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Decreasing Stigma Against Depression in Chinese International Students

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DECREASING STIGMA AGAINST DEPRESSION IN CHINESE INTERNATIONAL STUDENTS

A Capstone Experience/Thesis Presented in Partial Fulfillment

of the Requirements for the Degree Bachelor of Arts

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ABSTRACT

Higher levels of stress and a shift in support systems during the transition to another culture can put international students at risk for mood disorders like depression. Previous research supports there is also a higher level of depression stigma within Eastern cultures in comparison to Western cultures (Rao, Feinglass, & Corrigan, 2007). This may account for the strikingly low numbers from the Chinese population that seek and maintain professional counseling services while studying in the U.S. (Yakushko, Davidson, & Sandford-Martens, 2008). The present study sought to determine whether two self-produced Chinese videos regarding information about stigma, symptoms, and treatment of depression would significantly decrease stigma against depression and increase attitudes of help-seeking in Chinese international students in the U.S. Results of the paired sample *t* test with respect to the Social Distance Scale indicated a statistically significant decrease ($t(44) = -2.14$, $p < .05$), between the pre-test and the post-test in the participants' desire for social distance. However, there was no statistically significant difference in participants' association of negative attributes with individuals with depression. Post-test measures of attitudes toward helpfulness of different professions and treatment yielded no significant results, but attitudes toward the helpfulness of medicinal treatment of depression did significantly increase ($t(44) = -3.93$, $p < .001$). Therefore, our first hypothesis was partially supported and our second was minimally supported. Research with higher statistical power and a longitudinal design is necessary to further examine the relationship between these video interventions and reduction of stigma within Chinese international students.

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VITA

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INTRODUCTION

International Students & Acculturative Stress

According to the Migration Policy Institute (Zong & Batalova, 2016), over 975,000 international students studied in the U.S. during the 2014-15 school year. This was a 41% overall increase in enrollment from the 2009-10 school year, and a continued rate of growth is predicted. Of these students, the highest percentage (33.4%) originated from China and Taiwan. Understanding these students' acculturation experience is essential to serve them both academically and socially.

Berry (2003) defines acculturation as the process of cultural, psychological, and social adaptations that occurs when two cultures come into contact. Acculturative stress occurs whenever difficulties arise due to these adaptations. Chinese international students in the United States are at a particular risk for acculturative stress due to the vast differences in social and cultural norms and unique academic pressures (Yeh & Inose, 2003). Language difficulties are the most prominent concern, since lower English abilities negatively affects academic performance as well as seeking social support (Mori, 2000). Conversely, those with higher self-reported English abilities report lower levels of acculturative stress (Yeh & Inose, 2016). According to Holfstede's (1983) cultural dimensions, Eastern cultures promote a higher power distance, or degree to which unequal distribution of power is expected and accepted. Therefore, Chinese students are expected to maintain a respectful and attentive silence within classrooms. International students may experience unease in the change of classroom expectations from this

respectful silence to active class participation in the United States (Tung, 2011). Higher cultural power distance may also prevent students from reaching out to professors for help. Third, the loss of social support systems can significantly impact a student's psychological well-being. Physical distance from home coupled with the cross-cultural differences with American peers can leave Chinese international students distressed (Yeh & Inose, 2016). Those cultural differences may also lead to experiences of unequal treatment and discrimination, further exacerbating acculturative stress (Horn, 2007). Other sources of stress for some Chinese international students include financial difficulties, problematic perfectionism (unrealistically high expectations of excellence; Nilsson et al., 2008), high familial pressure (expected to honor family with achievement), and immigration requirements (Hyun et. al, 2007).

As a result of these additional sources of stress, Chinese international students have a higher risk for developing mood disorders like depression in comparison to domestic students (Han et al, 2013). During a mental health survey among Chinese international students at Yale University, 45 percent of respondents reported symptoms of depression and 29 percent reported symptoms of anxiety. Even more alarmingly, 27 percent of the participants reported that were not aware of availability of mental health and counseling services on campus. Meanwhile, Lindsey et al., (2009) reports that depression prevalence rates for domestic students are about 25 percent over the course of one year. In order for campus counseling centers to address the needs of Chinese international students adequately, it is important to understand the barriers that prevent students from seeking professional help.

