own stigmatizing attitudes. Such attitudes may

or may not agree with their perception of public stigma, also known as perceived public stigma (Eisenberg, Downs, Golberstein, & Zivin, 2009).

Social function of stigma. Stigma is a social construction serving social functions (Smith, 2007). Neuberg, Smith, and Asher (2000) posited a biocultural approach to understanding the social function of stigma. They argued that stigma protects group survival and that "people will stigmatize those individuals whose characteristics and actions are seen as threatening or hindering the effective functioning of their groups'' (p. 34). In other words, groups rely on successfully organizing individual effort, sharing resources, creating effective communication, protecting individual members, and creating a common group identity and stable bonds between members to function and achieve success (Neuberg et al., 2000). Naturally, Neuberg and colleagues identified counter-socialization as a threat to group success. This means that individuals who deviate from the social values of the group may be more likely to be stigmatized, and those who are more invested in the group values—and the protection of these values—may be more likely to stigmatize offenders. Moreover, when many individuals within a group share the stigma, it becomes more salient, insomuch that a person may not hold negative personal attitudes, but will nevertheless behave negatively towards the stigmatized group based on this saliency (Devine, 1989).

In sum, one of the central goals of stigma is to ensure the survival of a group. This has important implications for our own beliefs and behaviours, which are largely constructed and reconstructed based on the groups to which we orient ourselves, otherwise known as our reference groups.

Group Membership

According to Sherif (1962), a *reference group* is defined as "those social units to which the individual relates himself or *aspires* to relate himself psychologically," which can be accessed regardless of actual membership (p. 801). This definition is interesting because it allows for an individual to actively select and internalize elements from a multitude of reference groups, although the pressure to conform to the values of the group may be powerful. As Sherif noted, "there are profound differences between inwardly cherished values and goals of a group and conformity merely for the sake of surviving in a setting while inwardly relating oneself to other values" (p. 802). In other words, an individual's survival in a group may require them to adhere to the dominant values of that particular group, despite the fact that they may not agree.

In applying the concept of gender to reference groups, Wade (1998) suggested that male reference groups are central to a man's gender role self-concept. These may include males in the environment, males who are admired, males who are rewarding to the individual, and males who an individual perceives as being rewarded by other male role models. Wade posited that the degree to which a man psychologically orients himself with these groups could have implications on his identity as a man. For example, a man who is strongly dependent on a male reference group has a prominent and fully developed social identity, but is lacking in personal identity development. Consequently, he constructs his personal identity in conjunction with group norms, but also by contrasting himself to out-group norms; in other words, what he is and what he is not. Individuals who have developed this rigid and dichotomous conception of gender may face internal conflict when unable to live up to socially constructed standards of maleness. While these individuals may full-heartedly believe in the values of the group, others may experience conflict when conforming to the group values as a means of survival. In a sports setting, for

example, some researchers have found that the team environment creates pressure to conform to the team norms (Curry, 2000; Gage, 2008). Of course, team norms can be both positive and negative and the following section will explore some of the benefits of group membership.

Social capital. Particularly relevant to this thesis is Bourdieu's (1986) social theory and concept of capital. *Social capital* is defined by Bourdieu as a resource, "made up of social obligations" or what he termed "connections" (p. 243). Similarly, Putnam (2000) defined social capital as "connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them" (p. 19). Bourdieu suggested that capital can be divided into three types: economic, cultural, and social. Each type of capital is considered to be a resource that can be drawn upon to gain important ends.

Research across various populations and contexts has explored the relationship between social capital and health. For example, in their review of literature exploring this correlation, Chen, Stanton, Gong, Fang, and Li (2009) identified a number of studies demonstrating that poor social capital was associated with deviate and health risk behaviours, perceived poor health status, increased mortality, and mental health disorders. Regarding this last item, De Silva, McKenzie, Harpham and Huttly (2005) reviewed 14 studies exploring social capital at an individual level, and concluded that increased cognitive social capital (i.e. feelings of trust and reciprocity) was related to lower rates of common mental disorders. Moreover, connection to others has been linked to protective factors against binge drinking in universities (Weitzman & Kawachi, 2000), and depression (Lin,Ye, & Ensel, 1999).

In reviewing the literature on social ties and mental health, Kawachi and Berkman (2001) used Cohen and Wills' (1985) models to highlight several important structural and functional aspects of social relationships. At the structural level, the social influence found in group

membership may provide guidelines about healthy behaviours. For example, group norms on a sports team would encourage exercise and healthy eating—although negative behaviours such as excessive drinking may also be the norm of the groups. Membership in a group can also foster "positive psychological states, including a sense of purpose, belonging, and security, as well as recognition of self-worth" (p. 459). Finally, involvement in social networks may increase the individual's propensity to access support.

At the functional level, social capital plays a central role in moderating an individual's response to stressful events and perhaps inhibiting eventual mental illness (Cohen & Wills, 1985). Some scholars believe the inverse correlation between mental health disorders and social capital is because an individual with high levels of social capital can effectively seek out informational, instrumental and emotional support (Chen et al., 2009). Bourdieu (1986) points out that this network of resources is not natural, but rather must be established via continuous investment strategies that serve to build a network of people on whom one can draw in times of need. Courtenay (2004) also noted that is it especially important for health professionals to help young men locate supports such as significant others, friend, coworkers, family and classmates. To that end, researchers have advocated a focus on communication skills training as central to developing good social capital (Terrion, 2006).

In sum, research has demonstrated that for the most part social capital has beneficial outcomes for people's health and quality of life. However, while good social capital may increase an individual's propensity to access support, the act of help-seeking in itself is often highly stigmatized, especially by the male population. Seeking help is often labeled a sign of weakness and potential incompetence (Robertson & Fitzgerald, 1992). Research demonstrates that men in particular hold negative attitudes towards help-seeking (Good et al., 1989; Levant et

al., 2009). Mansfield et al. (2005) reviewed a large body of research demonstrating that men were less likely to seek help for problems such as depression, substance abuse and stressful life events, and therefore they underutilized professional health resources. Although there are various structural barriers to seeking professional help such as access to services, treatment and support, and associated financial costs, O'Neil (2008) stated "the stigma of seeking help because of masculinity conflicts appears to be a universal problem" (p. 396). In other words, the field of health and well-being and even the act of help-seeking is considered to be gendered.

Masculinity and Health

Research indicates that women are overall more likely to adopt healthy behaviours and live longer than men (Courtenay, 2000b). In a literature review synthesizing large studies, national data and meta-analyses, Courtenay (2000a) revealed that males of all ages are more likely than females to engage in over 30 behaviours that increase the risk of disease, injury, and death.

Relational theory of men's health. Coming from a social constructivist and feminist perspective, Courtenay (2000b) proposed the *relational theory of men's health* in an effort to understand why men engage in less healthy lifestyles and adopt fewer health-promoting beliefs and behaviours. He theorized that health beliefs and behaviours are considered to be social practices or tools men and women in North American culture use to demonstrate masculinity or femininity.

Central to Courtenay's theory is a constructionist perspective of gender. From this angle, gender is understood to be greatly influenced by culture and the interaction of people in that culture (Connell & Messerschmidt, 2005; Pleck, 1987). In other words, conceptions of masculinity and femininity adopt a certain flexible quality, whereby gender becomes a "dynamic,

social structure" (Courtenay, 2000b, p. 1387). In a recent revisit to the concept of masculinity, Connell and Messerschmidt (2005) agreed that simplifying masculinity to "an assemblage of traits" resulting in the "fixed character types" (p. 847) like the "alpha male" (p. 840) is problematic and should be discarded. However, because gender is dynamic and can have many meanings, people have tended to use stereotypes to organize and simplify information into dichotomous understandings about what constitutes manliness and womanliness (Pleck, 1987). In North American society, for example, there are widespread stereotypes about what it means to be masculine, and these tend to boil down to the perception that men are independent, strong, self-reliant, robust, and tough (Mahalik et al., 2003). Additionally, these traits are often highlighted by "symbols that have authority" or "exemplars of masculinity (e.g., professional sports stars)" (p. 846). Levant, Thomas, Hasan, Williams, and Smalley (2010) argued that men may also feel pressure to conform to these stereotypes because they make up the foundation of the roles traditionally reserved for males in many societies: "procreation (father), provision (worker), and protection (soldier)" (p. 25).

In line with with social constructivist perspectives, Courtenay (2000b) reminds us that men must be seen as "active agents in constructing and reconstructing dominant norms" (p. 1388). Similarily, Connell and Messerschmidt (2005) noted "men's and boys' practical relationships to collective images or models of masculinity, rather than simple reflections of them" is critical to our understanding of how men navigate, and ultimately, use masculinity. Masculinity in all its different forms becomes something that men can "dodge between", "distance themselves strategically" from (p. 841), and use as "tactical alternatives" (p. 847).

In a health context, Courtenay (2000b) proposed that health beliefs and behaviours have become tools or strategies men actively use to define their masculine self-conception. Borrowing

from feminist perspectives, Courtenay noted that health beliefs and behaviours can be understood as “transactions that help sustain and reproduce” (p. 1388) cultural beliefs that men are the stronger sex. In other words, “that men are more powerful and less vulnerable than women; that men’s bodies are structurally more efficient than and superior to women’s bodies; that asking for help and caring for one’s health are feminine; and that the most powerful men among men are those for whom health and safety are irrelevant” (p. 1389). To maintain these beliefs, some men may demonstrate health behaviours including denying weakness or vulnerability, controlling the emotional or physical self, appearing strong and robust, dismissing any need for help, pursuing sexual partners, and displaying aggressive behaviour or physical dominance. Courtenay illustrated his arguments with concrete examples of behaviours that many of us may recognize in the “average male” such as avoiding physical exams or doctor appointments, participating in risky sports, driving while claiming to be unaffected by alcohol, and even refusing to wear sunscreen.

In sum, healthy lifestyles have tended to be strongly associated with femininity, women and lower status men, and thus, “masculinities are defined *against* positive health behaviours and beliefs” (Courtenay, 2000b, p. 1389), paradoxically contributing to numerous health consequences in the male population.

Gender-role conflict theory. O’Neil’s (2008) *gender-role conflict* (GRC) theory has also been useful in evaluating the negative consequences that can occur when men adhere to or deviate from the dominant culturally defined masculine script. In other words, restrictive, rigid, and sexist attitudes generated from this socially constructed conception of masculinity lead to problems with mental health, homophobia, restricted emotionality, communication, intimacy, marital conflict, violence toward women, physical health, and substance abuse (O’Neil, 2008).

GRC has been specifically linked to depression and anxiety in men. In his extensive literature review, O'Neil (2008) identified 27 studies that assessed GRC's relationship to depression. Twenty-five of these examined diverse samples and showed significant correlations between depression and patterns of GRC, with *Restricted Emotionality*, or "difficulty and fears about expressing one's feelings and difficulty finding words to express basic emotion," (O'Neil, 2012, para. 10), being the most consistent predictor of depression. In the same review, O'Neil (2008) found 12 of 15 studies significantly linked GRC to men's anxiety and stress, while 18 of 19 studies found patterns of GRC significantly correlated to negative attitudes towards help-seeking, again, across a diverse sample of men.

Applying O'Neil's theory to an athletic context, Steinfeldt et al. (2009) explored the relationship between gender-role conflict, athlete identity, and stigma towards help-seeking. The authors again found disparities in football players' attitudes towards these norms. Of 211 varsity players, they found that what they termed "Gridiron Warriors" (48% of participants) reported stereotypic expressions of masculinity associated with athletes, while those they termed "Emotionally Expressive Competitors" (26% of participants) highly valued success, power and competition yet did not restrict emotionality or affectionate behaviour between men, and finally, their "Winning Isn't Everything" (26% of participants) individuals did not highly value success, power and competition. Interestingly, the Gridiron Warriors, who strongly identified with the athlete role, also held negative attitudes towards professional psychological help-seeking.

Together, these findings demonstrate that men who have higher levels of GRC are likely to experience psychological issues but, as previously mentioned, these same factors are likely to prevent men from seeking psychological help.

Help-seeking. Addis and Mahalik (2003) noted that while feminist and social constructionist conceptions of gender differ, both perspectives agree that gender is "something that is actively done in specific contexts rather than a property of individuals" (p. 9). Similar to Courtenay (2000b), this lens allows researchers to approach the question of help-seeking by asking: "why are some men, under some circumstances, able and willing to seek help for some problems but not for others?" (Addis & Mahalik, 2003, p. 7). Addis and Mahalik suggested that this psychological process is moderated by five elements, which are highly influenced by gender socialization and the process of constructing masculinity. These elements will be explored briefly: (a) *normativeness of problems*, (b) *the perceived ego centrality of problems*, (c) *characteristics of potential helpers*, (d) *characteristics of the social groups* to which individual men belong, and (e) *perceived loss of control*.

The first social psychological process is the perception of the normativeness of problems, which would refer to how normal a problem is perceived to be by the man in a specific context. Whether or not a problem is normal is largely moderated by social norms of masculinity to which a man might adhere. For example, in one study Mahalik, Burns, and Syzdek (2007) found that masculinity and perceptions of other men's health behaviours predicted participants' own health behaviours. Addis and Mahalik (2003) gave an example of a physician who perceives erectile dysfunction to be normal given his professional background; however, a man experiencing erectile dysfunction who has no knowledge of others suffering from the same condition may disagree. Paradoxically, when it comes to the issue of depression, men have been socialized to hide such feelings (Cochran & Rabinowitz, 2000), thereby decreasing the visibility of the issue, making the issue non-normative, and potentially decreasing help-seeking behaviours.

Next, the perceived ego centrality of problems deals mainly with how closely associated a problem is to a person's perception of their strengths. The problem becomes more threatening if it is perceived to challenge a person's self-esteem. Addis and Mahalik (2003) provided the example of a man who conforms to "emotional stoism" might feel threatened by the idea of getting help for depression; on the other hand, he may decide that a counsellor is the second best option if he cannot overcome it on his own. By taking this action, the authors noted, "He simultaneously supports the norm of emotional control while seeking help and constructing masculinity as a completion with one's emotional self" (p. 10).

Reciprocity or characteristics of potential helpers refers to the idea that in some contexts a male is more likely to seek help if he feels he can return the favour to avoid feelings of indebtedness. This idea deals primarily with maintaining image and status (strong, competent).

The element, characteristics of the social group, is similar to the idea of reference groups and in-group norms, whereby the group drives guidelines for acceptable behaviour. Addis and Mahalik provided a good example by noting "athletes who do not express the experience of intense physical pain and continue to compete despite serious injury are typically applauded for their intensity, commitment, heart, or toughness" (p. 9). In this case the social group, i.e. the football team, might value emotional stoicism and physical toughness, and equate these characteristics positively to masculinity. However, it is important to keep in mind that a man can hold membership with various groups, and may belong to a group that values the sharing of problems. Addis and Mahalik noted that this might increase his propensity to seek professional help.

The final regulator in the social psychological processes of help-seeking, perceived loss of control is essentially a threat to an individual's sense of autonomy. For some men, seeking

help for issues might be viewed as giving up his part in the decision making process. A popular stereotypical example of this is the joke that men don't like to ask for directions when driving somewhere.

In tracing this process, it is clear that help-seeking is contextual and often dependent on perceptions of gender-roles. Therefore, to "develop innovative ways to foster adaptive help-seeking" (Addis & Mahalik, 2003, p. 10), it is important to look a specific contexts and the masculinity norms that exist within that context. Courtenay (2000b) noted that there are a variety of activities used as resources for constructing and reconstructing gender. The field of athletics is a notable resource for this purpose, especially given its value and precedence in American culture. The following section will look at how gender is constructed in the context of football.

The Socialization of Males Through Sport.

Historically, theorists have identified sport as a social institution serving to discourage homosexuality (Harry, 1995), to maintain dominance over women (Messner, 2002; Pronger, 1990; Sabo & Panepinto, 1990), and to preserve socioeconomic and race divisions among men (Foley, 2001; Messner, 1992). For sport to achieve these functions, researchers have pointed largely to the pervasiveness of traditional masculine ideology and the saliency of particular ideological elements in male athletics. Sabo (1999) suggested "through sport men internalized patriarchal values which in turn become a part of their gender identity and conception of women and society" (p. 328). Football culture, as a prime example, is still considered by many to be an incredibly prominent socializer of young boys and men in America (Foley, 2001; Messner, 2002), producing "warrior narratives" that dictate and reward competitiveness, success (winning), aggression, violence, superiority over women, and respect for and compliance with male authority (Sabo & Panepinto, 1990).

More recently, authors have looked more closely at the relationship between athletic identity and conformity to masculine norms in 523 college football players. Steinfeldt and Steinfeldt (2012b) found that higher levels of athletic identity were related to high conformity to masculine norms (except for emotional control and sexual pursuits). More specifically, results indicated that players in defensive positions as compared to offensive positions had significantly higher conformity to traditional masculine values like heterosexual preservation and violence. The authors attributed this latter value to the more violent nature of the defensive player's position. Finally, when exploring the relationship between age (year-in-school) the authors hypothesized that the longer players were exposed to messages about masculinity through football, the greater their conformity would be. However, they found that in fact senior players reported the lowest levels homophobia and heterosexual preservation.

Coaches. Research exploring the relationship between compliance with male authority and the promotion of masculine ideology and the "warrior ethos" has generated some interesting findings. Messner (1992) found that for many young football players, coaches often fill one of two roles: the father figure and strong builder of men, or the authoritarian slave driver concerned only with winning and success. Sabo (1999) found that collegiate level football coaches often fell into the latter role and pushed their athletes "to take orders, to take pain, to 'take out' opponents, to take the game seriously, to take women, and to take their place on the team" (p. 327).

On the other hand, recent research has shown that football coaches are not endorsing traditional masculinity to the degree of previous findings. For example, Steinfeldt et al. (2011b) found that college football assistant coaches were diverse in their own conceptions of masculinity, and positioned accountability and responsibility as fundamental in the definition of

manhood. In the same study, nine of 10 coaches acknowledged the importance of an athlete's good mental health.

Regardless of a coach's style—builder of men, authoritarian slave driver or otherwise—the bottom line is that coaches have certain power over athletes (Kimball, 2007; Sabo, 1999). Messner (1992) stated that through coaches, "young males are learning to identify with adult male power and authority," which results in a strong bond between the two parties (p. 103). Indeed, Sabo and Panepinto (1990) include this submissiveness to male authority as a key component of the "football ritual" that perpetuates traditional masculinity ideology and the warrior code.

Coaches have also been found to use discourse to construct masculinity. In a study on traditional masculinity within a European soccer team, Adams, Anderson, and McCormack (2010) found that coaches used a particular style of discourse to either challenge or establish masculinity. Essentially, masculinity establishing discourse involved positioning the sport as a "man's game", referring to the men as "warriors" and the game as a "war", and using language that was homophobic, sexually violent, and misogynist. Masculinity challenging discourse used mostly by coaches associated the players' poor performance with female genitalia or homosexual tendencies (e.g. "What are you, a pussy?") (p. 287). The authors also found that the players themselves often engaged in this discourse, thus contributing to the construction and regulation of traditional masculinity ideology

Pain. Qualitative retrospective studies looking at retired athletes' understanding of the physical and emotional consequences of their participation in football demonstrate that during the height of their athletic careers, they just learned to 'take the pain' (Messner, 1992; Sabo, 1999; Sabo and Panepinto, 1990). The "pain principle" as described by Sabo (1999) is a learned

pattern not only in male athletes, but in many nonathletic men, that teaches them to "deny their authentic physical or emotional needs and develop health problems as a result" (p. 327). Hughes and Coakley (1991) identified a similar principle as the "sport ethic", which refers to the reluctance of athletes to talk openly about injury or pain, especially with authority figures, i.e. coaches and athletic trainers. The acceptance of physical pain and injury in football has been found to be a key element of initiation and bonding rituals (Sabo & Panepinto, 1990), inter-male dominance (Foley, 2001; Sabo, 1999), and success in competition and demonstrations of heroic courage (Foley, 2001; Messner, 2002).