Depression and Cultural Differences

The Diagnostic Statistic Manual (APA, 2013) describes major depressive disorder as a depressed mood, significantly less interest and pleasure in activities, significant weight loss or weight gain, insomnia or hypersomnia, fatigue, feelings of worthlessness, reduced concentration, and recurrent thoughts about death for more than 2 weeks. It can also include somatic symptoms such as aches, pains, or cramps that do not go away with appropriate medical treatment. Major depression occurs due to a combination of genetic predispositions, environmental stress, and maladaptive coping strategies (Durand & Barlow, 2013). According to the World Health Organization (2017) an estimated 300 million people worldwide are now living with depression, an increase of more than 18% between 2005 and 2015. The WHO considers it the fourth most common cause of disability, and is projected to rank higher in the future. Clinical depression is a treatable condition with the most common course consisting of treatment a combination of psychological counseling and antidepressant medications. Therefore, promoting education and access to mental health resources could potentially decrease worldwide impairment from major depressive disorder.

The WHO World Mental Health Survey Consortium (2004) indicates a substantial difference in prevalence rates of mood disorders, including depression, around the world. A recent meta-analysis of major depression prevalence rates in China estimates a 2.3 percent 12-month prevalence (Kessler & Bromet, 2016), while the Substance Abuse and Mental Health Services Administration (Ahrnsbrak et al., 2016) reports a 6.7 percent 12-month prevalence in the U.S. These differences could presumably result from substantive differences as well as differences in methodological process. Bromet et al. (2011) indicated that clinical biases can lead to differences in optimal diagnostic thresholds of

symptoms that affect national rates of depression. This could explain why countries with the highest depression prevalence rates have been correlated with the least impairment from depression (Simon et al, 2002).

Different cultural values affect an individual's experience with major depression. This includes the expression of symptoms, idioms used to report them, and choices about treatment (Kleinman, 2004). While a core group of depression symptoms, including negative cognition, sleep disturbances, fatigue, dysphoria, and loss of interest present themselves in the majority of all cultures (Manson & Kleinman, 1995), other somatic symptoms are more commonly reported by Eastern cultures than Western ones. For example, pain, dizziness, and heaviness in the chest or head can be used to communicate depression in non-Western patients (Kleinman, 2004). Some researchers have proposed that these variations occur due to the differences between western biomedical and nonwestern holistic medical practices (Bhugra & Mastrogianni, 2004), while others suggest it stems from language that encodes emotional and bodily experiences together (Lee, Kleinman, & Kleinman, 2007). In Chinese patients specifically, sleeplessness and bodily distress from social disharmony are more commonly directly expressed than low mood or sadness (Lee, Kleinman, & Kleinman, 2007). Failure to respect cultural differences in the experience of major depression can lead to therapeutic non-engagement.

Stigma Against Depression & Professional Help-Seeking

Stigma is a mark of shame associated with a certain situation or person. (Merriam-Webster, 2018). Studies around the globe showcase that individuals with mental health disorders are often associated with a negative stigma of unpredictability,

dangerousness, weakness, and other undesirable traits (Corrigan & Watson, 2002). Stigma against mental illness can be broken down into three categories; self-stigma, stigma by association and public stigma (Dalky, 2012). Self-stigma refers to the extent that an individual believes others will stigmatize him or her due to their mental illness. Friends, family, and other close relationships that receive prejudice due to their connection to an individual with mental illness experience stigma by association. Last, public stigma includes stereotypes, prejudices, and discrimination directed by the general public toward individuals with mental illness (Corrigan, 2000). Stigmatizing attitudes can compound psychological distress and lower self-worth so that there is an increased likelihood of relapse (Eshun & Gerung, 2008). Stigma can also prevent people from seeking professional help for fear that others will find out and perceive them negatively (Barney et al, 2006).

Several studies have investigated whether demographic factors like age, gender, and race have an effect on levels of perceived stigma. One factor of particular importance for this study is level of education, as the individuals in the target population have all received some higher education. Holmes et al. (1999) found that a higher level of education was correlated with a lesser likelihood to endorse stigmatizing beliefs.

Extensive research demonstrates that there are higher overall levels of depression stigma within Eastern cultures in comparison to Western cultures (Cheon & Chiao, 2012). In Eastern cultures, people with mental illness are perceived as shameful, threatening, abnormal, and morally deficient (Furnham & Chan, 2004; Yang, 2007). Eastern cultures also show a greater desire for social distance from mental illness (Rao, Feinglass, & Corrigan, 2007). In addition, psychological difficulties are often linked with

shame and selfishness in Chinese cultures (Parker et al., 2001), perhaps because emotional control promotes social harmony (Wei et al, 2007) and people with mental illness are perceived to lack emotional control. Cheon & Chiao (2011) confirmed that Asian Americans have both a higher implicit and explicit stigma against mental illnesses than do Caucasian Americans, so these cultural differences can remain despite immigration.

Negative perception of mental health disorders could be one cause of the underutilization of counseling services by international students at American universities. Nilsson et al. (2004) found that only 2% of the clients at a U.S. university counseling center were international students, despite international students making up 8% of its student population. They also found that over a third of clients dropped out after the initial session. In comparison, over the course of four years, Kim et al.'s (2015) analysis showed that only 18% of domestic students dropped out of counseling after the initial session. Additional studies have confirmed that a statistically lower amount of Chinese international students seek and maintain professional counseling services while studying in the U.S. despite the acculturative stress they experience (Yakushko, Davidson, & Sandford-Martens, 2008). However, there was no significant difference in rate of utilization between Chinese international students and other international students. These findings indicate that the reasons for underutilization of counseling services may stem from barriers that the majority of international students experience such as language barriers and cultural differences, rather than issues specific to Chinese students. Research on stigma specific to Chinese culture as well as their majority status in the international

student population in the U.S. is what led to the present study's specific stigma intervention.

Stigma Reduction Interventions

While the concept of stigma against mental health has been visible in the mental health field since Goffman's (1963) theory of stigma was published, the advocacy of stigma interventions did not gain momentum until the past decade (Dalky, 2012). Barney et al. (2009) recommends that all stigma interventions target attributions of blame, reduce avoidance of depressed people, label depression as a "health condition" rather than a "mental illness," and improve responses to help sources. Knaak, Modgill, & Patten (2014) conducted an analysis of anti-stigma programs for depression in order to determine the effectiveness of certain components of interventions. They found that programs that included the following "6 ingredients" were most successful: recovery emphasis, personal testimony from someone who has experienced mental illness, multiple forms of social contact, skills involving what to say or do, myth-busting, and an enthusiastic facilitator.

Dalky (2012) reviews a number of different stigma interventions. Of these, education and contact-based, cognitive and behavioral-based, and web-based education programs were the three most common. Since web-based allowed for more flexibility and attainability, we decided to use this form. A unique genre of health literacy is Entertainment-Education, where the new information is infused into an entertaining form of media. Hernandez & Organista (2013) utilized this tactic in their anti-stigma intervention within the Latina immigrant population. This study is of particular importance, because it specifically addresses stigma against depression in a minority

population in their native language. Because of the language translation and widespread participants, we chose to integrate a web-based approach with entertainment-education in order to reduce stigma against depression in Chinese international students.

Based on the previous research, we predict the following:

Hypothesis 1: After watching the culturally appropriate video interventions, participants' stigma against depression will significantly decrease.

Hypothesis 2: After watching the culturally appropriate video interventions, participants will have a significantly more positive attitude toward professional help-seeking.

METHOD

Participants

Participants were Chinese international students pursuing baccalaureate or graduate degrees at three Midwestern research institutions in the United States. International centers at participating universities distributed an e-mail containing a hyperlink that directed respondents to an online survey, which was then completed anonymously. A convenience sample of 45 participants (18 male, 26 female, 1 unspecified) resulted from this recruitment.