Accordingly, this habit of supressing pain, emotional or physical, leads male athletes to consider their bodies as machines for getting the job done (Messner, 2002). In his study of images and discourse by sports commentators regarding male bodies on ABC's *Monday Night Football,* Trujillo (1995) found a similar reoccurring theme: football players' bodies were often considered to be a tool and football was work. Taken in a health context, this idea introduces the following section, which will look at how the male body as a form of capital is contested within athletics.

Physical capital. In applying the idea of capital to masculinity, Coles (2009) emphasized the importance of the male body as a form of capital. He noted "the ways in which the male body is represented to personify dominant images of masculinity make it the object of struggles and valued as capital" (p. 38). As the body becomes a resource in projecting masculinity, its size and shape (i.e. low body fat, strength and power, large muscles), and its use, also become extremely salient (Coles, 2009). Studies have found that men who viewed advertisements featuring muscular men reported significantly lower body esteem following image exposure (Hobza, Walker, Yakushko, & Peugh, 2007; Hobza & Rochlen, 2009).

Male athletes, for example, typically conform to the muscular body type, especially in a high contact, power sport like football where physically dominating one's opponent is central to the game. In their study on football players' drive for muscularity, Steinfeldt, Halterman, Gomory, Gilchrist, and Steinfeldt (2011c) found that these athletes generally desired muscularity for functional reasons (i.e. increased athletic performance and injury prevention), but were also aware of the social benefits of being a muscular man (i.e. sex appeal, conformity, appearance). The male body as a valuable form of capital is thus linked to masculinity. More importantly, however, the value placed on the male body for athletic performance may also help to shed light on the physical health prejudice in football as compared to mental health.

Schwenk (2000) criticized the overall physical prejudice in sport noting that, "The current conceptualisation of and approach to mental illness in athletes is fraught with stigmatisation, denial, and dichotomous paradigms of "psychological" versus "physical" disease, which are inaccurate, unhelpful, and deprive the athlete of effective care" (p. 4). As an example, NFL wide receiver Ricky Williams gave a candid description of such an occurrence when he struggled alone with debilitating mental health issue: "When it's a broken bone, the teams will do everything in their power to make sure it's OK. When it's a broken soul, it's like a weakness" (Wertheim, 2010, para. 4). When Williams went to a coach requesting psychological help, the coach reportedly responded with, "Stop being a baby and play football" (Wertheim, 2010, para. 3). This example illustrates the discrimination that football players and elite athletes face when attempting to seek help for mental health issues. While many strategies in mitigating this stigma may be explored, one point of entry into mental health promotion may be the issue of concussions.

Concussions and mental illness. The highly debated issue of concussions in contact sport is an interesting example of a physically induced injury affecting brain function and leading to mental health problems and illnesses. A concussion is caused by a physical blow to the head and/or neck area, and can lead to both physiological injury (i.e. brain swelling) and psychological injury (i.e. depression, memory problems) (CDCP, 2012a). A concussion may be difficult to identify depending on its severity and often goes unnoticed by team physicians, which means players usually must disclose their symptoms. The player must immediately stop play, and follow strict “Return to Play” procedures (McCrory et al., 2009). For a Canadian varsity football player, whose season is a minimum eight games and maximum twelve games taking oneself out of play may be a difficult decision. In professional football, being sidelined with an injury may jeopardize an athlete’s position on the team, and consequently, his livelihood.

In their media analysis of NFLer Aaron Rodgers’ self-withdrawal from an important game due to a head injury, Anderson and Kian (2012) argued that there is shift away from the self-sacrificing, warrior culture and more emphasis on players’ health. They attributed this change to what they called a “triangulated causal-model – renewed concern for safety, a weakening hegemonic model, and liability issues” (p. 168). In this particular case, Rodgers was deterred from re-entering the game not by a team physician or a coach, but by teammate Donald Driver. As noted by Anderson and Kian, Driver’s actions reflect a “growing cultural awareness as to the significant, debilitating, and often times life-ending impact that concussions…have on players” (p. 167). Secondly, the authors suggested that the shift away from self-sacrificing mindset means that players “have less reason to build their masculine capital by upholding the ‘heroism’ of playing through concussion as they once did” (p. 168). In other words, as players begin to see that self-sacrifice does not equate to manhood, they may become more health-

conscious. Thirdly, the governing bodies in professional sport are being held more accountable for the safety of their players, which again contributes to an overall cultural shift (Anderson & Kian, 2012).

In a similar vein, Driver's actions can be linked back to the idea of social capital—there were clearly strong feelings of trust and caring between the two teammates, as evidenced in Driver's conversation with *The New York Times:* "I was very concerned about him. I kind of whispered in his ear, walked behind him during the time he was sitting on the bench and kind of told him: 'This is just a game. Your life is more important than this game.' I told him I love him to death, and you've got to make the choice, but this game is not that important" (Viera, 2010, p. 2).

In fact, some researchers have suggested that football might be a way for men to build these close connections that would otherwise seem "unmanly". Steinfeldt, Wong, Hagan, Hoag, and Steinfeldt (2011a) found that football players who had lower levels of *Restrictive Affectionate Behavior Between Men* (RABBM, a component of GRC) within the football domain had greater satisfaction with life. The authors suggest "the football domain can cultivate an environment where young men are provided with opportunities to develop their ability to express affection for other men…conversely, societal norms […] might constrain football players from expressing affection for men outside of their comfort within the football environment" (p. 318). Schrack-Walters, O'Donnell and Wardlow (2009) also provided research that challenges ideas about men's relationships with other men, noting that male athletes were very candid about their emotional and interpersonal relationships with their male teammates. In other words, intimate bonds between teammates were not solely motivated by reliance for athletic performance but were a central component of the athletic experience.

In sum, these findings contribute to a potential shift concerning masculinity as it operates within a football context. Concussions appear to be catalyzing this shift as awareness of the detrimental, long-term health effects come to light, consequently putting the focus on player safety and raising concerns with league liability. Within this process, masculinity appears to be operating a little differently: moving away from the self-sacrificing, warrior mentality that has historically pervaded football culture. The example of Donald Driver glimpses this shift, and simultaneously, highlights the role social capital can play in maintaining good health, or at the very least, avoiding risky situations. He is quoted as saying he loved his teammate to death, which supports other researchers findings that men may be more emotionally expressive towards other men in a football context.

Athletes and Help-Seeking Stigma

Overall, the literature exploring athletes and help-seeking attitudes is divided. This is due in large part to the existence of two related but different fields of psychological care in sports, often used interchangeably in studies. On one hand, sports psychology is a discipline that deals mainly with enhancing athletic performance through focus, confidence, communicating with coaches/teammates and so on. Sports psychiatry deals with the diagnosis and treatment of mental health problems or disorders in athletes, in addition to performance enhancement (Reardon & Factor, 2010). It is possible that many studies use sports psychology as an overarching term because of the current emerging and evolving nature of sports psychiatry. Gee (2010) noted in his review of the literature that this tendency to equate the two has been problematic for sports psychologists. Athletes and coaches regard sports psychologists as mental health professionals, and “this misconception has stigmatized the use of sport psychology services within the athletic domain” (p. 388).

Whether the athlete is considering sports psychiatry or sports psychology, the overall findings indicate that there is a general reluctance to seek professional help for psychological issues. Studies show that athletes have reported a fear of being stigmatized by various groups such as teammates, coaches, and fans, and that this stigma will affect campus celebrity status, playing time, and trust levels between coaches and teammates (Brewer et al., 1998; Linder et al., 1991; Watson, 2005). In addition, athletes may hold negative attitudes regarding a counselor's ability to relate to the athlete lifestyle (Watson, 2005). Martin (2005) found that male athletes in high school and college were more likely than female athletes to stigmatize sports psychology, and suggested that those participating in contact sports may have more negative views than those participating in non-contact sports. Similarly, Naoi, Watson, Deaner, and Sato (2011) found that for mental health issues, American male athletes preferred to seek help (in order of preference) from family, friends, coaches, teammates, doctors and, lastly, sports psychology consultants. The same study also found that student-athletes preferred to discuss performance-related topics (such as concentration/focus, dealing with pressure and/or stress, and confidence), coaches, teammates, and/or family, burnout/overtraining, and academic concerns, much more often than mental health concerns (depression, anxiety, eating disorders), injury, alcohol and drug issues, and career concerns.

The relationship between traditional masculinity and help-seeking stigma was recently studied by Steinfeldt and Steinfeldt (2012a) in a football specific context. They profiled 245 college football players and found three diverse clusters of players varying in the degree to which they conformed to masculine norms such as winning, emotional control, risk taking, violence, power over women, self-reliance and so on. Based on the findings, three groups were produced for evaluation. "Non-conforming players" (33% of participants) reported the lowest

levels of conformity to masculine norms. "Paradoxical competitors" (36% of participants) reported mixed levels of conformity. For example, these men had conformed to masculine norms like winning and heterosexual self-preservation and had scored low on items like playboy and risk-taking. Finally, "high conforming players" (31% of participants) reported the highest levels of conformity to masculine norms. Of note, the non-conforming cluster also reported the lowest levels of stigma towards help-seeking, while levels of stigma increased in the following two groups.

While athletes' attitudes towards professional help-seeking may contribute to the underutilization of services, Reardon and Factor (2010) suggested that the under-treatment of mental health problems and illnesses in athletes is a result of several other contributing factors: a) there is a general assumption that this is not a risk group, b) healthcare providers may buy into this assumption and deny existence of psychiatric symptoms, and c) athletic behaviours are sometimes similar to psychiatric symptoms and thereby lead to decreased recognition.

Again, stigma is acknowledged as a prominent barrier to seeking help, and when help is sought, it is usually for performance related issues. Moreover, help-seeking patterns in athletes—often turning to family and friends first—demonstrate the importance of social capital.

Mental Health Promotion and Protection Theoretical Framework

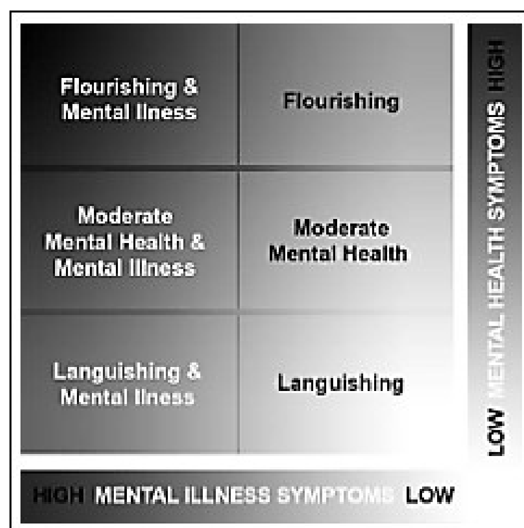
While highlighting the prevalence of disorders and illnesses is important to understanding the severity of the problems, this conventional framework of mental health research is also somewhat retroactive. Peter, Roberts, and Dengate (2011) criticized the conventional approach stating it "largely neglects factors that promote and enhance individual well-being" (p. 14). The following segment will explore these factors and justify why approaching mental health from a new theoretical perspective complements this thesis and the corresponding strategic

communication plan.

According to the World Health Organization, mental health is not just the absence of mental disorder. It is defined as, “A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (2013a, para. 1). In other words, an individual who has a severe mental illness like schizophrenia, but who also has supportive family and friends, accesses treatment or therapy, has a good job, and thrives in spite of their illness could be considered to have good mental health (Seedhouse, 2002).

The WHO (2013b) definition of mental health is supported by Keyes’s (2002) theoretical perspective of mental health, which positions mental health and mental illness on a dual continuum as illustrated by Figure 1 borrowed from Peter et al. (2006). The purpose of positioning the two dimensions in this way is to emphasize that mental health is “complete state” (Keyes, 2003, p. 302).

Figure 2: Keyes’ Dual Continua Model of Mental Health



(Source: Peter et al., 2006)

Keyes (2002) operationalizes *mental health* as “a syndrome of symptoms of an

individual's subjective well-being" (p. 208). An individual's subjective well-being includes *emotional well-being*, *psychological well-being*, and *social well-being*. Emotional well-being will be defined as positive feelings about life (i.e. happy, interested in life, and satisfied). Second, drawing from the work of Ryff and Keyes (1995), psychological well-being includes self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy. These feelings coalesce into an overall state described by Keyes (2002) where "individuals are functioning well when they like most parts of themselves, have warm and trusting relationships, see themselves developing into better people, have direction in life, are able to shape their environments to satisfy their needs, and have a degree of self-determination" (p. 208-9).

Finally, Keyes (1998) noted the importance of social well-being and its five dimensions. *Social integration* indicates the extent to which people feel they have something in common with others in their social groups; *social acceptance* refers to an individual's trust in others, belief in others' capacity for kindness, and is closely linked to personal acceptance; *social contribution* includes beliefs about one's societal value; *social actualization* is a broader hopefulness for social evolution—the belief that the future of society is bright; finally, *social coherence* refers to people's belief in the meaning of life and a concern for the world in which they live.

Central to Keyes (2002) theory is that this "syndrome of symptoms" comprising mental health can be present or absent. When mental health is present, the person is described as *flourishing*. Flourishing individuals have "enthusiasm for life [and] are actively and productively engaged with others" (Peter et al., 2011, p. 14). It is possible, according to Keyes' dual continuum, for a person to be flourishing and also have a mental illness. The complete absence of mental health constitutes a *languishing* person. Keyes (2003) defined languishing as "a state

in which an individual is devoid of positive emotion towards life, is not functioning well psychologically or socially, and has not been depressed in the past year" (p. 290). An individual falling in between flourishing and languishing is considered to have *moderate* mental health.

Mental illness, on the other hand, is considered to be on a separate but correlated continuum (Keyes, 2002). It is defined as "persistent and substantial deviation from normal functioning that impairs an individual's ability to execute their social roles […] and generates emotional suffering (Keyes, 2003, p. 293). Keyes appears to use depression and mental illness interchangeably. For the purpose of this thesis, mental illness will include depression, as well as anxiety disorders and substances abuse disorders, which will be explored in the following section.

Keyes (2002) maintains that increasing mental health leads to a decrease in mental illness. This was supported recently by Keyes, Dhingra, and Simoes's (2010) analysis of data collected from the 1995 and 2005 Midlife in the United States cross-sectional surveys (n= 1723). The surveys measured positive mental health, and 12-month mental disorders of major depressive episodes, panic, and generalized anxiety disorder. The researchers concluded that "gains in mental health predicted declines in mental illness, while losses of mental health predicted increases in mental illness" (p. 2366).

Keyes (2002) noted the benefits of completely mentally healthy adults: these individuals benefited greatly in day-to-day living with fewest workdays missed, fewest half-day or less cutbacks of work, the lowest level of health limitations of activities of daily living, the fewest chronic physical diseases and conditions, and the lowest health care utilization. Adults with complete mental health also had the highest psychological functioning and reported the lowest level of perceived helplessness, the highest level of functional goals, the highest level of self-

reported resilience, and the highest level of intimacy with friends and family.

On the other hand, Keyes (2003) noted that languishing is associated with substantial psychosocial impairment, poor emotional health, high daily limitations, and work cutbacks and missed workdays. Moreover, Keyes et al. (2010) found that languishing was a strong predictor of future mental illness. When comparing the data from 1995 and 2005, the researchers found that "adults who either stayed languishing or became languishing were more than 7 times more likely to have had a 2005 mental illness" (Keyes et al., 2010, p. 2369). A languishing individual with high mental illness symptoms is considered to have complete mental illness.

Finally, individuals may exhibit moderate mental health but have no mental illness. Notably, Keyes et al. (2010) found that moderate mental was a good predictor of future mental illness. If an individual has moderately mental health and moderate mental illness, their mental illness is categorized as incomplete.

In sum, this theoretical framework describes specific, tangible factors (social, emotional, and psychological well-being) with positive effects across life domains. The theory places mental health and mental illness on two separate but correlated continua, which contributes to the understanding that mental health is a complete state, not just the absence of mental illness. The promotion-protection approach provides new directions away from the conventional mental health framework. Keyes et al. (2010) noted, "mental illness treatment and prevention through risk reduction has not reduced the prevalence, burden, or early onset of mental disorder" (p. 2366). This means that more steps must be taken to develop and protect mental health. In support of this, Peter et al. (2011) stated, "the benefit of a proactive approach (rather than constantly reacting to illness) is that it can be applied within a population health framework, because promotion of positive mental health should be directed to all people" (p. 20). This means that the

promotion-protection approach does not discriminate: individuals with or without mental illness can benefit positively in life as they strive to achieve flourishing mental health. Moreover, promoting the understanding that mental illness can exist in conjunction with mental health could be an effective anti-stigma strategy. For example, the Faces Campaign produced by the Canadian Alliance on Mental Illness and Mental Health (2013) implements a similar strategy by telling the story of individuals who currently have or have recovered from a mental illness but are flourishing regardless: "Their experiences are proof that through proper diagnosis, treatment and awareness, people with mental illnesses can live productive and fulfilling lives" (para. 2).

Overview of Mental Health Problems and Illnesses Common to Male Athletes

Schiavo (2009) recommends generating an evidence-based, in-depth understanding of the health problem, which aids in the selection of the key audience for the strategic communication plan. Mental health problems and illnesses are numerous, vary in degrees of severity, and are determined by multiple social, psychological and biological factors (Mental Health Commission of Canada, 2012). Although it is certainly possible for varsity football players to develop any one of the many mental health problems or illnesses, the following issues have been selected specifically based on research attesting to their prevalence in college-age individuals and male athletes.

Depression. As defined by the World Health Organization (2013b), *Major Depressive Disorder* (MDD) or simply *depression* is defined as "a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration" (para.1). Depression is a state lasting three or more weeks where the individual may demonstrate these symptoms, and consequently, experiences a decrease in their quality of life.

Current perspectives determine causes of depression to be associated with multiple factors such as a genetic or family history of depression, psychological or emotional vulnerability to depression, biological factors, and life events or environmental stressors (CAMH, 2012). Particularly in college students, the development of depression is often associated with rapid social change with less opportunity for family support, taking on part-time or full-time jobs to finance education, increased stress related to academic success, and increased use of alcohol and drugs (Kadison & Richard, 2004). For example, the American College Health Association (2009) found that 26% of male students and 33% of female students reported feeling "so depressed that it was difficult to function" (p. 14), with 6% of males and 11% of females being diagnosed with or treated for depression in the last 12 months. Men tend to experience depression differently than women do: Women often experience feelings of worthlessness, sadness or guilt, while men are more likely to be very tired or irritable, lose interest in once-pleasurable activities, and have difficulty sleeping (Cochran & Rabinowitz, 2000; Pollack, 1998).