Translations

All of the Chinese surveys were gathered from existing studies that had formally translated and back-translated the measures. Translation for video scripts, informed consent, and engagement questions were through Certified Straker Translators. These translations were edited by Dr. Zhao (who is fluent in Chinese and English) until satisfactory. We chose to conduct this survey in Chinese, so that it could have the largest impact on Chinese international students. Specifically, the lack of a language barrier, would allow students to engage and relate more to the intervention. Lastly, in bilingual speakers, language often performs as a code switch between the different cultures. For example, in two different studies (Hull, 1987; Dinges & Hull, 1992; in Matsumoto & Juang, 2017), Chinese and Korean bilingual immigrants completed the California Psychological Inventory (CPI) twice, once in their native language and once in English. The results indicated that the immigrants presented different personality profiles

depending on whether they completed the inventory in their first language or English. So reading the Chinese language may also induce the higher rates of stigma associated with Eastern culture, and allow the intervention to have more a lasting impact if they return to their country of origin.

Research Design

This study had a within-subjects design; each participant's pre-existing attitudes toward depression was compared with his or her post-intervention attitudes toward depression. Due to the limitations of the participant pool and time constraints, we needed to conduct both the pre-test and post-test in one setting. In order to decrease potential practice effects, we utilized distractor surveys prior to the intervention and immediately afterwards.

Materials

Depression Literacy Questionnaires (Wong, Lam, & Poon, 2010, Appendix A). In this instrument, participants read a vignette of a 30-year-old man, Xiaojuan, with depression. They were then asked whether they believed he needed professional help. Next, it assessed what people could help Xiaojuan on a Likert Scale of 1 (very helpful) to 5 (very harmful). Some of these people included a family doctor, chemist, counselor, psychiatrist, Chinese medicine doctor, herbalist, family, and friends. The next question addressed how helpful different medications such as sleeping pills, pain relievers, antidepressants, and Chinese medicine would be. Last, it posed the question of what actions Xiaojuan should partake in to help his situation. Some examples include exercising, counseling, yoga, hypnosis, Qigong healing, and going out with friends more.

Personal Attributes Scale (Angermeyer & Matschinger, 2003, Appendix B). Participants answered a series of questions regarding Xiaojuan's likely characteristics in the Personal Attribute Scale. They represented the most prevalent stigmas against depression: dangerousness and dependency. Respondents were asked to indicate, with a five-point Likert scale, ranging from 1 (definitely true) to 5 (definitely not true), to what extent these attributes apply to the person depicted in the vignette. When creating the Chinese version, Wong (2011) chose 7 of the original 8 attributes for cultural appropriateness. The attributes included were unpredictable, lacking control, aggressive, frightening, dangerous, dependent on others, and helpless.

Social Distance Scale (Angermeyer & Matschinger, 2003, Appendix C). For the assessment of participants' desire for social distance, we used the Chinese version of Link et al.'s (1987) Social Distance Scale. Using a five-point Likert scale ranging from 1 (in any case) to 5 (in no case at all), the respondents could indicate to what extent they would, in the situation presented, want to accept the person described in the vignette. Wong's (2011) translation excluded renting a room, job brokering, and childcare and added marriage into the family for cultural appropriateness. Therefore, the particular settings we used in this survey were social gatherings, weekend hangouts, neighborhood, workplace, and marriage into the family.

Achievement Goal Questionnaire (Sun, H. & Hernandez D., 2012, Appendix D). This was the first distractor survey that we employed. Using a Likert-scale from 1 (does not correspond at all) to 5 (corresponds exactly), participants answered 12 statements about academic goals. Some statements focused on the goal of mastery, or understanding the material as thoroughly as possible, and others focused on the goal of

performance, or doing better than others in the classroom. This survey was chosen due to its different subject, accessibility, and brevity.

Adaptation of the World Health Organization Quality of Life-Brief Version (2004, Appendix E). Following the interventions, participants answered the second distractor survey, an Adaptation of the World Health Organization Quality of Life-Brief Version (2004). This survey also followed the pattern of 5-point Likert scales, but the terms associated with them changed several times to best fit the nature of the question. Some of these scales were not at all—completely, very satisfied—very unsatisfied, and not at all—an extreme amount. In order to shorten the length of the distractor survey and omit any potentially disturbing questions, only 19 of the original 26 statements were used. Topics addressed were life satisfaction, emotional support, and physical health.

Interventions.

"I had a black dog; his name was depression." For this particular population, a web-delivered service was necessary in order to reach the highest number of participants as possible. Therefore, a combination of entertainment education, similar to Hernandez & Organista's (2013) and web-deliverance seemed the most ideal. Videos are a form of media that also may be more effective for the age demographic, so this is the method of intervention that we chose. Due to the previous research in anti-stigma effectiveness (Knaak, Modgill, & Patten, 2014), the present study sought to include as many of the "6 ingredients" as possible (recovery emphasis, personal testimony from a trained speaker who has experienced mental illness, multiple forms of social contact, skills involving what to say and what to do, myth-busting, and an enthusiastic facilitator).

First, a thorough search on YouTube's platform revealed that there were no pre-existing videos in Chinese (with English transcripts) that reached the above-mentioned criteria. Therefore, it was necessary to translate existing videos or produce new ones to reach the goals of reducing stigma in Chinese international students in a short time constraint. The World Health Organization posted an animated video named "I had a black dog; his name was depression" on October 2, 2012 that displayed an engaging portrayal of a personal experience with depression. It is an extended metaphor about how the individual recovered from the "black dog" controlling his life to one where they can get along. In it, he illustrates his symptoms, treatment, and recovery. With the animation and metaphor, it successfully takes an abstract concept like depression and illustrates it in a more tangible way. This met the goals of recovery emphasis and personal testimony, and presented them in an intriguing way. The transcript of the video was translated by Straker translators and a local graduate student volunteered to record all of the individual phrases of Chinese (script found in Appendix F). These were then dubbed over the appropriate parts of the original video.

"International student transitions." A second intervention was needed to address depression in a more educational way. We wanted to maintain the recovery emphasis with the addition of skills involving what to say and what to do, myth-busting, and an enthusiastic facilitator. We also wanted to target the specific issues that international students face in order to make it more relatable and helpful. After a YouTube search yielding no results that contained these requirements, we decided to compose a new video.

The beginning of the video focuses on the unique experience of being an international student in both positive and negative aspects. In order to be culturally relevant, the comparison between physical health and mental health was created. The symptoms listed were also ones that are more commonly described for the experience of depression more common to Chinese culture. Specifically, the video highlighted the somatic symptoms of depression. Next, the video utilized the 5 myths that the International Student Alliance's video (2015, May 4) "[m]ental health awareness for international students" includes. The rebuttal facts to break those myths were also included (script found in Appendix G). The 5 minute and 10 second video concluded with resources for international students, such as the international office and the counseling center on campus. Dr. Zhao acted as the primary deliverer of this information in this video in order to have a sense of authority that is highly valued in Chinese culture.

Procedure

Pre-test. Participants read Xiaojuan's vignette of depression and answered the Depression Literacy Questionnaire (Wong, Lam, & Poon, 2010), Personal Attributes Scale (Reavley & Jorm, 2011), and Social Distance Scale (Reavley & Jorm, 2011). In order to separate the pre-test and post-test as much as possible, we placed a distractor survey prior to the intervention and immediately following. The first one the participants answered was the Achievement Goal Questionnaire (Sun, H. & Hernandez D., 2012).

Interventions. Next, participants viewed the first video, "I had a black dog; his name was depression." The survey did not allow the participants to continue with the survey until they had waited the appropriate 5 minutes and 34 seconds that the video lasted. In order to check for engagement, two questions about the content were posed

afterwards. Then the participants viewed the next video, "International Student Transitions." As with the previous video, participants were not allowed to continue the survey until the allotted time had passed. Two engagement questions followed to check for comprehension (Appendix H). Following both interventions, participants answered the second distractor survey, the adaptation of the World Health Organization Quality of Life-Brief Version (2004).