In their extensive review of the literature on mental illness in varsity athletes, Reardon and Factor (2010) concluded that depression may be no more likely in athletes than in non-athlete populations. In fact, physical exercise has been shown to protect against and reduce the symptoms of depression (Strathopoulou et al., 2006). However, Reardon and Factor (2010) found that when cases of depression in varsity athletes did arise, they were likely triggered by psychosocial stressors similar to those found in the general population, as well as sport-related issues such over-training, competitive failure, injury, aging, and retirement from the sport. Indeed, a strong, exclusive identification with an athletic role and subsequent interruption or termination of that role has been linked to depression (Brewer, 1993).

Depression and suicide are considered to be closely related. Suicide is a major societal and health problem, and was found to be one of the three leading causes of death among those aged 15-44 worldwide (Patton et al., 2009). While more depressed women than men attempt suicide, four times as many men actually kill themselves (CMHA, 2012). Suicide is also the second leading cause of death among individuals aged 15-19 (Patton et al., 2009).

Suicide in athletes has not been extensively studied; however, Baum (2005) reviewed medical and periodical literature pertaining to both elite and varsity athletes between the 1960 and 2000, and discovered 71 cases of athletes who contemplated, attempted or completed suicide, of which 66 were completed suicides. The average age across all cases was 22, with 61 men and 10 women. The author noted that the male to female ratio of 5.5:1 was greater than the general population and speculated that this may be due to either a reporting bias or the fact that men still largely dominate athletics. When broken down by sport, football players were reported most often, followed by athletes in basketball, swimming, track and field, baseball and other sports. In examining the reasons behind football's position at the top of the list, the authors looked at several factors including injury, psychosocial stressors, substance abuse, retirement, and concussions.

Concussions. A large body of research has been devoted to examining the relationship between depression and concussions. Concussions are a type of traumatic brain injury occurring most often in contact sports such as football, hockey and rugby. Though the link between the two is still unclear, in general, athletes who have sustained a concussion have a higher risk of depression (McCrory et al., 2009). A concussion is defined as "a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces" (McCrory et al., 2009, p. 186), resulting in very serious health problems including "a wide range of functional short- or

long-term changes affecting thinking, sensation, language, or emotions" (CDC, 2012a). In the United States, there are an estimated 173,285 sports- and recreation-related traumatic brain injuries, including concussions, among children and adolescents, from birth to 19 (CDC, 2012b). Bloom et al. (2008) found that male athletes sustained more concussions—as well as more unrecognized concussions—than female athletes. Given the violent nature of football, where head-to-head or shoulder-to-head contact is encouraged by the presence of protective headgear, it is not surprising that concussions are repeatedly cited as the most prevalent injury in Canadian and American intercollegiate football (Ellenbogen, Berger, & Batjer, 2010; Meuwisse, Hagel, Mohtadi, Butterwick, & Fick, 2000). Recently, with the violent deaths or suicides of high-profile athletes linked to degenerative brain diseases caused by repeated blows to the head, there has been a surge in media attention calling for rule changes and more protection for players (Breslow, 2013; Ellenbogen et al., 2010).

Anxiety disorders. There are many forms of anxiety disorders including *generalized anxiety disorders*, where one finds that worry or apprehensive expectation are difficult to control causing fatigue, distraction, and agitation; *panic disorders*, which are characterized by unexpected attacks of "sheer terror" resulting in sweating, racing heat, shaking or trembling, trouble breathing and choking sensations; *obsessive compulsive disorders*, whereby individuals "experience intrusive, disturbing thoughts, impulses, or images that cause anxiety or distress"; and *social anxiety disorders,* where the individuals deals with persistent fear of being judged by others in social or performance situations (Kamm, 2008, pp. 182-88). Again, the risk factors associated with anxiety problems appear to be a combination of biological, psychological and challenging life experiences, including "stressful or traumatic life events, a family history of anxiety disorders, childhood development issues, alcohol, medications or illicit substances, other

medical or psychiatric problems" (CAMH, 2009).

In Canada, anxiety disorders affect 12% of the population (Health Canada, 2002), and affect 18.1% of the adult population in the United States (Kessler, Chiu, Demler, & Walters, 2005a). Women are 60% more likely than men to suffer from an anxiety disorder (Kessler, Berglund, Demler, Jin, & Walters, 2005b). In a study of 1,347 college students in the United States, 4.2% of undergraduate and 3.8% of graduate students reported an anxiety disorder (Eisenberg, Gollust, Golberstein, & Hefner, 2007). Anxiety disorders can have negative impacts across a student's life domains including academic performance, attendance, retention, career selection, relationship development, and physical health and general well-being (Baez, 2005). For varsity athletes, uncontrollable anxiety issues can negatively affect performance both in and out of competition—although some anxiety is thought to be healthy for competitive drive (Thompson & Trattner-Sherman, 2007).

Addictive disorders. Reardon and Factor (2010) stated that *addictive disorders* including substance abuse are "characterized by a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of a substance" (p. 967). There is no definitive answer regarding the role of substance use disorders in creating new or exacerbating pre-existing psychiatric issues; however, the two are closely associated and often comorbid (Anthenelli, n.d.). For example, the 2010 National Survey on Drug Use and Health: Mental Health Findings (Substance Abuse and Mental Health Services Administration, 2012) showed that adults with a mental illness were more likely to have substance use disorders than adults without mental illness. Again, it is still not entirely clear whether or not substance abuse precedes mental illness or if substance abuse is a method of coping with a mental illness. The following sections will look separately at three addictive disorders specific to the target

population of male varsity football players: *alcohol abuse and dependence*, *anabolic steroid use* and *pathological gambling*.

Alcohol abuse and dependence. In the United States, alcohol use disorders affect approximately 18 million people (NIAAA, n.d.), and are justly described as "a widespread and serious personal and public health problem" (Hasin, Stinson, Ogburn, & Grant, 2007, p. 837). Alcohol abuse occurs when the individual is not dependent on alcohol but experiences many problems across life's major domains as a result of their drinking. Alcohol use disorder also includes the more serious alcohol dependence, whereby the body craves and depends on alcohol, the person often loses control over consumption and has a very high intake tolerance (APA, 1994).

In 2002, 19% of American college students between the ages of 18 and 24 met the criteria for alcohol abuse or dependence (NIAAA, 2012). In Canada, 32.0% of undergraduates reported hazardous or harmful patterns of drinking according to the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) screener (Adlaf, Demers, & Gliksman, 2005). College students may abuse or depend on alcohol due to their family and/or college environment, social acceptance of drinking, the availability of alcohol, or to cope with stress or other problems. Alcohol abuse has been linked to mental health problems and illnesses including major depressive disorder and anxiety disorder in college students (Deykin, Levy, & Wells, 1987; Kushner, Sher, & Erickson, 1999) and in varsity athletes (Miller et al., 2001).

In their extensive literature review on substance use in college students, Lisha and Sussman (2010) found one study demonstrating that varsity athletes reported lower or no difference in consumption of alcohol compared to regular students. However, they synthesized a plethora of more recent findings indicating that varsity athletes consume alcohol more

frequently, consume greater amounts, abuse alcohol, and suffer more adverse effects. Some researchers have speculated that the competitive nature of athletes (Lisha & Sussman, 2010) and stress due to athletic role and performance requirements (Thompson & Trattner-Sherman, 2011) are reasons why student-athletes turn to alcohol.

Another factor to consider when exploring alcohol use is the importance of acceptance from peers and teammates in the sporting culture. In a NCAA college study (Green, Uryasz, Petr, & Bray, 2001), 637 of 991 schools responded and reported that 68.6 to 94.8% of men and 75.3 to 95.9% of females participating on teams consumed alcohol in the 12 months preceding the study. This finding is consistent with studies reporting adolescent and college population's increased use of alcohol when in a team setting (Garry & Morrissey, 2000; Nattiv, Puffer, & Green, 1997; Wechsler et al., 1997; Wichstrom & Wichstrom, 2009).

Anabolic steroids. Another substance warranting mention is anabolic steroids. Essentially, this drug has the same chemical structure as the male sex hormone, testosterone, and leads to increased muscle mass (CAMH, 2003). The literature on the abuse of this substance is not overly rich and this could perhaps be due to the efforts of governing bodies in sports to promote clean competition. For example, Canadian Interuniversity Sport in collaboration with the Canadian Centre for Ethics in Sport (2011) requires that each athlete complete an anti-doping learning module and imposes strict restrictions on substance use in sport.

Despite these efforts, cases of anabolic steroid use continue. Most recently, a University of British Colombia football player was handed a two year suspension after traces of stanozolo, a prohibited anabolic steroid, were found in his urine sample (CCES, 2012). In one national study, 38% of athletes who had used steroids indicated that the drug was obtained from a team physician or other physician (Green et al., 2001). This finding is particularly concerning given

that anabolic steroids not only have harmful physiological side effects, but also psychiatric side effects, including hostility, aggression, irritability and mood liability (Su, Pagliaro, & Schmidt, 1993), as well as major mood syndromes such as mania, hypomania or major depression and additional substance dependence (Pope & Katz, 1994). Reardon and Factor (2010) maintained that is it not clear if athletes use substances more to enhance performance or if it is abuse/dependence related. Regardless of the motivation for varsity athletes to use anabolic steroids, the health consequences are clearly documented and should be included in addictive disorders for this population.

Pathological gambling. Finally, pathological gambling is considered to be an addictive disorder. Reardon and Factor (2010) described it as a "persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or vocational pursuit" (p. 968). A survey of gambling behaviour in the United States reported that pathological gambling occurred in 1.4% of 2,630 U.S. residents aged 18 or older (Welte, Barnes, Wieczorek, Tidwell, & Parker, 2002). Moreover, males are more likely than females to have gambling problems (Ladouceur, Dubé, & Bujold, 1994; Welte et al., 2002). Similar to other addictive disorders, pathological gambling is often comorbid with mental health problems or illnesses such as nicotine dependence, substance use disorder, mood disorders, and anxiety disorder (Lorains, Cowlishaw, & Thomas, 2011).

In their literature review, Miller et al. (2001) found that male varsity athletes are more likely than female varsity athletes to engage in gambling. These findings were similar in multiple NCAA studies, which also classified more male athletes as disordered or pathological gamblers as compared to female athletes (Ellenbogan et al., 2008; Huang, Jacobs, Deverensky, Gupta, & Paskus, 2010; Temcheff, Derevensky, & Paskus, 2011). In particular, male student athletes in

high profile sports such as football were more likely than low profile sports like volleyball and track and field to report gambling behaviours or related problems (Ellenbogan et al., 2008).

Chapter 3: Methodology

This chapter will discuss the research design adopted to inform this thesis. Specifically, this thesis uses a combination of relevant literature and primary data. The review of existing literature in chapter two consists mainly of peer-reviewed journals and publications from health organizations accumulated through database and Internet searches. As suggested by Schiavo (2009), the key purpose of the literature review was to help gather information about the health issues and the intended audience, while simultaneously providing a framework for the qualitative interviews.

From an exploratory perspective, qualitative in-depth interviews (Creswell, 2009, 2013) with the intended audience were utilized in this thesis to gain a better understanding of the health issue in a non-theoretical context with valuable insights from the audience. The interview data were used to compare and contrast the literature. The following section will outline the specific methods used in the collection and analysis of the qualitative interviews, and offer a justification for the qualitative approach using stimulus text selected to investigate the opinions and attitudes of male varsity football players regarding mental health.

Sample

Research was conducted with permission from the University of Ottawa Human Research Ethic Committee (UHREC). Participants were 8 full-time student athletes on the varsity football team at the University of Ottawa, Canada. This team competes at the highest competitive level of university sport in Canada, which is overseen by Canadian Interuniversity Sport (CIS). Participants were recruited using volunteer sampling (Miles & Huberman, 1994), whereby initial recruitment and information letters were distributed to the head coach to circulate among all 89 players via the team email list (see Appendix A for copy of the recruitment and

introduction letter). Interested players were invited to contact the researcher if they were willing to participate in the research study. A total of 8 players volunteered for the interviews, which were conducted at the University of Ottawa campus in a private office. The mean age of the participants was 22.25. Programs of study and years of study varied from graduate studies in Occupational Therapy (year 1), and Sports Management (year 1), to undergraduate disciplines in Psychology (year 5), Economic and Political Science (year 5), Bio Pharmaceutics (year 1), Human Kinetics (year 5), Health Science/Human Kinetics (year 3), Classical Studies and Ethics (year 3). Participants' positions on the field included one linebacker, three defensive backs, two receivers, one offensive lineman, and one defensive lineman. Participants reported starting football at ages 8, 10, 12, 13, 15, and 18.

Data Collection

Qualitative interviews. Eight qualitative interviews ranging from 90-120 minutes were conducted and digitally recorded with study participants. The interviews focused on opinions, trends and insights of the participants (Andreasen, 1995) in relation to mental health, mental illness and stigma. After participants signed an information sheet and consent form (see Appendix B), they were briefed on the structure of the interview and given a short written background document describing the project. The researcher proceeded to gather demographic information including age, year and program of study, position played, age started football, and self-reported ethnicity. The formal interview began with two questions pertaining to the participants' sense of identity as football players, and sense of connectedness to teammates or non-teammates in their life: "When you think about who you are as a person, describe much being a part of a football team shapes your sense of identity?" And " Can you tell me about someone or a group of people outside of your team that you look up to or feel connected to in

some degree? What is it about this person/group of people that makes them special?" The two subsequent parts of the interview were conducted using stimulus text.

Stimulus text. An approach called stimulus text (Törrönen, 2002) was a major component of the interviews and was intended to encourage participants to speak about the topic. According to Törrönen, stimulus text refers to a "description, narrative, story fragment, picture continuum or collage that is more extensive than a question, sentence or proposition" (p. 344). In other words, the stimulus text generates meaning by expressing a cultural phenomenon. Participants become "empowered" as they re-interpret the cultural phenomenon through their own experiences.

Stimulus text can be used strategically in three ways as a *clue, microcosm,* and *provoker*. Törrönen summarized the use of each:

> When we use stimulus texts as clues, we build the interview session so that the texts, together with the interview questions, induce our interviewees to extrapolate how the texts stand for the whole (metonymy). When we use stimulus texts as microcosms, we pose the interview questions so that our interviewees compare their worlds and identity positions against those of the stimulus objects (mimesis, identification). When stimulus texts are used as provokers, the researcher chooses cultural products that challenge, with the aid of provocative questions, the interviewees to deal with the established meanings, conventions and practices (symbolic dimension, naturalness, normality) of the phenomenon under examination (p. 343).

This means that using stimulus texts like clues can be envisioned as "hints" or "tracks" that stir the respondent just enough to help them "deduce to what entirety" the stimulus refers (p. 351). With microcosms, on the other hand, the respondent's views are more intimately explored,

but through the lens of the stimulus text, creating a sense of “distance or proximity” for the participant (p. 355). Finally, provokers provide a “substitute world” used to “challenge” respondents to discuss issues that are “otherwise delicate and difficult to discuss” (p. 357).

This study did not make use of stimulus text as a clue, but did find use for its role as a microcosm and as a provoker. The first stimulus text was presented when participants were asked to read a short excerpt from an article entitled, “McKinley’s Apparent Suicide Casts Light on Athletes’ Risk of Depression”, written by Jon Wertheim (2010) in *Sports Illustrated Magazine* (see Appendix C for this excerpt). The story reported on a National Football League (NFL) athlete’s experience with mental illness. Interview questions in this section almost always referred back to the text, while prompts were designed to elicit more personal reactions. For example, one question asked:

> *Try to imagine that you were in a similar situation to Ricky Williams and you were dealing with a mental illness similar to his. What do you think you would do?*
>
> **Prompt:** *Who would you tell?* [i.e. what are your preferences for help-seeking?]
>
> **Prompt:** *What is it about these people that make you reach out for help*? [i.e. what are the important characteristics of support groups?]
>
> **Prompt:** *Can you think of any barriers that would maybe make you think twice about talking to someone about your problem?* [i.e. what are the perceived barriers? Are they personal, social, structural, etc.?]

In this context, the stimulus text was used as a microcosm, meaning that the interview questions were built to “encourage the interviewees to compare their own conceptions and experiences to the world constructed in the stimulus text” (Törrönen, 2002, p. 354). The world constructed in the stimulus text described the experiences of a professional football player with

mental illness stigma, and by extension, the broader health issue concerning masculinity and health beliefs and behaviours.

The strengths of using this microcosm approach are twofold. First, Törrönen recognized the difficulty researchers might have in eliciting responses to direct questions about values or personal issues. In this study, the researcher hypothesized that the players had not had personal experiences with mental health problems, thus the stimulus text acted as a reference point to which participants could "relate their way of being and doing in the world" (p. 355). Additionally, the researcher anticipated that, based on the gender of the participants and the stigma around the topic of mental health, a stimulus text would—"in its distant and safe setting or frame" (p. 355)—be perceived as less threatening, allowing for participants to "express their distance or proximity in relation to the subject positions and the world evolving in it: what things they consider to be positive (identification, us) in it and what things to be negative (distinction, them), correspondingly" (p. 355). Thus, interview questions were designed to elicit participants' opinions and attitudes as they compared their experiences or observations to the stimulus text.

The second form of stimulus text used in the interviews was a minute-long public service announcement produced by the NFL. Entitled "Lean On Me", the video features NFL Hall of Famer Michael Irvin addressing the lack of conversation by men around mental, physical, and life problems. This particular stimulus text was selected because of its progressive content and its positioning in a highly traditionally masculine domain like the NFL. According to Törrönen, stimulus text used in this way becomes a provoker and is intended to "question established social practices and cultural conventions by representing anomalies, liminal states, extreme phenomena or taboos" (p. 356). This segment of interview was also designed to explore participant preferences about potential spokespeople for Phase II efforts. In other words, they were asked

whether someone like Michael Irvin was an appropriate person to lead this discussion, why or why not, and who else would be a strong face for a campaign?

Data Analysis

Following Creswell (2009), who recommended blending general steps for a qualitative analysis with specific research methods, data analysis procedures began with a careful reading of all the interview transcripts to gain an overall sense of the data. A list of rough topics was devised and then narrowed down by grouping similar topics, while the review of literature acted as a guide to determine the relevancy of each topic. The selected topics were 1) *Masculinity*, which broadly included all references to masculinity, 2) *Mental health*, which broadly referred to attitudes and opinions about mental health and psychological help-seeking, and 3) *Capital*, which referred to accumulated labour, resources and support drawn upon to gain important ends.

Following phenomenological approaches outlined by Moustakas (1994), the researcher then identified “significant statements”, intended to “provide an understanding of how the participants experience the phenomenon” (Creswell, 2013, p. 82). The statement selection criteria required the statements to illustrate or challenge guiding theoretical perspectives. Statements were also deemed significant if they were unexpected and contributed to an understanding of the phenomenon.

A second careful reading of the significant statements produced relevant subthemes guided by the literature and theoretical framework. Masculinity comprised the following subthemes: “health-related stereotypes”; “power/separation/status; “gender-role conflict/resistance/alternative masculinities”; “health behaviours”; and an item from the Conformity to Masculine Norms Inventory, “winning”, which is defined as wanting to be admired and respected, successful/ powerful/competitive, performing competently, and being

physically adequate (Mahalik et al., 2003).