Post-test. Participants reread Xiaojuan's vignette of depression and answered the Depression Literacy Questionnaire (Wong, Lam, & Poon, 2010), Personal Attributes Scale (Reavley & Jorm, 2011), and Social Distance Scale (Reavley & Jorm, 2011) again. Once this was complete, the participants answered in a 3-sentence open response, "what is your favorite aspect of being an international student?" With this question, our goal was to reduce any psychological distress this survey could have caused and remind them about all of the benefits of being an international student. Last, participants listed their gender, how long they had been in the United States, and an email address for potential contact about follow-up studies.

RESULTS

Hypothesis 1 – Stigma Reduction

A two-tailed paired-samples *t* test was used to determine whether there was a statistically significant difference in means from the pre-test to the post-test for both hypotheses (Table 1). The first analysis involved combining the Chinese-adapted versions of the Social Distance Scale (Reavley & Jorm, 2011) and the Personal Attributes Scale (Reavley & Jorm, 2011) into an overall measure of stigma. The results between the pre-test ($M = 3.69$ $SD = 0.47$) and the post-test ($M = 3.74$, $SD = 0.56$) were not significant ($t(44) = -1.24$, $p > .05$).

In order to provide further clarity on what type of stigma might have been reduced within the participants, we conducted separate tests for the Social Distance Scale and the Personal Attributes Scale. Results of the paired sample *t* test with respect to the Social Distance Scale indicated that the participants' desire for social distance significantly decreased ($t(44) = -2.14$, $p < .05$) from pre-test ($M = 2.37$, $SD = 0.71$) to post-test ($M = 2.28$, $SD = 0.69$). Cohen's effect size value ($d = 0.32$) suggests a small to medium level of practical significance. However, there was no statistically significant difference ($t(44) = -.25$, $p > .05$), between the pre-test ($M = 3.97$, $SD = 0.57$) and the post-test ($M = 3.960$, $SD = 0.685$) in the attribution of negative characteristics. Therefore, Hypothesis 1 was partially supported.

Table 1: Paired Samples t-Test

	Paired Differences					t	df	Sig. (2-tailed)
				95% Confidence				
	Mean	Std. Deviation	Std. Error Mean	Lower	Upper			
Stigma- Combined	.05000	.27143	.04046	-.03155	.13155	1.236	44	.223
Personal Attributes	-.01481	.40016	.05965	-.13504	.10541	-.248	44	.805
Social Distance	-.09778	.27177	.04051	-.17943	-.01613	-2.413	44	.020
Help Seeking- Combined	-.05345	.27269	.04065	-.13538	.02847	-1.315	44	.195
Formal Professionals	-.02222	.51737	.07713	-.17766	.13321	-.288	44	.775
Informal Professionals	.02222	.39344	.05865	-.09598	.14043	.379	44	.707
Formal Activities	-.07778	.39664	.05913	-.19694	.04139	-1.315	44	.195
Informal Activities	-.01111	.35112	.05234	-.11660	.09438	-.212	44	.833
Medicine	-.17778	.30374	.04528	-.26903	-.08653	-3.926	44	.000

Hypothesis 2 – Increase in Attitudes Toward Help-Seeking

First, we conducted another two-tailed paired-sample *t* test to determine the total difference between attitudes toward help-seeking as measured by the Chinese Depression Literacy Survey (Wong, Lam, & Poon, 2010). As 1 on the Likert scale was associated with "very helpful" and 5 with "very unhelpful," we expected that the means would decline from pre-test to post-test. There was no statistically significant difference, $t(44) = -1.32$, $p > .05$, between pre-test ($M = 2.76$, $SD = 0.31$) and post-test ($M = 2.71$, $SD = 0.48$) attitudes toward helpfulness of professionals, activities, and medicine for treatment of depression (Table 2).

To further analyze the effects of the intervention on help-seeking attitudes, we ran separate tests on the different components (professionals, activities, and medicine) of the instrument, as well as the informal and formal subscales within the first two categories. There was no statistically significant difference between the pre-test ($M = 2.54$, $SD = 0.40$) and the post-test ($M = 2.54$, $SD = 0.52$) with respect to positive (helpful) attitudes toward both formal and informal help-seeking ($t(44) = 0.04$, $p > .05$). Likewise, there was no statistically significant difference between pre-test ($M = 2.65$, $SD = 0.32$) and post-test ($M = 2.62$, $SD = 0.48$) attitudes toward both formal and informal depression-reduction activities ($t(44) = -0.77$, $p > .05$). However, the last paired sample *t* test, $t(44) = -3.93$, $p < .001$, showed statistically significant differences in pre-test ($M = 3.28$, $SD = 0.49$) and post-test ($M = 3.10$, $SD = 0.57$) attitudes toward medicinal treatment of depression. Therefore, Hypothesis 2 was minimally supported by the results.

The original Depression Literacy survey questions (Wong, Lam, & Poon, 2010) compared attitudes toward help-seeking in Australian, Japanese, and Chinese Australian

populations with percentages of three responses: helpful, harmful, or neither. To directly compare with the previous literature, we collapsed our 5-point Likert scale so that "very helpful" and "helpful" were placed in the "helpful" category, "neither helpful nor harmful" was placed in the "neither" category, and "harmful" and "very harmful" were placed in the "harmful" category. On average, our sample had lower percentages of helpfulness and higher percentages of harmfulness than did Chinese Australians (Table 2a, 2b, and 2c).

Table 2a- Comparison to Chinese Australians (Wong, Lam, & Poon, 2010)

	Helpful %		Harmful %	
Professionals	Current Study	Wong et al.	Current Study	Wong et al.
1. Doctor	33.3	74	0	2.1
2. Pharmacist	20	27.6	8.9	8.6
3. Counselor	84.4	90.2	0	0.5
4. Social worker	48.9	86.9	2.2	1
5. Telephone counselor	62.2	77.4	6.7	1.1
6. Clinical psychologist	97.7	83.6	0	0
7. Close family members	80	82.2	4.4	2.1
8. Close friends	80	76.4	0	2.6
9. Naturopath	46.7	39.2	11.1	4.2
10. Religious practicioner	26.7	58.5	33.3	2.1
11. Deal with it alone	24.4	28.2	53.3	61.7
12. Traditional Chinese medicine doctor	24.4	31.8	20	8
13. Traditional healer	2.2	2.7	62.2	54.9
% Average	**48.5**	**58.4**	**15.5**	**11.5**

Table 2b- Comparison to Chinese Australians (Wong, Lam, & Poon, 2010)

	Helpful %		Harmful %	
Medicines	Current Study	Wong et al.	Current Study	Wong et al.
1. Vitamins, minerals	33.3	26.8	0	5.7
2. St. John's wart	4.4	2.6	26.7	17.5
3. Pain relievers	2.2	6.8	26.7	55.7
4. Antidepressants	73.3	40.9	20	14
5. Antibiotics	2.2	37.5	80	4.4
6. Sleeping pills	31.1	31.1	64.4	31.1
7. Antipsychotics	35.6	27.5	53.3	25.9
8. Tranquilizers	15.6	26.4	66.7	29
9. Chinese herbal medicine	15.6	17.4	24.4	18.5
% Average	23.7	24.1	40.2	22.4

Table 2c- Comparison to Chinese Australians (Wong, Lam, & Poon, 2010)