The main theme of mental health included “perceived public stigma”, which is the notion that an individual is socially unacceptable, and this theme dealt with the participant’s own perception of public stigma; “personal stigma”, which refers to people’s own stigmatizing attitudes, which may or may not agree with their perception of public stigma or perceived public stigma; “social function of stigma”, which comprised notions of group survival and contribution to the football team; and “mental health services”, referred to any experiences or general understanding of mental health services on campus.

The theme of capital was divided into “social-structural” referring to the social influence of group membership, positive psychological states, including a sense of purpose, belonging, and security, as well as recognition of self-worth, and propensity to access support; and “social-functional”, which referred to perceived availability of social capital. This theme also included “physical capital”, whereby the body is a resource in projecting masculinity.

Finally, statements were interpreted by the researcher using information from the theory and literature. These helped to “confirm past literature or diverge from it” (Creswell, 2009, p. 189).

Chapter 4: Findings

This chapter will synthesize the formative research and the findings of the qualitative interviews into a comprehensive profile of the audience. In particular, predominant health beliefs, attitudes and behaviours of the target group will be explored including stigma and weakness, masculinity in football, and social capital. These findings contribute to the strategic communication plan in chapter five.

Stigma and Weakness

Findings from the interviews revealed that participants unanimously reported mental illness to be perceived by the public as a reflection of weak character. This finding is consistent with common stereotypes associated with mentally ill individuals (Brockington et al., 1993; Taylor & Dear, 1980). Collectively, participants hypothesized that these perceptions could be fuelled by a general lack of education about mental health disorders; the lack of visible symptoms affirming mental illness as a real medical condition; and social expectations that individuals who withstand immense physical distress in a game like football should have equivalent mental strength. This latter factor is consistent with Addis and Mahalik's (2003) social psychological processes of help-seeking where the health problem becomes more salient if it is perceived to threaten a person's strengths. In other words, athletes pride themselves on having the mental toughness to compete consistently, to overcome setbacks such as losses or injuries, and to perform under immense pressure. Thus, mental health problems directly threaten the mental toughness all athletes strive to build and could perhaps cause an athlete to internalize negative public stigma more thoroughly than non-athletes. Moreover, researchers like Vogel et al. (2007) found that men may internalize stereotypes about mental illness more fully than

women. Given these patterns, it could be suggested that male athletes may be more likely to self-stigmatize.

The perception that one is weak regardless of the source of that “weakness” (whether mental or physical) was a concern expressed by a number of the participants. Moreover, how that weakness affected an individual’s status within the group was reiterated throughout interviews. One participant illustrated this conflict:

> There are one hundred players on the team, so if you come out with this thing and everybody knows about it, players might hate on you and think you are weak […] I wouldn’t want everyone talking about it behind my back. They probably would, even though they are all your brothers […] That would be the biggest thing: fear of my peers not accepting me.

Fear of peer rejection was echoed by other participants noting that teammates who didn’t understand mental illness would use stigmatizing labels like “freak” and behave unfavourably towards that individual. According to Smith (2007), “The labeling process (a) brings attention to the group’s stigma, (b) stresses that this is a separate social entity, and (c) helps to differentiate the stigmatized group from the normals” (p. 469). Thus, labels are important to keeping stigma alive because they simplify many different meanings into singular terms, helping to undermine the stigmatized person on various levels, and perpetuating harmful self-stigma (Vogel et al., 2007).

Rejecting a peer who had a mental illness was also seen as a survival strategy in a competitive group setting. One participant discussed stigma by association, whereby his public support for a player with mental illness would reflect negatively on him. In his own words, stigma became leverage for teammates to abuse:

> If you show [a teammate who has mental illness] your support and you show you understand his weaknesses, they are going to associate those weaknesses with you and they are going to associate you with being weak minded […] You never know when they are going to use that to make fun of you, when they are going to use that to hurt you when they need to take your spot.

This example demonstrates that while a person may not personally agree with the public stigma, they must sometimes adhere to it to survive in the group (Sherif, 1962). Moreover, this example illustrates the need for a power situation allowing for the stigma process to occur with labeling and stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). Due to the competitive nature of elite sport, the participant feels that he is giving teammates power over him by empathizing with a "weaker" player's situation.

Mental illness as a crutch. The majority of the participants suggested that mental illness could be used as a crutch, an excuse, or a scapegoat in different contexts. For example, several participants speculated that some teammates might use mental illness to justify their lack of will to compete or avoid training and practices, while others suggested that teammates may use mental illness to justify bad life choices (financial, relational, and academic). In one such example, a participant said:

> I would say some guys that are not tough enough mentally to play or be involved in competition, in a world of competition—because that is the life of football, it's competition all over the place—they will try to use that to justify their lack of will […] It's hard [to separate] those that use that as an excuse and those who have good will and have those issues.

Another participant noted that mental illness might be viewed as a crutch within a certain

timeframe, but if the problems persisted past a certain point, then the illness would be legitimized. Conversely, another participant suggested that being mentally ill for an extended period of time was unacceptable: “I would try to help them out but a certain point you have to get better […] you have to figure this out for yourself and come through. Pretty much just ‘man up,’ we have a game on Saturday”. Mental health problems repeatedly take the form of a weakness and in this example are linked to masculinity. This same example places responsibility squarely on the shoulders of the stigmatized individual. Responsibility, as noted by Smith (2007), is concerned with perceptions of choice and control, whereby “people believe that members of a stigmatized group *choose* their stigmatized condition” (p. 470). On a positive note, a number of the participants stated that an individual was not to blame for his or her mental illness and that is should not be seen as weakness.

Participants’ personal commentary regularly revealed a circumstantial acceptance of mental health problems and illnesses, often contingent on individual and group factors. At the individual level, participants tended to be more empathetic, more accepting, and more likely to get personally involved in a person’s recovery based on several conditions including the “ill” person’s reliability and trustworthiness, work ethic, and willingness to compete. When asked what he would do if a teammate opened up to him about mental illness, one participant said:

> I would try to be there for this guy, but it depends though, eh? It is weird to say that, but if it’s a guy—regardless if he is senior or freshman—if it’s a guy who works hard and pushes it, I am going to help him for sure […] But if it’s someone who is just slacking and everything and just comes up to me […] maybe I don’t feel like its genuine or maybe I don’t feel like he deserves it, so maybe I would refer him to somebody. So I would try to help him, but on a different level. I would be more personally involved in somebody

> that I feel like, regardless of potential, just works hard and has good ethics.

Other participants listed reliability, work ethic, trustworthiness or similar positive characteristics as indicators of an individual's contribution, and ultimate integration and acceptance on the team. It could be suggested that individuals who might have a mental illness but have aligned themselves with team values such as those described are still contributing to the team's success.

Group survival. From the perspective that stigma is a social function intended to protect group survival (Neuberg et al., 2000; Smith, 2007), the negotiation process of accepting an individual's mental illness also appeared to be regulated by the perceived threat of a mentally ill teammate as a "weak link". One participant made several comments demonstrating this attitude:

> There are ninety people out here who are giving it their all and […] if one guy's head is just not in it, then he's going to get hurt or someone else is going to get hurt […] If you can't fix it then take a year off and come back. You can't just be on the team and be around and be here and there. It's either you are fully committed and you are fully committed to getting better and you can stay. But if you're semi-committed and still want to be on the team but you're kind of dragging other people's feelings down, then go away for a year and come back.

From this angle, a mentally ill individual becomes a threat to the team members' individual effort, to creating effective communication and a common group identity, to protecting individual members (Neuberg et al., 2000), and is cast out until he is well enough to return and contribute to the team's success.

Not being viewed as a weak link on the team was significant for many players, particularly when it involved the coach. One player observed that coaches might value the collective team's best interests, which is "a matter of personal interest first", over those of the

individual players perhaps causing the coach to hold stigmatizing attitudes. An analogy that resurfaced multiple times in discussing perceived coach stigma was that of a "factory": "If you can't do the job, then there is going to be someone who can do it for you". Another player said, "[The coaches] won't rush to help you with that because they are going to say, 'Oh, next guy in line doesn't have any problems like that? I don't need to deal with that […] Get the hell out of here and I will put the next guy in'". Thus, stigma is once again enabled by a power situation where the coach controls players' playing opportunities. Fear of losing status with the coach was echoed in other studies exploring barriers to college athlete help-seeking for psychological issues (Brewer et al., 1998; Linder et al., 1991; Watson, 2005).

When asked if coaches had ever discussed mental health, the participants unanimously agreed that they had not specifically, but rather the focus, when discussing psychological issues, was firmly on either performance-based mental training or concussion education. For example, one participant observed:

> All that is important for coaches or people at this school is if we perform. Perform on the football field and perform at school. The athletics director and the assistant athletic director—the first thing they want is us being successful in school and after on the football field. But the coaches are the opposite. They want us to be successful on the field, and then successful in school, and after that they don't care.

This finding reflects the lack of emphasis on mental health for athletes and the physical prejudice in sport noted by other researchers (Reardon & Factor, 2010; Schwenk, 2000).

Most players stated that they would like to see an increased emphasis on mental health in the football domain and noted that a program or resource designed to that end would be useful or beneficial. However, several players noted that such a resource might be difficult to incorporate

due to the various elements competing for attention in their lives (i.e. school, practice, social lives). One player was uninterested in the idea of a resource because he did not perceive mental illness as a personal threat; however, when the researcher pointed out that it would be useful to equip him with the tools to help his friends or teammates, he agreed that this was an attractive option.

Taken together, these findings and the supporting literature demonstrate that the environment of a competitive elite sport team comprises the power element needed to enable stigma to survive. Mental illness was repeatedly linked to weakness threatening an athlete's self-perception of mental strength; threatening status within the group; and threatening status with the coach. Stigma was also seen as a strategy to protect one's survival in the team, as well as to cast out individuals who threatened the team's success. Participants noted the lack of mental health resources and speculated that such a tool would be potentially valuable in addressing the mental health needs of football players.

Masculinity in Football

References to gender and its effect on health attitudes and behaviours were recurrent throughout the interviews, echoing O'Neil's (2008) observation about the universality of masculinity conflict. Participants reported the influence of stereotypically male values and behaviours from childhood to adulthood, both in and outside of the football context. One participant noted that isolation is a cultural problem beginning in childhood: "When you are a little girl, it's like, 'You can cry, tell me what is wrong.' And when you are a little guy, it's like, 'Suck it up, you're a boy, you're not supposed to do that". Phrases like "suck it up" and "man up" are commonly used in social vernacular to challenge individuals to live up to the expectations held for males: being tough, strong, independent and so on. One participant

summarized the socialization process that influences how men and women alike think about male roles:

> Throughout history, from the beginning of our time, men were men: we don't need help from anyone, we don't need the women to help us, we support, we are strong, we are the fighters, the warriors, the hunters [...]. That is always embedded in us: get the most women, get the most money, get the most power – that's manly, that is men. Whether we want to say so or not, that is in us. [...] Our society says, 'Give in to that temptation, give in to that sexual desire of being with 100 women, it's fine, it's fine' [...] Men are doing this stuff—there are guys on the team like that [...] It is almost encouraged to be a macho über-copulating kind of guy, let's sleep with as many women as we can, let's go drink till we puke our brains out, let's go party here, let's go there, and do all those things to show that we are men.

This example reveals the messages that many men receive in North American culture about male values and demonstrates the behaviours men may adopt to project their masculinity (Levant et al., 2010). While the behaviours in this example revolve mainly around promiscuous sexual activity and drinking behaviour as a way to define one's maleness, further analysis of the interviews revealed a number of health opposing behaviours (Courtenay, 2000b) male athletes might adopt to project a masculine image within a football context.

First, it is important to understand the environment in which football players spend the majority of their time. For many of the participants the football domain could be compared to a theatrical stage (Steinfeldt et al., 2011b) or often to a combat zone (Jansen & Sabo, 1994). One participant observed that:

> Football players are the biggest actors if anything. In any macho sport, any macho

> athlete, they are the biggest actors because they are performing in front of the largest masses of crowds every day and you see them on the field going, 'Yeah! I just knocked him out!' And they are freaking out and going crazy, but you don't know what they're like outside of that.

This macho act can serve as a tactic to mask "weakness" or pain as one participant recalled a similar reaction after being hit hard: "I got up and it was because I didn't want to show weakness to the guy that just smacked me, I screamed something like, "Wooo, I don't care! Hit me harder next time!" In this way, acting macho became a defense mechanism to protect survival on the field and to not be labeled as weak by the opponent or teammates. This finding is similar to Connell and Messerschmidt's (2005) comment about the function of masculinity. In other words, using certain elements of masculinity—in this case "macho male"—tactically.

One tool football players may use to gain "alpha-male" or "big dog" status in the field of play is to play through injury, and ironically, these same players are attributed with high mental strength. According to Courtenay (2000b), men adhering to traditional masculinity believe that "the most powerful men among men are those for whom health and safety are irrelevant" (p. 1389). In other words, denial of physical pain becomes a strategy for setting oneself apart from other men and enabling inter-male dominance (Foley, 2001; Sabo, 1999). As one participant noted:

> The guys who are really, really good have that high mental strength and that is where I want to be, especially because mentors I have are like that. There are no excuses […] they can play through it and perform well even with those kinds of injuries…[My teammate] put on his [back brace] and played, and this guy is willing to risk his career, or walking, to play a game. So I really have no excuse to ever miss a game. That is my

> mentality. He's an All-Canadian, I want to be an All-Canadian, and so I'm going to do that too.

This example illustrates the social influence of group membership on health behaviours as noted by Kawachi and Berkman (2001). In a similar case, thinking back to his first year, one participant recalled playing with teammates who were significantly older and the pressure that this put on him to survive in the group. He was expected to play through injury and "live up to the same standard as them because you are competing with them". Another participant noted, "When we started to play, everyone was like, 'You have a headache? Get the fuck in and go!' and 'If you are able to walk, you are able to play'". Failing to live up to standards set on the team appeared to be received negatively— males who are injured or appeared not to be tough are labeled "wimps", "sissies", "girls", or "pussies". Similar to stigma theory, labels have a specific purpose and, used this way, they are intended to challenge masculinity (Adams et al., 2010).

Playing through injury and accepting pain is reflective of Sabo's (1999) pain principal. For the most part, players justified or defended health opposing behaviours (Courtenay, 2000b), saying it was just a part of the game. Taking the "white pill" and "tons of painkillers just to play" or hiding concussion symptoms from the athletic therapists were justified by the fear of letting teammates down. Others boasted about playing through injury and displayed these behaviours like "badges of honour" (Courtenay, 2000b, p. 1389):

> I tore my shoulder in 2009 […] It was terrible. For the first two games it sucked. I remember coming back and thinking to myself, "How am I going to do this?" But I just played because they needed me to play, pretty much. And that is what I did. It was okay after the first two games. But it was really bad— I couldn't hit anything with this shoulder. And I tore my hip in 2010, so that kind of sucked but I still played with it. I

know I can deal with it but I am sure there are players who can't deal with it. They don't understand the severity of it.

Participants who were more willing to play through injury tended to demonstrate more reluctance towards asking for help and a displayed greater self-reliance. One said, "I didn't want to take any help. I tried to do it all by myself—that whole alpha male thing […] it's your pride". For some players, maintaining this sense of pride and confidence also meant being the stronger man and physically dominating others on the field: "[…] you feel good about yourself. 'I am better than this guy, I know I am.' It is hard to equate that outside of football".

Physical capital. In a similar vein, the body was found to be instrumental in constructing and projecting images of masculinity (Coles, 2009). The male body's size, speed, shape and use were all important in this process. In other words, a man's amount of physical capital greatly influenced the amount of masculine capital he had (Coles, 2009). One participant noted that his body was a large part of his identity as a football player: "[it's] visible just in the way you act, your physical stature, everything else. It exudes. People grab that right away. It just comes out". Similarly, one participant described a professional football player as " a specimen [because of] the way he is built and just his muscles, size, speed, just everything". Physical capital in this sense is easily projected and becomes part of that person's social identity.

The body could further be considered as a tool to achieve certain ends. Trujillo's (1999) media analysis of *ABC's Monday Night Football* concluded that football player's bodies were considered to be "tools" and football was the "work". While this finding could be linked to several participants' expression of masculinity, it can also be seen as a strategy to show commitment to the team. One participant noted, "It doesn't matter what is going on with their bodies, they are going to bleed for this team and they are okay with it." Another said, "Some

guys have things to prove, to prove to themselves or prove to the team. So they will go that extra yard to do it and sometimes it's not beneficial for them because they end up getting hurt". Similarly, one player found that increasing his physical capital could be used as a valuable resource for gaining acceptance on the team: "I was nervous to play football with these guys. I was really weak […] I was around, with my head down. Then they talked to be a bit more and I was like, 'They kind of like me, they know my potential so maybe I will start working out, get stronger, I can see where this is going now".

Steinfeldt et al. (2011c) found that football players' drive for muscularity was mostly performance-related. Given the competitive context within in which these males live, it was not surprising that performance and winning were highly valued by the participants. However, it seemed that the value placed on performance via physical capital produced a physical prejudice in sport that others have criticized (Schwenk, 2000). The participants unanimously agreed that this was the case in football. One participant noted that, "If you have a broken bone or a torn muscle you can't really perform, but if you have a mental illness you can still perform. I mean you are not totally in the mental state, you are not totally aroused, but you can still get some performance out of a person".

In addition, many participants made comments about the visibility of physical injuries, which made them easier to understand, accept and treat, thus increasing the value placed on physical capital. The increased value on physical capital did not go unnoticed by players. One participant asked rhetorically, "At the end, and this is another issue with football players, are we here just as a piece of meat to sprint fast and tackle people? Or are we a person who plays football?"

A particularly interesting finding was the role that physical capital and masculine capital

played in facilitating discussions around mental health. For example, when shown the NFL Lifeline Video featuring Hall-of-Famer Michael Irvin, the majority of participants agreed that this was an appropriate person to discuss highly stigmatized issues. Collectively, participants highlighted the physical and masculine capital of Irvin— dominating physical presence, intense message conveyed with a deep, male voice, and his overall tough, masculine appearance. Irvin's credibility was further increased by his personal experiences with mental health problems and his success on the field in spite of this. As one participant observed that "you need someone who has succeeded to talk about [mental illness] because you don't want people to think about failure and [mental illness] at the same time[…] You need serious people that the peers, the teammates, the players, and the friends of the players see as a tough guy talking about mental illness". This finding is similar to the *Real Men, Real Depression* campaign evaluated by Rochlen, Whilde, and Hoyer (2005) which used very traditionally masculine spokespeople to link health and masculinity. While the authors noted that such a strategy may not be well received by non-traditional men, all participants agreed that Irvin or someone with a similar background would be a good candidate for message delivery.

Challenging masculinity. Some participants challenged the stereotypes associated with men and appeared to use football as way to reconstruct the meaning of masculinity (Courtenay, 2000b). For example, one participant noted:

> People get the wrong impression. They see me and they think I am probably mean, I'm not a nice guy, all sorts of different labels are placed on me until people meet me and then they see me differently. I play hard, on the field I am a machine the way I play but off the field, I don't go party with the guys, I kind of keep to myself, I like to do my own things, I don't want to be part of that group think – not because I don't want to be part of

> the group – but because I'm here for football and school. I'm not here to do *that sort of stuff*. I don't like confrontation and there are a lot of times where guys in the team can get in these fights when they go out. I don't have the mental – not that I don't have the mental strength, but I get all tense in those situations, I don't know what to do. Am I going to fight? Or am I going to run? Fight or flight experience."

These findings are similar to Courtenay's (2000b) contextualization of men's health. He noted that, "On the football field, a college student may use exposure to injury and denial of pain to demonstrate masculinity, while at parties he may use excessive drinking to achieve the same end." (p. 1393). In this particular case, the participant chooses to reconstruct his masculinity by opposing stereotypical behaviours associated with men and college football players such as drinking and fighting. The fact that this participant "plays like a machine on the field" may compensate for prioritizing school and refusing to conform to group norms. On the other hand, another participant believed, "That guy who prioritizes school doesn't understand football fully—he is the one who messes up all the time versus the one who has the heart who would grind through everything". This statement was echoed by another player who admitted that his priority in school might lead others to perceive him as "soft", "[…] they will say, 'Oh, that's an intellectual guy who has good grades. He is not really a tough football player', which I know I am […] I know I can do work".

Other instances of masculinity non-conformity existed throughout the interviews. One participant comfortably stated that he cried in public and was emotional with family, friends and other men, while another reported that within the field context, it was okay to be affectionate with teammates. Off the field, however, "You are being observed by people in society, so you try to conform to the way things are". The context of football in which athletes can explore different

masculinities was echoed by both Steinfeldt et al. (2009) and Schrack-Walters et al. (2009)

Many of the players were hopeful that social expectations for men are changing and becoming more relaxed, but recognized that it will take a lot of work. One participant noted the challenge that men face as a result of changing social roles:

> We are always caught between this pulling, between going here versus going here. And in our society now because women are starting to become more powerful in a lot of ways, men are still fighting to be men, we are still trying to be these sources of power and control, but at the same time we are coming to grips with the fact that we can be weak sometimes, if you want to call that being weak. We are able to break down. Real men cry, in other words, but the stigma here is that no, men don't cry, don't get hurt, we are unemotional, we are machines.

This example reflects the gender role conflict studied extensively by O'Neil (2008). This participant is expressing the difficulty traditional men face as power roles and gender roles in society begin to change. As a reminder, GRC was specifically linked to anxiety, depression, and stigmatized attitudes towards help-seeking (O'Neil, 2008).

In sum, the findings and literature pertaining to masculinity mainly position opposing health behaviours as tools to succeed in a football context. However, it could be suggested that these learned behaviours in a football context could contribute to unhealthy behaviours outside the football world and after retirement. On the other hand, given the increasing incidences of non-conformity and a potential shift occurring within the football culture, particularly with regards to concussions, masculinity within the football world may be evolving. This has implications for the topic of mental health problems and illnesses, which have traditionally been stigmatized as a weakness because of the conflict with traditional masculine norms. However, as

norms begin to shift and health behaviours become associated with maleness, it may help to decrease the stigma associated with mental health problems and illnesses, and help-seeking.

Diversity in football players. Similar to the findings of the recent body of research conducted by Steinfeldt and colleagues which concluded that college football players were a heterogeneous group when exploring help-seeking stigma, athlete identity, and conformity to masculine norms, participants in this thesis also appeared to be a relatively diverse group of men with varying beliefs and attitudes about the major themes explored.

Steinfeldt and colleagues (2009, 2011a, 2012a, 2012b) discovered significant percentages of NCAA football players who demonstrated high levels of gender-role conflict, high levels of conforming to masculinity norms, and high levels of stigma towards psychological help-seeking. The qualitative data from this thesis, while by no means statistically significant, complements the work done by Steinfeldt and colleagues. The data showed some patterns and trends that could suggest 3 out of 8 participants have higher stigmatizing attitudes, not necessarily towards mental illness itself but towards the stereotype that mental illness is a weakness. These same players tended to conform strongly to masculine norms such as winning, emotional self-reliance, and risk taking (playing through concussions and serious injuries), and correspondingly, were more reluctant to seek help, psychological or otherwise. These players also had strong athletic identities, with one seeking to play professional, the second saying he would give up 20 years of his life to play another season, and the third, who attributed much of his identity to his football life (i.e. “My growth has been through the football team” and “I am with my football friends all the time”). This strong athletic identity was linked by Steinfeldt and colleagues (2009) to gender role conflict and stigmatized attitudes towards seeking psychological help.

In sum, these findings support the literature pertaining to the heterogeneous nature of football players, contribute to a shift in the way some males think about mental health, masculinity, and help-seeking, while simultaneously reminding researchers that this group of men are important to keep within the scope of mental health promotion.

Social Capital

Collectively, it appeared that the participants had a relatively well-developed network of social resources that they could access. Outside of the team, family and friends were often cited as sources of support. The perception of having support was of great importance to many of the players and indicated a greater propensity to access support, as well as increased positive psychological states (Kawachi & Berkman, 2001). One participant said, “I feel like if I ever have a problem, my mom is there for me. She is going to find a way to help me. That helps me a lot […] It just makes me feel better”. Another participant said, “It’s just a cycle of positive correlation—if you know that there is somebody out there that cares about you, cares about how you feel, then it’s just like having something to fall back on”.

Within the team, which participants often referred to as a “family” or a “brotherhood”, most participants named 2-3 players with whom they were very close. Team leaders were recognized as critical to developing an environment where younger players perceived that they had resources: “It does help you feel you have a support system so even if it is the little guy and no one really talks to him, I am sure if one of the more prominent figures on the team were to come up and say, ‘Hey, what is going on?’ That would probably right there would give them help, boost them up in a lot of ways”.

Creating this environment might become all the more important for players who do not come from a tight family or support network. Consciously building these networks is reflective

of Bourdieu’s (1986) work in capital theory. One participant attested to this idea and pointed out that it takes conscious effort to create and maintain these relationships, especially when you are no longer linked by football:

> We need to be a family because you really are. When you break it down, on the field you get hurt, you mess up on a play, people are like, “Forget about it man, its okay. Pick it up, get out there, do it again”—slap you on the arse and you get out there again. But off the field, a lot of guys… I may not go out with all the guys all the time, people ask me [why not] and I say, “It’s not for me. I don’t need to be there”. But it doesn’t mean I am not there for you or they won’t be there for me if I have an issue. I know guys on the team, certain people I can talk to if I need to […] you don’t just need to be on the field to help one another, you need to be off the field helping one another because a lot of these guys don’t even have family. When you think about it some of these guys don’t come from the greatest of backgrounds, so they may not have that support system outside of football, and so for them, football is that support system. That is their life. That is their family. That is their every being and the reason to continue their lives, so when you leave and you cut off contact with these friendships that you have built over a long career, you are alone again. So it is imperative that you keep those relationships, I think.

Some participants didn’t show as much dependence on the team to the extent described in the above example; rather, they had built up strong relationships with people outside of the team, which was perceived by players to be beneficial in a post-football life.

Coaches who held a father figure role (Messner, 1992) were seen as important in creating a supportive environment on the team, but were often last resorts for help-seeking— most players reported turning to family, friends, and teammates first. This finding is similar to that of

Naoi et al. (2011) and confirms the help-seeking preferences of male athletes.

Collectively, these findings demonstrate that most of the participants had a strong support network on football team or otherwise at which could contribute to their individual positive psychological states (Kawachi & Berkman, 2001). Moreover, involvement in a social group like the football team could be an indicator of participants' greater propensity to access supports. As noted by Cohen and Wills (1985), the functional aspect of social capital plays a moderating role in terms of dealing with stress. It could be suggested that teammates going through similar physical and mental stresses together (football, school, social life, financial issues), develop reliance on each other for support.

Chapter 5: Game Changer Strategic Communication Plan

This chapter comprises Phase II of the thesis project and uses the inductive evidence gathered in the previous chapters to propose a tentative strategic communication plan (from here on referred to as “Game Changer”). The first section of this chapter will review literature regarding recent efforts to promote mental health to men. Next, Rogers’ (2003) diffusion of innovations theory will be reviewed and applied the proposed plan. Following this, the key audience, the overall outcomes, short term/intermediate outcomes and the communication strategy will be explicitly stated. While not every element of a communication plan could be included given the scope of the thesis, this chapter does attempt to outline the tactical plan, which includes elements of framing theory and specific drivers. This will be followed by an explanation of a web-based mental health resource and other tactics supported by inductive evidence. Finally, suggestions for the future evaluation of the Game Changer components will be made.

Marketing Mental Health to Men

Clearly health communication researchers face various complex issues when it comes to marketing mental health to men, particularly men who adhere to traditional views of masculinity. That said, some research indicates that men may be responsive to alternate forms of marketing mental health. For example, Robertson and Fitzgerald (1992) explored the preferences of 435 male college students concerning personal counselling. The study concluded that men with highly masculine attitudes preferred alternative helping formats to traditional ones. In other words, these men responded more favourably to brochures emphasizing self-help, technical competence, and an achievement orientation over a traditional description of counselling (e.g., as the expression of personal feelings).

Rochlen et al. (2005) critically examined the *Real Men, Real Depression* campaign developed by the National Institute of Mental Health, which was released in 2003 and sought to inform men, as well as the general public, on the occurrence and characteristics of depression. The authors noted several strategies that were vital to delivering sensitive information to this population. First, the campaign focused on "male-based depression", describing the ways in which men may experience depression differently than women through such activities as substance abuse, risk-taking behaviours, severe social isolation, aggression and violence, and sexual misconduct and promiscuity.

The second strategy was countering the link between femininity and help-seeking. To do this, the campaign established a traditionally masculine peer reference group to act as spokespeople. This group comprised alpha-male prototypes such as paramilitary and military men giving testimonials about their struggles with depression. Rochlen et al. pointed out that such a hypermasculine reference group may not resonate with non-traditional men. In the ads, the spokespeople recounted how they sought help in crisis situations (i.e. losing one's job, families, contemplating or attempting suicide). Rochlen et al. noted that this rhetorical strategy works because it "successfully [avoids] threatening male audiences with a highly protherapeutic stance [and] gently [challenges] audience members to seek treatment before they get to the point of becoming suicidal, jobless, or emotionally incapacitated" (p. 191). The authors point out, however, that this approach may deter help-seeking in men experiencing less severe symptoms of depression.

Finally, the campaign reframed the action of help-seeking by challenging men to use their courage to ask for help. This message aligned positively with traditionally masculine men's competitive and success-orientated natures (Rochlen & Hoyer, 2005). However, Rochlen et al.

(2005) question whether or not this strategy so closely aligned with traditionally masculine norms "ultimately reifies, rather than challenges, restrictive gender roles" (p. 191). In other words, this strategy may be problematic depending on how masculine gender roles are presented, and should not be used without considering all the angles and potential repercussions on the target audience.

A second relevant initiative reviewed by Rochlen and Hoyer (2005) was called *Tackling Men's Health* and was released by the National Football League (NFL). The initiative sought to provide information about both physical and mental health issues affecting men. The authors looked closely at the linguistic techniques (metaphors) used on the website and noted, "The site uses terminology relevant to sports, athletics, competition, and planning to convey its messages. For example, the words 'coach's corner,' 'game plan,' and 'playbook' appear in each of the health links" (p. 681-82).

In 2012, following the suicides of several high-profile NFL players, the NFL provided a grant to launch the *NFL Lifeline* website, which is described as, "A free, confidential, and independently operated resource that connects callers with trained counselors who can help individuals work through any personal or emotional crisis" (NFL Lifeline, 2012). The website hosts videos featuring current and retired NFLers encouraging the viewer to seek help, accept help and to use the resources available. An evaluation of this resource is not yet available, although Thomas Insel (2012), Director of the National Institute for Mental Health, noted that the NFL Lifeline is modeled after the *Military Crisis Line,* and that crisis lines have been shown to be effective in reducing caller distress.

Lessons from these findings indicate that selecting approaches that highlight self-help, technical competence, and an achievement orientation, use male reference groups to normalize

issues, and use appropriate language may be effective in communication mental health promotion to male athletes.

Diffusion of Innovations Theory

Developing a health communication plan to achieve attitude and behaviour change, and overall societal change, requires selecting the most appropriate theory to guide the design. The following section will explore and provide arguments justifying the selection of Rogers's (2003) diffusion of innovations theory.

According to Rogers (2003), *diffusion* is a process whereby an innovation, or "an idea, practice, or object that is perceived as new by an individual" (p. 12) is communicated via "certain channels over time among the members of a social system" (p. 5). Thus, the process of diffusion consists of four central elements of 1) a new *innovation*, 2) *communication channels*, 3) *time*, and 4) the *social system*.

Innovation. In this thesis, the innovation can be contextualized as a "new idea" about mental health—guided by Keyes (2002) theory—that mental health is the presence of symptoms of emotional, psychological and social well-being and may in fact coexist with mental illness. This new paradigm challenges the notion that mental health is simply the absence of mental illness. Such a dichotomous way of thinking about mental health and illness is oversimplified which aids in the perpetuation of stigma.

The rate at which football players adopt this new idea is regulated by several characteristics of the innovation as explained by Rogers (2003). First, the *relative advantage* refers to the idea that the innovation is better than the existing idea. For example, the relative advantages of having complete mental health include greatest benefits in day-to-day living and the highest psychological functioning and protection against future mental illness (Keyes, 2007).

Second, *compatibility* refers to what degree the new innovation aligns with existing values, past experiences, and needs of potential adopters. For example, the research shows that mental illness and seeking help for psychological issues is generally incompatible with the values of most male athletes in a high contact sport like football. According to Rogers, this incompatibility will slow down the adoption rate. Therefore, such incompatibility will be anticipated in Game Changer.

The third characteristic of the innovation, *complexity*, refers to how difficult an innovation is to understand and use. From a communication perspective, the creation of the messages and the channel through which it is delivered is critical to how quickly that idea will be adopted.

Next, *trialability* is the degree to which an innovation may be experimented with on a limited basis. This characteristic refers more to the adoption of new technologies, while the innovation in this context is primarily a new idea. However, trialability can be applied to the communication tools utilized to diffuse the messages. Taken this way, an Internet resource for football players as an example could aid in the adoption of the new idea because it allows the players to experiment with new ideas and resources with minimum risk and in a private setting.

Lastly, *observability* refers to visibility of results of the innovation. In other words, if the innovation has tangible, visible benefits, then adoption is more likely. Applied to mental health promotion, this could mean highlighting statistics and success stories featuring a role model for that group.

Communication channels. Rogers defined a communication channel as “the means by which messages get from one individual to another” (p. 36). This can include mass media channels (radio, television, newspaper), which are effective in diffusing knowledge to a large

group; interpersonal channels, which are connections between two or more individuals exchanging ideas; and interactive communication via the Internet.

While interpersonal channels remain important—especially in a team environment where members spend extended amounts of time with each other—interactive channels via Internet are important to consider. For example, in 2009, 59% of Internet users aged 16 to 24 in Canada reported using the Internet for searching for medical or health-related information (Statistics Canada, 2011). Additionally, Internet use among university educated Canadians is very high at 95% (Statistics Canada, 2010). Of note, 97% of individuals aged 16-24 years reported using the Internet for email, with 75% downloading or watching movies or video clips, and 91% using social networking sites (Statistics Canada, 2011). Collectively, these statistics demonstrate that Internet use among university students is high with a preference for social media, video consumption and email, and that health-related searches are prevalent in younger Internet users. Given the demographic profile of varsity football players, interactive communication via Internet appears to be a major communication channel.

Web-based health resources have increased significantly since the emergence of the Internet (Schiavo, 2009). Skinner, Maley and Norman (2006) noted the advantages of using information and communication technology (ITC). Specifically, these included "interactivity, use of active learning methods, multimedia presentation, temporal flexibility, relative ease of tailoring, and low costs" (p. 407). Some barriers to Internet access were income, level of education and language (Skinner et al., 2006). Justification for adopting a web-based resource for Game Changer is presented later in this chapter.

Time. The third element of the diffusion process is time. Social change is preceded by individual change, which occurs over time and follows a five-step process outlined by Rogers

(2003). The process is described as follows: 1) *Knowledge* is gained through an individual's awareness and basic understanding of the innovation; 2) *Persuasion* occurs when this individual adopts either a favourable or unfavourable attitude towards the innovation; 3) *Decision* encompasses the stage whereby the individual participates in "activities that lead to a choice to adopt or reject the innovation" (p. 20); 4) *Implementation* is a turning point in the process where the individual actively uses the innovation; and 5) *Confirmation* is the last step where the individual "seeks reinforcement" (p. 20) that they have made the right decision to adopt the innovation. It is important to understand this process in order to devise different tactics to move individuals through each stage.

Social system. Finally, Rogers defined a social system as "a set of interrelated units that are engaged in joint problem solving to accomplish a common goal" (p. 37). This element deals largely with how the "structure" of the social system affects the diffusion of the innovation. Social structure according to Rogers is similar to a hierarchy, whereby the lower ranking individuals are expected to follow the directions and example set by the higher ranking individuals. Within a football team, hierarchy is established by seniority. In other words, the more senior players are established as the leaders or team captains, while the first and second year players must earn and find their place within the team structure. Within this broader structure, there is a smaller communication structure involving "homophilous sets of individuals [that] are grouped together in cliques" (p. 24). On a football team, these smaller homophilous groups can exist because individuals are grouped by position (i.e. offensive linemen, receivers, defensive linemen, etc.) and they share similar attributes, beliefs and experiences. The qualitative interviews confirmed the existence of these homophilous sets, and more importantly, the importance of interpersonal communication within the sets. For example, one participant said,

"The offensive line group is the most connected group on the team… We'll talk with other people but we talk about it within our own group because we want our unit to be as strong as possible." Understanding how the social and communication structure operates within a team has important implications when determining rates of adoption.

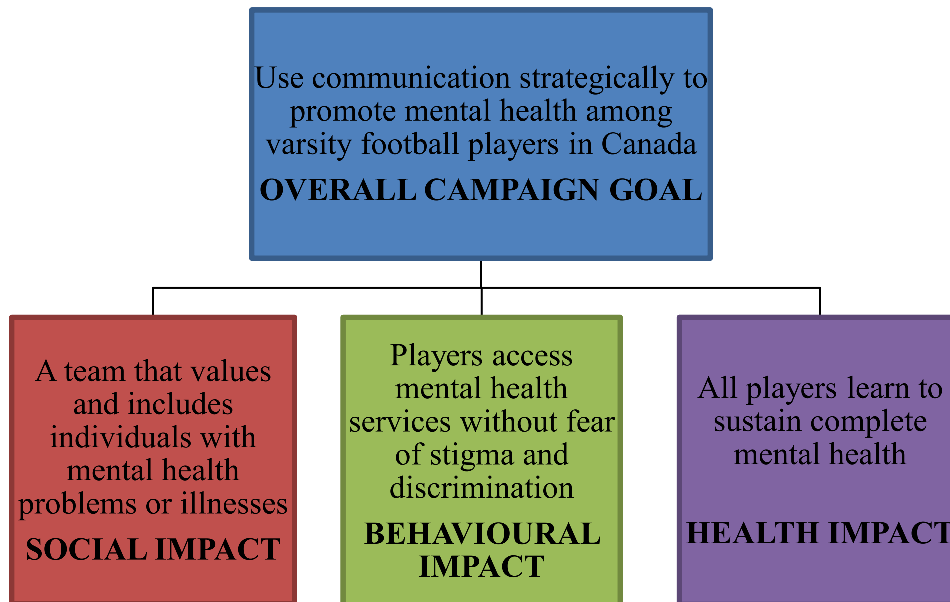
The diffusion of innovations theory relies largely on the communication of new ideas among individuals, and not everyone will adopt the new idea at the same time. Rogers discussed the idea of "adopter categories", which include *innovators*, *early adopters*, *early majority*, *late majority*, and *laggards*. In the context of this thesis, early adopters could be considered to be of utmost importance. These individuals are "localites", meaning they inhabit the condition under exploration (i.e. the football team). They are considered to be "role models" and are defined as successful and respected, with "the highest degree of opinion leadership" in their respective social system (p. 283). Other individuals who are considering adopting the new innovation look up to early adopters. Within a football team, these individuals would generally be team captains who have achieved status and success on the team, and with that, the respect of their teammates. In returning to the idea of homophilous sets of individuals, it may also be effective to recruit a leader from each sub group to aid in the launch of the innovation, regardless of captaincy.

Key Audience

Shiavo (2009) noted that the primary audiences of a health communication program are the people the program seeks to influence, while secondary audiences are "all individuals, groups, communities and organizations that have an influence on the decisions and the behaviours of the primary audiences" (p. 243). Given the commonality of mental health issues in university aged males and athletes, the primary audience of this health communication program are young men currently playing varsity football in Canada. The scope of this health

communication plan dictates resources to be focused on the primary audience—players and their teammates. The following Figure 2 outlines the Game Changer Strategic Communication Plan overall goal, and the second level social, behavioural, and health impact for this key audience.

Figure 3: Game Changer Strategic Communication Plan Goals and Outcomes



Both the social impact and behavioural impact are designed to address the stigma that contributes negatively to the experience of having or seeking help for mental health problems and illnesses. The health impact, on the other hand, is directly in line with Keyes's (2002) promotion-protection approach to maintaining good mental health and reducing the likelihood of developing mental illness.

Short Term/Intermediate Outcomes and Communication Strategy

The following outcomes are tentative and are expected to be measurable after a year piloting phase with a relatively small sample (2-3 varsity teams) before a national launch. The following statistical expectancies are based on a sample of that size. Additionally, the following

are only short descriptions of expected outcomes. Objectives and impact are explored more thoroughly in the evaluation plan at the end of the chapter.

- By end of pilot phase, increase awareness/knowledge surrounding mental health problems and illness, and contribute to a more holistic understanding of mental health in 50% of sample;
- By end of pilot phase, increase the saliency of mental health and work towards levels of high involvement in 20% of sample;
- By the end of pilot phase, decrease stigma around professional help-seeking for psychological problems in 15% of sample.

A communication strategy is the guiding statement that helps to achieve the short-term and impact outcomes, and shape the tactical plan (Shiavo, 2009). Coffman (2003) noted that a common misconception in many communication campaigns is the belief that simply educating the public about a topic will catalyze change in their attitudes or behaviours. This is especially true given the information-saturated environment in which we must compete for the attention of our audience. We must therefore move beyond the dissemination of information and compel the audience to adopt and act on a new idea. Therefore, the promotion-protection approach was selected over a solely prevalence-focused approach because it promotes positive psychology, targets the entire population (not just those currently with mental illness), and outlines specific, tangible elements that can be drawn upon to build proactive communication messages about mental health. It should be noted, however, that the proper diagnosis and early treatment of mental illness by health professionals is still important. Thus, Game Changer will combine the promotion-protection paradigm with efforts to encourage professional help-seeking. The communication strategy is as follows:

"The 'Game Changer Mental Health Strategic Communication Plan', in partnership with governing bodies in varsity athletics, creative professionals, and mental health experts, will combine the promotion-protection mental health paradigm with strategic efforts to encourage professional help-seeking for mental health problems and illnesses in Canadian varsity football players."

Framing

To effectively concentrate the findings and theory thus far into a coherent tactical plan, elements of framing theory were adopted. Hallahan (1999) offered the following as a way to envision the role of framing: "The framing metaphor is best understood as a window or portrait frame drawn around information that delimits the subject matter and, thus, focuses attention on key elements within" (p. 207). Given that the subject matter explored so far is complex as it deals with "underlying psychological processes" that individuals use to construct their social reality (p. 206), it is necessary to "select some aspect[s] of perceived reality and make them more salient in the communicating text" (Entman, 1993, p. 55). In short, framing essentially involves narrowing the scope of the information and directing the audience towards the 'bottom line' of Game Changer.

Hallahan (1999) outlined seven different framing models with various strengths and uses; however, in the context of this thesis, the "framing of issues model" is adopted, and focuses on the way a public health issue is presented and how this influences the affected group. Within issues framing, Snow and Benford (1988) noted three distinct framing processes. *Diagnostic framing* refers to the "identification of an event or aspect of social life as problematic or in need of alteration" (cited in Hallahan, 1999, p. 219). *Prognostic framing* attempts to solve the problem and map out a plan to achieve this end. Thirdly, *motivational framing* represents a "call

to action" and the "rationale for engaging in ameliorative or corrective action" (cited in Hallanhan, 1999, p. 219). In other words, this model creates a "causality chain" and answers three questions to provide the central argument of the plan: what, how and why? (Nahon-Serfaty, personal communication, February 27, 2012). Thus, mental health promotion for varsity football players will be framed in the following way:

WHAT: Varsity football players learning about complete mental health, which includes symptoms of social, emotional and psychological well-being, and may exist in conjunction with mental illness.

HOW: Taking control of your mental health can be done through education and awareness, assessing your level of mental health symptoms and seeking out help when appropriate, and learning how to increase mental health symptoms.

WHY: Developing high mental health symptoms will help protect against future mental illness, manage and perhaps decrease existing mental illness symptoms and ultimately lead to a high quality of life.

Mental health is framed positively by highlighting the relative benefits (Rogers, 2003) of adopting a promotion-protection stance. The decision to assume positive over negative framing is supported by research exploring the relationship between persuasion tactics and the audience's level of involvement with an issue. For example, Maheswaran and Meyers-Levy (1990) conducted a study with 98 undergraduate students to determine the correlation between negative and positive messages and people's level of involvement with a health issue. Based on previous research, they hypothesized that participants who had high involvement with a health issue (i.e. personal relevance, perception of high-susceptibility, and importance) would experience greater persuasion through negatively framed messages and, in contrast, that participants with low

involvement would experience greater persuasion through positively framed messages. This hypothesis was supported. The authors concluded that when an issue more directly affected the individuals, they took negative information more seriously, and were persuaded to take action. On the other hand, when issue involvement was low, individuals essentially did not work as hard to understand and integrate messages. Specifically, the authors found that these low involvement individuals "refrained from processing the message in detail, and instead based their attitude on simple inferences" (p. 366) such as attractiveness, credibility and prestige (Petty, Cacioppo, & Schumann, 1983). In sum, understanding the audience's level of involvement with a health issue is critical when deciding which appeals will most effectively communicate Game Changer messages.

At the broadest level, Game Changer will work under the assumption that the majority of players have low-involvement with mental health based on several patterns derived from the primary data and the literature. The following summary of the inductive evidence supports this assumption: athletes tend to have expectations of high mental strength and, therefore, perceptions of low susceptibility to mental illness; mental illness is publicly stigmatized as a weakness, which conflicts with stereotypical masculine and athlete values; mental illness is sometimes viewed as a crutch to justify lack of willingness to compete or train in the athletic domain, or to explain bad life decisions; and help-seeking for psychological issues is perceived negatively by the male population. These findings demonstrate that psychosocial factors contribute greatly to low involvement. Therefore, messages in Game Changer should follow positive framing to attract low-involvement players. On the other hand, Keyes' (2002) mental health continuum theory advocates for increasing mental health symptoms, which is primarily the responsibility of the individual and implies a higher level of personal involvement. Thus, the first level of

messaging will be framed in a way that resonates with low-involvement players, but will move towards a framing that seeks to increase the involvement of players.

In sum, Game Changer's central argument is that athletes have the ability to take control of their mental health through education, self-assessment, and resources to achieve complete mental health. Future mental illness could be developmentally interrupted by cultivating these protective factors, and existing mental illnesses may become more manageable as issues become better understood, less stigmatized, and properly diagnosed and treated.

Drivers

Framing is used to develop the communication plan's central arguments; however, it is important to identify which drivers can be used to support those arguments (Nahon-Serfaty, personal communication, February 27, 2012). The research shows that certain aspects of masculinity are dominant barriers to adopting healthy behaviours, to help-seeking in certain contexts, and simultaneously, that they play a role in exacerbating the stigma that already exists around mental health problems or illnesses.

Courtenay (2004) noted that while traditional masculinity is associated with the abovementioned issues, there are certain "masculine-identified characteristics" (p. 67) that can be highlighted to promote healthy behaviours such as acting independently, and being assertive and decisive. This means that aspects of masculinity are important, valued and potentially effective in driving Game Changer's creative platform. Findings from Mahalik et al. (2007) further support this statement: the authors suggested that interventions for health promotion to men should attempt to modify "men's masculine-related cognitive schemas" (p. 2207). Thus, messages should be designed to reflect the most prominent masculine values in athletics such as winning, competition, performance, strength, power (Richman & Schaffer, 2000) as well as

toughness, resilience, and brotherhood, ultimately making the messages audience-appropriate. However, based on the cautionary advice from Rochlen et al. (2005) messages will have to be careful not to reinforce restrictive gender roles. Similarly, several of the studies by Steinfeldt and colleagues (2011a; 2012b) suggested that sport psychologists should design messages and educate athletes and coaches about the way masculinity socialization is operating within the sport of football, thereby enabling athletes to internalize positive messages and refuse maladaptive messages about being a man.

The use of a male role model as a spokesperson is expected to be an effective driver. Findings from the interviews confirmed that traditionally masculine athletes with physical and masculine capital, credibility, and success were the most appropriate option to facilitate discussions around mental health. Additionally, a spokesperson who fits these criteria implicitly supports several approaches to mitigating barriers located in the social psychological processes of help-seeking posited by Addis and Mahalik (2003); in particular, perception of normativeness, ego centrality of the problem, and loss of control. In other words, male athletes who see the men in their reference groups (Wade, 1998) discussing, advising, and dealing with mental health problems may begin to perceive such behaviours as normal, thereby contributing to more favourable attitudes towards mental health and help-seeking. Similarly, using a spokesperson of this nature counters the expectation that someone with such physical strength is immune to mental health problems or illnesses, thereby potentially reducing the threat of the problem to an athlete's ego. In terms of the issue of loss of control, the spokesperson may be perceived to exhibit emotional stoicism, but demonstrates his control of the situation by taking action versus letting his problems control him (Addis & Mahalik, 2003).

Collectively, elements of masculinity used effectively to relate to the audience without reinforcing restrictive ideologies will be ideal for disseminating many of Game Changer's messages about mental health and help-seeking for psychological problems. Consulting with key members of the audience in this objective will be essential.

eHealth Promotion

The formative research indicating traditional males' preference for mental health information that emphasizes self-help, technical competence, and an achievement orientation (Robertson & Fitzgerald, 1992), combined with the Internet consumption patterns of young, university-educated people provides a compelling argument for the development of a web-based mental health resource. In addition, the advantages to this approach (delivery of interventions that are timely, tailored, low cost, and interactive) (Skinner et al., 2006) outweigh the associated barriers typically affecting other populations (low-literacy levels and limited accessibility). However, researchers advocating for the use of web-based health resource have lamented the lack of an "explicit model to guide design, evaluation, and ongoing improvement" (Skinner et al., 2006, p. 406). To theoretically ground the design of Game Changer website the following section will explain and apply the Spiral Technology Action Research model of Skinner et al.

Spiral Technology Action Research (STAR) model. The STAR model is intended to provide practical and theory-based guidelines for health promotion researchers by combining information and communication technology (ICT) development with health promotion principles, behaviour change theories, quality improvement, and community mobilization practices. A strength of the model is the inclusion of the target audience in program design, which not only contributes to their sense of product ownership (Skinner et al., 2006), but also ensures that messages and materials are culturally-appropriate (Schiavo, 2009). In addition,

involving members of the target audience is critical to the technological development of the site—the system must be easy to learn and use (Skinner et al., 2006).

The STAR model consists of a five-cycle process (listen, plan, do, study, and act). Formative research presented in chapters one through three of this thesis denotes the "listen" cycle, whereby the goal was to "interact with the target community and population(s), identify their needs and wants, and understand how the community relates to the technology" (Skinner et al., 2006, p. 409).

The "plan" cycle precedes technical programming and is primarily concerned with designing systems to fit "human wants, needs, and behaviours" (p. 409). In other words, this cycle combines the psychosocial audience profile with a web-based medium to deliver messages. For example, in Skinner et al.'s evaluation of a smoking cessation website, understanding the audience was integral to designing a five-stage guided intervention. This website provided users with information, self-assessment tools, guided self-change, and teaches coping skills and action planning. Drawing from this approach, the website content for Game Changer is described in Table 1. Each component is envisioned and theoretically and/or conceptually grounded.

Next, the "do" and "study" cycles are primarily concerned with the website aesthetics, navigation and functionality, and financial and technological feasibility. While these "iterative cycles" (Skinner et al., 2006, p. 409) would involve the expertise of external partners (i.e. web developers and graphic designers), from a communication perspective, they can be compared to

TABLE 1
Theory Incorporated Into the Game Changer Website

Component	Theory/ Concept
"The Low Down" (Information) Users learn the definition of complete mental health and explore prevalence, signs and symptoms for common mental illnesses for university aged males and athletes in high contact sports: depression, anxiety disorders, addictive disorders, and mental health side effects of concussions. Users gain awareness and basic understanding of certain issues.	**Diffusion of Innovation Theory**— (Rogers, 2003)
"M-Camp"[1] (Self- assessment) Users participate in an interactive self-assessment to determine degree of mental health symptoms and presence of depressive symptoms. The self-assessment uses the same measures as Keyes including emotional well-being, psychological well-being and social well-being, (see Appendix D for description of measures and process) and mental illness. Overall scores categorize individuals as "languishing", "moderate", or "flourishing"; however, these official terms are translated to football terminology (Rochlen & Hoyer, 2005) to be more positive and more athlete specific: "Languishing" will translate to "Rookie: Time to hit the mental health gym"; "Moderate" will translate to "Starter: Son, you've got potential"; "Flourishing" will translate to "Impact Player: Doing great! You can help your buddies". Upon completing the survey, a profile will open with an interactive video of the spokesperson. He will describe what the profile means and provide links to the "Playbook" section dealing with self-change and coping skills. The above categories are for individuals who do not report mental illness. Should a user report high enough symptoms of mental illness, each category would be designed to suggest resources for seeking professional help. For example, if the user reported high mental illness and languishing mental health, the profile might say: "Hit the mental health gym and sign up with a trainer. Here's how." [2] At this point, the user would have the option to arrange a confidential appointment with a mental health professional.	**Mental Health Continuum Theory** (Keyes, 2002)

[1] The Canadian Football League's Evaluation Camp or "E-Camp" is a camp where top CFL prospects perform a series of physical tests to evaluate athletic ability. "M-Camp" is a play-on-words and refers to "Mental Camp".
[2] The website is not intended to replace professional psychological diagnosis and treatment. It is designed as a starting point for exploring mental health. If post-assessment results reveal high mental illness, then users will be directed to appropriate resources.

<table>
<tr><td>E-alerts are sent to players who choose to complete the survey to remind them to perform a mental health symptom check-up every 6 months.</td><td></td></tr>
<tr><td>“Playbook” (Guided self-change and coping skills)</td><td rowspan="2">Mental Health Continuum Theory (Keyes, 2002); Social Capital Theory (Bourdieu, 1986; Putnam, 2000; Cohen and Wills, 1985)</td></tr>
<tr><td>This section links back to the self-assessment and is intended to provide users with activities and resources that can help them increase their mental health symptoms.

Activities and information to achieve this are based on flourishing dimensions of the mental health continuum (see appendix x for description) and strategies for building social capital.

Note: The constraints of the thesis do not allow for a full development of activities and resources.</td></tr>
<tr><td>“Peep This”(Video resources)</td><td rowspan="2">Relational Theory of Men’s Health (Courtenay, 2000b); Physical Capital Theory (Coles, 2009); Male Reference Group Identity Dependence Theory (Wade, 1998)</td></tr>
<tr><td>This section hosts humorous videos challenging male health behaviour stereotypes featuring athletes with high physical and masculine capital.

Other videos include player profiles capturing CIS, CFL or NFL player’s success on the field, intercut with their lives off the field in a mini-documentary style, short three minute film. These are intended to promote diverse conceptualizations of masculinity. Additionally, athletes who are willing to speak about their experiences with mental illness will be featured.</td></tr>
<tr><td>“Questions”</td><td rowspan="2">Participation and interactivity</td></tr>
<tr><td>Users have ability to send in questions that would be directed to mental health experts as a part of the partnership. This component is equipped with a function that allows the user to select whether they want their question and the answer to be published, or if they prefer to have the response sent to them personally.</td></tr>
</table>

the pretesting phase of messages, concepts, and other materials (Schiavo, 2009). At this juncture, audience members would be called on to provide feedback via focus groups and focus testing; Skinner el al. (2006) suggest that as few as six individuals are necessary for this process. Storyboards depicting the video components would also be a useful and low-cost way to present ideas to the audience. These components would be evaluated based on the clarity, relevancy, easy to understand and persuasiveness. In testing web-components specifically, delivery could take the form of non-functioning “prototypes” such as “paper sketch outlines, computer screen images, and/or early versions of the final product” (p. 410).

The final cycle, “act”, involves launching the website after making the necessary changes based on user feedback. Skinner et al. (2006) noted that this stage might involve revisiting previous cycles in the process. This cycle also ties back to diffusion of innovations theory (Rogers, 2003), which suggests that opinion leaders could be important for introducing an innovation into their respective groups. These individuals are highly respected on the team, have gained substantial experience, and are looked to by younger players for leadership. Therefore, a sub-tactic in this cycle involves developing relationships with team opinion leaders to successfully launch the web resource to other players.

Additional communications materials will be developed to complement the launch of the website, notably an introductory video featuring the spokesperson and wallet cards. The purpose of the introductory video using the athletic role model is to get the attention of low-involvement players who will likely respond well to attractiveness, credibility and prestige (Petty et al., 1983) as mentioned in the framing section above. The take-away wallet cards are intended to provide basic, succinct information about Game Changer to the participants.

Potential Partners

Schiavo (2009) noted that a partnership plan contains two thoroughly developed phases. Given the scope of this thesis, a simple description and justification of potential partners (the first phase) will suffice, though in the future a more specific plan would include elements of the second phase such as organizational constraints, a timeline for all partner activities, protocols for decision-making and so on.

Governing bodies in university sport. Canadian Interuniversity Sport (CIS) is the governing body in Canadian varsity athletics. Members of CIS spanning the country include Atlantic University Sport, Réseau du sport étudiant du Québec, Ontario University Athletics, and Canada West Universities Athletic Association. Partnerships with these sport organizations would enable key access to the target population, increase program credibility, and provide funding.

Male health and mental health leaders. Partnering with mental health groups like the Canadian Mental Health Association (CMHA), for example, would provide access to expert knowledge in the mental health field. Additionally, Movember Canada is an organization that supports prostate cancer initiatives and, more recently, male mental health initiatives. In November of each year, the program encourages men to grow moustaches and raise funds and awareness for men's health. The Canadian Male Health Network is a Movember Foundation initiative addressing men's health and the primary focus is men's mental health (Movember, 2013). Partnering with this organization would provide opportunities to "piggy-back" on Movember events, and increase Game Changer's visibility and credibility. Finally, it may be valuable to work with sports psychologists who typically have a strong understanding of athlete

psychology. Partnering with these experts could further help in the creation of tailored messages that resonate with the target audience.

Canadian Football League and/or National Football League. A CFL or NFL endorsed message would increase credibility, reach and relevancy. Additionally, a partnership would allow access to professional athletes who are often idols to amateur players. In other words, professional athletes would be included in the male reference groups (Wade, 1998) that would help deliver messages.

Evaluation Directions

While the STAR model (Skinner et al., 2006) touches on evaluation directions for a web-based resource, a more communication-specific approach is necessary to assess Game Changer's overall effect. It should be noted that while evaluation is valuable in determining the efficiency of the communication strategies, guiding improvement, supporting partnership development and so on, limitations in evaluation do exist. As stated by Shiavo (2009), "It is difficult to make a direct connection between the actual communication program and the behavioural or social outcome" (p. 328). In other words, there are many uncontrollable factors that could contribute to or deter from social/behavioural change. That said, the work by Coffman (2002, 2003) synthesizes the best practices for communication campaign evaluation and is particularly useful; therefore, her work will be relied on heavily to guide the evaluation directions for Game Changer

. According to Coffman (2002) there are four types of evaluation. On the "front-end", formative evaluation essentially precedes the tactical plan or the strategic communication plan's "creative design plan" (p. 13). This evaluation step comprises key elements such as understanding the target audience, identifying strategies, how messages should be framed, determining the saliency of the issue and so on. The majority of the thesis to this point has been

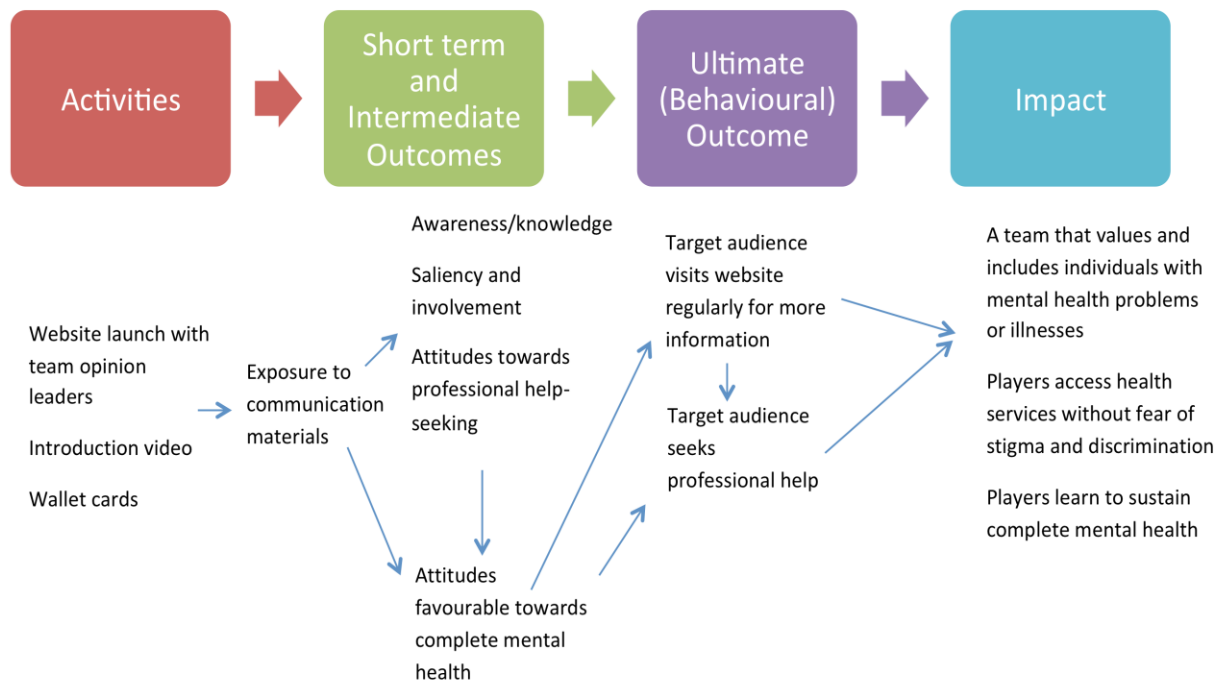
dedicated to this phase. The remainder of this section will focus on “back-end” evaluation types include process, outcome and impact evaluation.

Figure 3 guides the envisioned change process and follows the skeleton of the general theory of change model applied by Coffman (2003) in her evaluation case studies. This model comprises the communication activities, the short-term or intermediate outcomes, the behavioural outcome, and the impact. Additionally, the general theory of change model works well in tandem with the time element of the diffusion of innovation theory, which encompasses knowledge, persuasion, decision, implementation and confirmation. Therefore, Figure 3 represents the application of the diffusion of innovation theory (Rogers, 2003) to Coffman’s (2003) general theory of change model.

As illustrated, exposure to the communication materials should result in increased awareness and knowledge, increased issue involvement and saliency, and affected attitudes towards professional help-seeking. Next is the persuasion stage, where the individual forms a favourable (or unfavourable) attitude towards working on complete mental health. A favourable attitude towards the innovation is expected to lead to decision stage encompassing a trial period where there is a behavioural decision to participate in activities on the website. From here, the individual may adopt the website as a resource to a) work on their mental health symptoms, and/or b) seek professional help for issues they may identify. These latter outcomes represent the implementation stage.

Process evaluation. According to Coffman (2002), process evaluation deals primarily with assessing the delivery of Game Changer materials (i.e. reach and exposure) and is not meant to capture overall impact. This means that for a web-based resource, process evaluation can be

Figure 4: Application of Diffusion of Innovations Theory to Theory of Change Model



accomplished by looking at website traffic including number of hits on homepage or specific pages, time spent on pages, navigation patterns, “hot and cold” content areas, and so on (Coffman, 2002, p. 26). In addition to evaluating the reach and exposure, these measures may also be used as behavioural indicators (Coffman, 2003). Hypothetically, web-partners would be tasked with monitoring these trends and providing monthly reports. Other materials that are implemented after the website launch such as new videos or print ads could be evaluated using the same parameters as pretesting phases outlined in the “do” and “study” segment of the STAR model. Again, specific organizations could be hired to accomplish these tasks.

Outcome evaluation. According to Coffman (2002), outcome evaluation involves measuring the outcomes comprising the “social context around the issue” (p. 21). For example, in Coffman’s (2003) case study of a gun safety campaign, outcomes such as awareness, attitudes, and behaviour were assessed using “three target audience surveys with repeated measures”

implemented pre, during, and post implementation. The sample of the target audience was randomly selected each time.

The outcomes of the Game Changer include awareness/knowledge about mental health, saliency of mental health, and attitudes towards professional help-seeking, and are described below. As with the gun safety campaign, surveys would be designed to measure each outcome, and administered at three different intervals with random samples.

Awareness/knowledge. Coffman (2002) noted that determining the audience's level of awareness regarding an issue is usually done prior to the strategic communication plan's creative design. While the qualitative data and the literature review did reveal that audience awareness and knowledge about mental health was incomplete, quantitative data with a larger sample would provide a greater base with which to compare outcomes during and after implementation. Surveys designed to this end would provide significant data; however, Coffman noted that while awareness could be very high, this may not be enough to compel individuals to take the recommended behaviour. She refers to the issue of smoking: despite the high awareness that smoking causes multiple significant health problems, people continue to engage in this activity.

Saliency and involvement. Very similar to involvement theory discussed in the framing section of the tactical plan, saliency deals with the degree to which the audience cares about the issue. Rather than measure this by assessing the audience's perceived risk of developing mental illness, given the positive approach adopted Game Changer, it would be more appropriate to measure the audience's perceived benefits of working towards mental health. In other words, can they identify what benefits they will receive, and more importantly, to what degree do they really care about these benefits? This outcome would be important for improvement because results may determine if a more negative framing approach is necessary.

Attitudes towards professional help-seeking. Attitude change is often the most common outcome of many campaigns, though Coffman (2002) noted that this outcome could be measured incorrectly depending on the design. She stated, "If a campaign is seeking behavior change by trying to affect attitudes about the behavior, then in order to assess whether the campaign is working, the evaluation needs to measure the attitude *towards the behavior*" (p. 22). Therefore, measures assessing attitudes—or stigma—towards psychological help-seeking should be used in this outcome evaluation. A variety of measures exist for this purpose, one being the Stigma Scale for Receiving Psychological Help (Komiya, Good, & Sherrod, 2000), which assesses perceptions of the stigma associated with receiving psychological professional help.

Collectively, achieving progression in these outcomes is expected to lead to favourable attitudes towards mental health, which will in turn lead to behavioural outcomes such as using the website's main components including the self-assessment, and the Playbook resources.

Impact evaluation. Impact evaluation is considered to be much larger scale or "community-wide", longer term, and is more expensive and resource intensive (Coffman, 2002, p. 24). Coffman noted that assessing impact necessitates experimental or quasi-experimental research designs. Because the Game Changer combines the promotion-protection approach to mental health with efforts to encourage professional help-seeking via stigma reduction, two ways to measure this impact will be suggested.

In exploring Game Changer's impact on stigma at various levels, Vogel et al.'s (2007) study could be useful given the variety of measures implemented. As a reminder, the study showed that perceived public stigma significantly predicted self-stigma, and self-stigma predicted attitudes toward seeking counselling, which, in turn, predicted willingness to seek counselling for psychological and interpersonal concerns. To assess this within Game Changer's

population, it would be helpful to draw from Vogel et al.'s (2007) study using the following measures:

- Perceived public stigma: 12-item Perceived Devaluation-Discrimination scale (Link, Cullen, Frank, & Wozniak, 1987). Participants rate from 1 (*strongly agree*) to 6 (*strongly disagree*) the degree to which they believe statements about how most people view current or former psychiatric patients.[3]
- Self-stigma: 10-item Self-Stigma of Seeking Help Scale (Vogel et al., 2006). Participants rate from 1 (strongly *disagree)* to 5 (strongly *agree)* the degree to which they believe statements like "I would feel inadequate if I went to a therapist for psychological help".
- Attitudes towards seeking professional help: 10-item Attitudes Towards Seeking Professional Psychological Help Scale (Fischer & Farina, 1995). Participants rate from 1(*disagree)* to 4 (*disagree*) the degree to which they believe statements like "If I believed I was having a mental breakdown, my first inclination would be to get professional attention".
- Willingness to seek counseling for psychological and interpersonal concerns: 17-item Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). Respondents rate from 1 (very *unlikely)* to 4 (very *likely)* how likely they would be to seek counseling if they were experiencing the problem including relationship difficulties, depression, personal worries, and drug problems.

Regarding the promotion-protection approach, the tactical plan outlined how once introduced to the website, players can choose to fill out the self-assessment to determine their

[3] The authors noted this measure as a limitation because it focuses on the public stigma surrounding being a former mental patient. To capture the idea of counseling versus help-seeking in a psychiatric hospital, a different scale designed to this end may be more useful.

current level of mental health and mental illness symptoms. For tracking purposes, they would be assigned an identification number and password, which would keep record of their profile, but contain no other identifying information. The measures used to garner a complete portrait of a player's mental state follow Keyes (2009):

- 14 item Mental Health Continuum-Short Form (MHC-SF, see Appendix D for full description of scoring instructions). Three items to represent emotional well-being (happy, interested in life, and satisfied); six items to represent psychological well-being; five items social well-being.
- Mental illness: Keyes et al. (2010) used Kessler, Andrews, Mroczek, Ustun, and Wittchen's (1998) Composite International Diagnostic Interview Short Form (CIDI- SF). It is a 26-measure scale to measure 12-month major depressive episode, generalized anxiety disorder, and panic disorder.
- Respondents will be sent an e-alert after six months to reassess, followed by a third assessment after 12 months.

Combining these two larger scale studies is expected to yield greater results to capture the impact of Game Changer. A necessary direction is to pilot the website, and then conduct the formative, process, and outcome evaluation using a smaller scale audience. This means that costs could be greatly reduced and the website could be improved not only by the quantitative measures, but also by qualitative measures capturing users' personal experiences. Following a one year pilot phase, the website could be re-evaluated and subsequently launched on a national level.

Chapter 6: Conclusion

Chapter six explores the contributions that the thesis makes to future research, policy, and practice. The researcher sought to explore varsity football players' understanding of mental health and illness within an athletic domain, how stigma functioned in an elite competitive environment, and what messages should be conveyed about mental health and how to best deliver them. Using stimulus text to facilitate communication about this stigmatized topic seemed to be particularly effective, and may aid not only in future research exploring male mental health, but also in practical intervention. The strength of stimulus text is that it allows individuals to express their opinions about a delicate topic without committing to a vulnerable state where the focus would be entirely on their personal feelings or experiences. Given what the research leads us to understand about men and their general attitude towards vulnerability and emotional exposure, such an approach may be the most appropriate moving forward.

Collectively, the research findings contribute to and advance literature exploring various aspects of masculinity, and psychological help-seeking and stigma. Notably, the findings help to further illustrate the literature—particularly the work of Steinfeldt and colleagues (2009, 2011a, b, c, 2012a, b) who demonstrated the heterogenous nature of varsity football players. While such research helps to displace common stereotypes about these athletes, more importantly it speaks to the need for more specialized approaches in mental health promotion. While a significant percentage of the samples in the studies conducted by Steinfeldt and colleagues demonstrate that male athletes adhere to restrictive masculine gender-role norms (2009, 2011c, 2012a), identify strongly with their athlete role (2012b), and have highly stigmatized attitudes towards psychological help-seeking (2009, 2012a), the remaining samples in the same studies demonstrated variability in their attitudes towards the aforementioned topics. This means that not

only is the nature of football changing, it also means that there are players on teams who could be instrumental in advancing a positive focus on mental health. The findings and comments made by participants in this thesis imply that creating effective communication to promote mental health and help-seeking (when appropriate) may be increasingly well received at this time and moving forward.

While the quantitative measures and large samples used by Steinfeldt and colleagues were useful in enabling generalization, the qualitative methods used in this thesis provide the reader with a more richly illustrated account of some additional attitudes and beliefs. For example, in the case where one participant expressed reluctance to publicly support his teammate who came out with a mental health problem to the team, his response may have been quantified as simply someone who stigmatizes mentally ill individuals; however, the qualitative approach allowed the participant to justify why he might take that action, and contributed to our understanding of how stigma functions in a competitive team setting. Moreover, the qualitative approach captured the conditions that regulated the acceptance of a mentally ill individual; again, it is unlikely that a quantitative design would have afforded such a rich understanding. Another important finding enabled by both the stimulus text and the qualitative methodology was the use of a masculine role model to talk about mental health and help-seeking. Selecting Michael Irvin, a specific role model who is well known in the football world, to deliver the message was particularly useful to enable observation of the participants' reaction to the video. The follow-up discussion confirmed the expected value of masculine capital and physical capital in football players' reference groups, ultimately leading to the strategic decision to select an individual fitting these criteria to deliver messages.

Implications for Future Research

There are several suggested directions for advancing research in mental health promotion and varsity athletes. As outlined in the evaluation plan, a large-scale impact evaluation could contribute to existing literature pertaining to the mental health continuum (Keyes, 2002), as well as to stigma attitudes in this specific population. This research could potentially inform mental health promotion and stigma reduction in other varsity male team sports, and apply lessons to efforts for female athletes. Based on the literature and the qualitative findings, coaching staff seemed to strongly influence the decisions and behaviours of the primary audience, and therefore, should be considered as secondary audiences in future efforts. Moreover, an independent evaluation of the Game Changer website would contribute to the literature regarding web-based health resources. Lastly, from a communication perspective, an overall evaluation would provide case study material, which in turn has the potential to contribute to health communicators' best practices.

Implications for Future Policy

The qualitative findings from this thesis could contribute to policy changes surrounding mental health in athletes. One of the major findings from the qualitative interviews in this regard was the lack of mental health services for athletes, or perhaps the poor communication of existing services in university settings. Athletes felt that psychological services were there solely for the purpose of improving performance in their respective sport and in the classroom. If athletes are under the impression that these services are there to help them with their performance, this may contribute not only to a reluctance to seek help for non-performance related mental health issues, but also to the belief that mental illness in athletes is not normal. More research and action is needed by sport associations, universities, and government to design

guidelines that prioritize mental health in athletes apart from performance, with more of a focus on long-term well-being.

Implications for Practice

Early interventions beginning in high school might use the Mental Health Continuum Short Form as a screening tool (Keyes et al., 2010) with athletes to predict future mental illness and be used as a starting point in determining areas of well-being (emotional, psychological, and social) to target for development. This approach could be beneficial in developing resiliency to stressful life events, as well as coping techniques (Mental Health Commission of Canada, 2012). Serious elite athletes in high school may go on to pursue athletic careers in post-secondary institutions where the stakes are higher, the pressure to perform in the classroom and in their sport increases, and the need to maintain a social life in a new environment away from home becomes important. It could be suggested that if an individual has languishing mental health prior to this transition, the combination of these factors could increase stress and potentially contribute to the development of mental health problems and illnesses. Therefore, equipping student-athletes with the tools to develop and sustain good mental health (independent of their sport performance) in high school, and as they transition into university, could be valuable in reducing mental health problems and illnesses.

In a similar vein, communication skills training may be a particularly useful avenue to explore in reducing the likelihood of mental health problems and illnesses, as well as increase social capital, especially in male athletes. For example, O’Neil (2008) found that restricted emotionality was the most significant predictor of depression in men. To remind the reader, restricted emotionality essentially describes the fear of or inability to express basic emotion and one’s feelings. Communication skills training may help in this regard as men become more

comfortable not just talking about personal issues, but also actively exploring ways to resolve various problems. One participant made a comment about the value of communication skills training for male athletes. In his interview, he hypothesized that it might be useful to conduct small group sessions with teammates to work on discussing problems or ask questions of other teammates. While he conceded that this may be difficult to implement, and may not be well received at first, he noted that it would be vitally important for these sessions to be conducted by an individual with high masculine capital and physical capital. In addition, many participants in the qualitative interviews noted that "just talking to someone" was a big help in dealing with stressful life events, which was reflected in Cohen and Wills (1985) functional model of social capital. In other words, simply having people to talk to can play a major role in moderating an individual's response to stressful events and perhaps inhibiting eventual mental illness. Finally, specialized training in this area may aid men with limited communication skills to build up their network of resources as noted by Bourdieu (1986).

Limitations. There are several limitations to be noted given the scope of this thesis. The sample of participants was selected from only one Canadian university. Findings may have differed if multiple universities had been used and, in particular, if both Canadian and American universities had been included in the sample. In addition, the sampling method used may have limited diversity in experience as it relied on volunteer participation. In other words, participants who did not come forward may have had greater experiences with mental health problems and illnesses, but elected not to do so because of the stigmatized nature of the topic. Finally, this thesis focused primarily on male football players, whereas it may have been beneficial to explore opinions and attitudes of other male varsity athletes in other centre sports (Messner, 1992) like rugby, basketball and hockey, as well as non-centre sports like track and field or swimming.

This thesis used open-ended qualitative interviews to collect data. It is possible that open-ended anonymous questionnaires would have enabled a greater number of participants, thereby yielding more data. In particular, evaluating the extent to which a person identifies with his social group is important to understanding what shapes his attitudes towards certain issues. This critical element may have been better explored using open-ended questionnaires and a larger sample. Moreover, the gender of the researcher as a female must be acknowledged as potentially biasing the male research sample. However, several participants did note that, had the researcher been male, they would have been uncomfortable expressing opinions about sensitive topics.

In Phase II, there are other significant limitations to be noted. In particular, time constraints and the theoretical focus of this thesis did not allow for a full development of the communication materials outlined in the tactical plan. Secondly, the resource suggested in this thesis is not intended to replace mental health professionals. Rather, it is intended to help players begin to explore and take responsibility for their mental health, and consequently, take responsibility for seeking professional help when they may need it. Given that this is a Master's thesis, all suggestions are limited by theoretical perspectives and by research conducted by others, with contributions from a modest sample of 8 participants at the University of Ottawa.

Final remarks. In closing, this creative thesis joins the conversation around mental health approaches and explores more deeply how stigma functions within an elite varsity athlete setting, but more specifically in a football setting where masculinity has tended to exacerbate stigma around mental health problems and illnesses, and stigma around help-seeking for psychological issues. Despite common perceptions of football players as alpha males, top dogs, and warriors, this group of men is not immune to mental health problems and illnesses. There is a significant body of research demonstrating that male athletes, and particularly those in high

contact sports, face problems with depression, anxiety disorders, and addictive disorders. In addition, the current debate on the health impact of concussions in the NFL has helped to shed light on “invisible injuries” like mental illness.

While highlighting the prevalence of mental health problems and mental illnesses is important to demonstrating the existence and severity of issues, this thesis attempted to move beyond this limited paradigm and work with the idea that mental health is not just the absence of mental illness. That said, the strategic communication plan was designed to operate within the promotion and protection approach, which could potentially complement the target audience’s preferences for self-help, technical competence, and an achievement orientation, as well as increase mental health symptoms and thereby decrease mental illness. Moreover, the strength of the proposed strategic communication plan working under the promotion and protection approach is that it targets all players, not only those with mental illness, which implies exclusion and could contribute to stigmatizing attitudes.

The lack of mental health education noted by the participants spoke to the need for a mental health resource. Based on the research, a web-based resource was selected as the central communication channel to deliver messages. In support of this direction, the web-based resource follows the explicit STAR model implemented by Skinner et al. (2006) to guide design, evaluation, and ongoing improvement. The individual components of the website included information, self-assessment tools, guided self-change, and coping skills and action planning, which are well-suited to the promotion-protection approach advocated by Keyes (2002). In addition to those elements, video components suggested as a complement to this design are intended to displace common stereotypes about male athletes, and mental health problems and illnesses, as well as depict alternative representations of masculinity. The justification for using

masculinity as a central driver was that masculinity was found to play a highly influential role in male's health beliefs and behaviours, including the psychosocial process of help-seeking. Therefore, researchers suggested that positive elements of masculinity be drawn upon to convey messages about health.

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Appendix A: Recruitment Letter

Dear _______________,

I am a graduate student pursuing a Master's degree in the Department of Communication at the University of Ottawa and am conducting research on promoting mental health to varsity football players. With permission from the University's Research Ethics Board, I would like to invite you to participate in an interview to explore your opinions and reactions to campaign message concepts and to elicit your feedback regarding the best strategies to communicate varsity football players. The goal of this research project is to develop a video production that will demonstrate new ways to talk about mental health as it relates to varsity football players.

Your participation will last approximately 75 minutes and you will only be asked to participate in this one interview.

The interview will take place at the University of Ottawa or at Minto Sports Complex. You may be invited to participate as an actor in the video production, but such a decision will be completely voluntary and totally independent from your participation in the study. The nature of the questions posed is such that there is no risk to you, as a research participant.

The answers that you provide in the interview will be tape-recorded and, later, transcribed and printed. Your answers will be treated as confidential, and therefore will be kept in a secure area. Once the data from the completed interviews have been transcribed, any information that could identify you, the individual – for example, your name – will be omitted and will not be used in any of the analyses or subsequent reports or published articles.

I do hope you will agree to participate in this study. If you are willing to participate in the interview, please contact me so that we may set up a time to meet. Please let me know the best way to contact you.

Sincerely,

Samantha DeLenardo, Master's Candidate.
Department of Communication

Jenepher Lennox Terrion, Ph. D., Project Supervisor
Associate Professor, Department of Communication

Appendix B: Information Sheet & Participant Consent Form

Reframing the conversation around mental health for varsity football players

Researcher: **Samantha DeLenardo, Master's candidate, Department of Communication, University of Ottawa**

Please read this Information Sheet and Consent Form carefully and ask as many questions as you like before deciding whether to participate.

Introduction: You have been invited to participate in a research project entitled: *Reframing the conversation around mental health for varisty football players.* The purpose of this project is to develop a video production that will use communication strategies that are relevant to varsity football players regarding mental health. The study will involve you participating in an interview with a researcher at either the University of Ottawa or the Minto Sports Complex. Your participation will last approximately 75 minutes. 10 participants will take part in the study.

Procedure: If you agree to participate in the study the researcher will take 75 minutes to interview you. The researcher will record your conversation on an audiotape.

Risks and Discomforts of Participation: Participation in this study requires approximately 75 minutes of your time to complete an interview with the researcher. There are no known risks to participating in this study.

Benefits of Participation: You may not receive any direct benefit from your participation in this research. Your participation in this study will allow the researcher to gain a better understanding of the varsity football culture, ultimately informing a more accurate and relevant final video production.

Confidentiality: You will not be identifiable in publications or presentations but you may be directly quoted from the interviews in publications or in presentations. Only the researcher will have access to the raw data and anonymity in publications and presentations will be preserved. Interview audio-tapes and transcripts will be kept in the locked office of the principal investigator.

Data gathered during this research study will be conserved for 5 years after any publications that result from it.

Ethics: The Research Ethics Board (REB) of the University of Ottawa has approved this study. The REB considers the ethical aspects of all research projects involving human subjects at the University of Ottawa. If you wish, you may talk to the Research Ethics Board by calling 613-562-5800 Ext. 1787 or at ethics@uottawa.ca.

Participation: **Participation in this research is completely voluntary.** You are free to choose to participate or not to participate in this research study. If you agree to participate in this study, you may choose to withdraw your participation at any time. You may also refuse to answer any specific questions.

Consent to Participate in Research

I understand that I am being asked to participate in a research study to help gain a better understanding of the varsity football culture, ultimately informing a more accurate and relevant final video production.

I have read and understood this Information Sheet and Consent Form. All my questions at this time have been answered to my satisfaction. I understand that there are two copies of the consent form, one of which is mine to keep.

I voluntarily agree to participate in this study.

Participant's Name

____

Participant's Signature

____

Date

____

Researcher's Signature

____

Appendix C: Interview Guide

Demographics

1. When you think about who you are as a person, describe much being a part of a football team shapes your sense of identity?

2. Can you tell me about someone or a group of people outside of your team that you look up to or feel connected to in some degree? What is it about this person/group of people that makes them special?

Part 1: Reactions to Ricky Williams article

1. What is your first reaction to this story?
2. Based on what you read (or if you are already familiar with his story), what is your impression of Ricky Williams?
3. If this were a guy on your team, how do you think you would react to him?
4. Think about Haslett's reaction to Williams requesting help for a mental health issue.
    a. Did the coach handle the situation well?
    b. In your opinion, could the coach have handled the situation differently and if so, how?
    c. How important do you think coaches are in enabling players to come forward when they need help?
5. Try to imagine if you were in a similar situation to Ricky Williams.
    a. What do you think you would do?
    b. Who would you tell?
    c. What is it about these people that makes you reach out for help?
    d. Can you think of any barriers that would maybe make you think twice about talking to someone?
6. Ricky Williams had a social anxiety disorder. Can you think of other mental health problems or illnesses that might be prevalent with football players?
7. Has mental health ever been a topic of discussion in your varsity career?
    a. If not, why do you think it hasn't been prioritized?
8. Williams talks about a physical prejudice in sports saying that, "When it's a broken bone, the teams will do everything in their power to make sure it's OK. When it's a broken soul, it's like a weakness".
    a. What do you think of this statement?
    b. Have you ever been physically injured to the point of not playing? If yes, how did you cope with this?
    c. How did teammates treat you?
9. Some research is showing that players are starting to shift away from the self-sacrificing warrior mindset that's been so long engrained in the sport of football. Do you see any evidence of this happening?
    a. Would you say that there is a shift in the way players think about their health?
    b. What do you think needs to change in the game for players to take their health more seriously?

Part 2: Reactions to NFL Lifeline.org videos

1. In your opinion, what is the main message in this video?
2. How did the message resonate with you?
3. What do you think about Irvin's comment, "We can't isolate. It's the worse thing in the world for a man to do", especially when men are generally socialized not to show emotion and to be very stoic?
4. What does this video say to you about the NFL's position on mental health?
5. If this video were being shown as a resource to varsity-athletes, is Michael Irvin the right guy or can you think of someone better? If yes, who and why?
6. Was there anything he said that that you really agreed with or disagreed with?

Appendix D: Sports Illustrated Excerpt
The Case of Ricky Williams
(Ricky Williams is an NFL running back who played for the New Orleans Saints, Baltimore Ravens, Miami Dolphins and Toronto Argonauts, CFL)

Source: Sports Illustrated

McKinley's apparent suicide casts light on athletes' risk of depression

Jon Wertheim
Tuesday, September 21, 2010

It was before the famous tent stint in Australia, the various drug suspensions, the holistic medicine, the Toronto Argonauts and the Redemption. In the summer of 2003, Ricky Williams was passing through New York on a media tour and we ended up talking. Williams said a few words about his football career, but then, candid as ever, he took the conversation on a hairpin turn and began to talk about his battles with mental illness.

You may recall that during his fairly disastrous tenure with the New Orleans Saints, Williams had a habit of answering questions without removing his football helmet. But that wasn't all. After practice, he would leave the locker room and head to the Burger King drive-thru, only to realize that he would have to interact with someone to place an order. So he would head home to spend the rest of the day in seclusion. The phone would ring and he wouldn't pick up. "At practice [the next day] my teammates would be like, 'Hey, what did you do last night?' " Williams recalled. "I'm thinking, I went from the living room to the office to the bedroom."

The team did little to help. Only after tooling around the Internet did Williams self-diagnose himself with social anxiety disorder. He finally massed the courage to confront the Saints' hidebound coach, Jim Haslett. He explained that he was seeking treatment for a psychological issue. According to Williams, Haslett used profanity to tell him, in so many words, "to stop being a baby and just play football." (Haslett did not respond to SI's questions about the incident.)

Around the same time, Williams broke his ankle. The team treated his recovery as a matter of vital importance. Trainers and rehab specialists oversaw his every move and asked for near-daily updates on his condition. Teammates texted him daily. Williams was struck by the contrast. "There's a physical prejudice in sports," he says. "When it's a broken bone, the teams will do everything in their power to make sure it's OK. When it's a broken soul, it's like a weakness."

I recalled this when the news broke that Denver Broncos wide receiver Kenny McKinley was found dead on Monday afternoon in Arapahoe County of an apparent self-inflicted gunshot wound. While the investigation is ongoing and McKinley hasn't been officially linked to depression, one has to wonder if he was depressed, especially after he was placed on injured reserve with a knee injury. (According to the National Institute of Mental Health, the risk factors for suicide include depression and other mental disorders or a substance abuse disorder. More than 90 percent of people who commit suicide have these risk factors.)

To the uninitiated, it makes no sense. Aren't these young, sculpted, famous, rich gladiators antithetical to the whole concept of depression? Aren't pro athletes supposed to be impervious to all manner of pain? Don't they collide violently against each other, and need to be

talked out of playing with the kinds of injuries that would incapacitate most of us for weeks?

In the macho, less-than-enlightened Republic of Sports, depression and other mental illnesses are often stigmatized as maladies for the weak. "Gutless" was the term Bobby Valentine, then the Mets manager, allegedly used to describe Pete Harnisch after the pitcher suffered a depressive episode. "Run it off," an NBA coach once told Vin Baker when the player tried to explain his depression. "Don't let the blues get you down!"

"Head case" remains one of the most damning labels in the front office. Sports psychologists know that if they want acceptance among athletes, they're better off re-branding themselves as the less-menacing "performance coaches."

The abiding irony: it's entirely possible that athletes in pro sports -- the ultimate kennel of alpha dogs -- might be MORE prone to mental illness than members of society at large. After hereditary influences, the biggest risk factor for depression is stress. Performing in front of thousands of fans, having your work scrutinized and judged regularly, and laboring in a field where success and failure are so clear-cut can exact a huge psychic toll. There's also the stress of knowing that your career, and thus the window of opportunity to make millions, is narrow. As McKinley's agent, Andrew Bondrarowicz, told the *Denver Post*: "These guys, they're made of steel on the outside. But for a lot of them, the challenge of being at your best and living up to all the expectations is a difficult situation. Some people are better equipped and have the support system."

Appendix E: The Mental Health Continuum-Short Form (MHC-SF) Items and Scoring

Table 1
Type of Well-Being,DSM-Type Categorical Diagnosis, and Questions in the Mental Health Continuum Short Form.

Emotional Well-Being: Flourishing requires "almost every day" or "every day" and languishing requires "never" or "maybe once or twice" during the past month on 1 or more of the 3 symptoms of emotional well-being. "How often during the past month did you feel …" 1. Happy 2. Interested in Life 3. Satisfied
Positive Functioning: Flourishing requires "almost every day" or "every day" and languishing requires "never" or "maybe once or twice" during the past month on 6 or more of the 11 symptoms of positive functioning. "How often during the past month did you feel …" 4. that you had something important to contribute to society. (*Social contribution*) 5. that you belonged to a community (like a social group, your school, or your neighborhood). (*Social Integration*) 6. that our society is becoming a better place for people like you. (*Social growth*) 7. that people are basically good. (*Social acceptance*) 8. that the way our society works made sense to you. (*Social coherence*) 9. that you liked most parts of your personality. (*Self acceptance*) 10. good at managing the responsibilities of your daily life. (*Environmental mastery*) 11. that you had warm and trusting relationships with others. (*Positive relationships with others*) 12. that you had experiences that challenged you to grow and become a better person.

(*Personal growth*)
13. confident to think or express your own ideas and opinions. (*Autonomy*)
14. that your life has a sense of direction or meaning to it. (*Purpose in life*)

Adult MHC-SF (ages 18 or older)

Please answer the following questions are about how you have been feeling during the past month. Place a check mark in the box that best represents how often you have experienced or felt the following:

During the past month, how often did you feel …	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	ABOUT 2 OR 3 TIMES A WEEK	ALMOST EVERY DAY	EVERY DAY
1. happy						
2. interested in life						
3. satisfied with life						
4. that you had something important to contribute to society						
5. that you belonged to a community (like a social group, or your neighborhood)						
6. that our society is a good place, or is becoming a better place, for all people						
7. that people are basically good						
8. that the way our society works makes sense to you						

9. that you liked most parts of your personality						
10. good at managing the responsibilities of your daily life						
11. that you had warm and trusting relationships with others						
12. that you had experiences that challenged you to grow and become a better person						
13. confident to think or express your own ideas and opinions						
14. that your life has a sense of direction or meaning to it						

The *Mental Health Continuum-Short Form* (MHC-SF) Scoring

Continuous Scoring: Sum, 0-70 range (use 10 point categories if desired).
Categorical Diagnosis: a diagnosis of flourishing is made if someone feels 1 of the 3 hedonic well-being symptoms (items 1-3) "every day" or "almost every day" and feels 6 of the 11 positive functioning symptoms (items 4-14) "every day" or "almost every day" in the past month. Languishing is the diagnosis when someone feels 1 of the 3 hedonic well-being symptoms (items 1-3) "never" or "once or twice" and feels 6 of the 11 positive functioning symptoms (items 4-8 are indicators of Social well-being and 9-14 are indicators of Psychological well-being) "never" or "once or twice" in the past month. Individuals who are neither “languishing” nor “flourishing” are then coded as “moderately mentally healthy.”

Symptom Clusters and Dimensions:

Cluster 1; Items 1-3 = *Hedonic,* Emotional Well-Being
Cluster 2; Items 4-8 = *Eudaimonic,* Social Well-Being
Item 4 = Social Contribution
Item 5 = Social Integration
Item 6 = Social Actualization (i.e., Social Growth)

Item 7 = Social Acceptance
Item 8 = Social Coherence (i.e., Social Interest)
Cluster 3; Items 9-14 = *Eudaimonic,* Psychological Well-Being
Item 9 = Self Acceptance
Item 10 = Environmental Mastery
Item 11 = Positive Relations with Others
Item 12 = Personal Growth
Item 13 = Autonomy
Item 14 = Purpose in Life

SPSS Syntax for creating the categories for the categorical diagnosis
***Assumes item responses have been coded as follows**: **never=0, once or twice=1, about once a week=2, about 2 or 3 times a week=3, almost every day=4, every day=5**

```
count hiaff=mhc1 mhc2 mhc3(4,5).
count loaff=mhc1 mhc2 mhc3(0,1).
count hifunc=mhc4 mhc5 mhc6 mhc7 mhc8 mhc9 mhc10 mhc11 mhc12 mhc13 mhc14(4,5).
count lofunc=mhc4 mhc5 mhc6 mhc7 mhc8 mhc9 mhc10 mhc11 mhc12 mhc13 mhc14(0,1).
recode hiaff (1,2,3=1) (else=0) into hiaffect.
recode hifunc (6,7,8,9,10,11=1) (else=0) into hifunct.
recode loaff (1,2,3=1) (else=0) into loaffect.
recode lofunc (6,7,8,9,10,11=1) (else=0) into lofunct.

if hiaffect=1 and hifunct=1 mhc_dx=2.
if loaffect=1 and lofunct=1 mhc_dx=0.
if hiaffect=1 and hifunct=0 mhc_dx=1.
if hiaffect=0 and hifunct=1 mhc_dx=1.
if loaffect=0 and lofunct=1 mhc_dx=1.
If loaffect=1 and lofunct=0 mhc_dx=1.

variable labels mhc_dx 'MHC-SF Three Category Diagnosis of Positive Mental Health'.
value labels mhc_dx 0 'Languishing' 1 'Moderate' 2 'Flourishing'.
compute mhc_total = mhc1 + mhc2 + mhc3 + mhc4 + mhc5 + mhc6 + mhc7 + mhc8 + mhc9 +
mhc10 + mhc11 + mhc12 + mhc13 + mhc14.
compute mhc_ewb = mhc1 + mhc2 + mhc3.
compute mhc_swb = mhc4 + mhc5 + mhc6 + mhc7 + mhc8.
compute mhc_pwb = mhc9 + mhc10 + mhc11 + mhc12 + mhc13 + mhc14.
```