	Helpful %		Harmful %	
Activities	Current Study	Wong et al.	Current Study	Wong et al.
1. Physical activity	97.8	97.5	0	0
2. Read about problem	82.2	64.6	6.7	4.1
3. Get out more	37.8	60.2	8.9	8.9
4. Learn to relax/yoga	97.8	83.1	2.2	0
5. Cut out alcohol	68.9	82.6	4.4	4.6
6. Counseling	95.6	N/A	0	N/A
7. Cognitive behavior therapy	86.7	69.6	0	0
6. Psychotherapy	97.8	89.8	0	0
8. Hypnosis	40	69.6	17.8	7.2
9. Psychiatric ward	13.3	15	64.4	34.2
10. Electroconvulsive treatment	15.5	9.4	55.6	16.1
11. Occasional alcohol	11.1	10.3	66.7	44.1
12. Change in diet	35.6	32.6	11.1	11.9
13. Qigong healing	2.2	26.9	37.8	9.3
14. Consult a fortune teller	6.7	N/A	40	N/A
15. Ask the gods for an oracle	6.7	N/A	40	N/A
% Average	**57.2**	**59.3**	**23**	**11.7**

DISCUSSION

The results of this study helped determine whether an intervention of two culturally appropriate videos could significantly decrease stigma against depression and increase attitudes toward help-seeking. We incorporated as many of the "6 key ingredients" (Knaak, Modgill, & Patten, 2014) strategies for stigma reduction as reasonable within the study's limitations in order to reduce stigma. In line with previous research findings (Dalky, 2012; Hernandez & Organista, 2013), an entertainment education intervention successfully reduced depression stigma as evaluated through the Social Distance Scale (Reavley & Jorm, 2011). These findings indicate that students were less likely to desire distance in social contexts from individuals with depression after engaging with the video interventions. This indicates that they would be less likely to perpetuate the public stigma of discrimination by isolation against others with depression. It may also, in turn, decrease the likelihood of self-stigma if they themselves experience depression. The exact behavioral outcomes are unclear, but a significant reduction in desire for social distance could have a range of positive impacts for Chinese international students. These 5-minute videos are a low-cost, low-investment intervention that could be incorporated into international student orientations in order to yield similar reductions in stigma.

However, the findings did not support a reduction in the association of negative personal attributes against individuals with depression. The mean actually decreased from pre-test to post-test. The Personal Attributes Scale is reverse-coded, so a lower mean

indicates a stronger association of negative attributes with individuals with depression. Since the *p*-value is high, this unexpected slight raise in stigma could be due to random statistic error. In order to address this specific measure of stigma though, future interventions need to focus on the association of unpredictability, lack of control, aggressiveness, scariness, dangerousness, dependency on others, and helplessness with depression in a more direct way than the present study. It would also be useful to know the different levels of malleability in social distance and personal attributes stigma, as there is a gap in the existing literature on this subject. With a decrease in stigma in the context of social distance and no effect on stigma in the context of personal attributes, the findings show partial support for the first hypothesis.

Contrary to previous findings (Hernandez & Organista, 2013) and hypothesized results, the intervention did not significantly increase positive attitudes toward informal or formal help-seeking in association with depression. Means regarding attitudes toward informal activities (exercise, getting out, change in diet), and formal activities (counseling, cognitive-behavioral therapy, hypnosis, etc) did move in the predicted direction in the post-test. The mean associated with attitudes toward informal help (friends, family, herbal remedies, etc) moved opposite of the predicted direction in the exact amount (0.022) that the mean for attitudes toward formal help increased (0.022). Due to the lack of statistical significance ($p > .70$ of both of those changes), there is limited room for interpretation. Theoretically, it could indicate that the intervention's focus on formal help-seeking slightly shifted participant's attitudes in favor of formal help, but more research would be needed to assess the accuracy of this interpretation.

There are several reasons why these insignificant results could have occurred. The first is that they are simply due to a lack of statistical power. The effect size associated with this type of method and intervention is probably going to be fairly small, and thus would require a larger sample size to detect. Unfortunately, due to time constraints, the current study could only include 45 participants.

Also, as mentioned earlier, higher levels of education have been associated with more positive attitudes toward help-seeking in the past (Holmes et al., 1999). However, when the Chinese international student population's pre-test attitudes toward help-seeking were compared to the Chinese Australian population in Wong, Lam, & Poon's (2010) study, they had more negative attitudes despite their greater education level. An attributing factor that could explain these differences is level of acculturation. The Chinese Australian participants had been living in Australia for 10 years on average, so they could have adopted a lower level of stigma. In comparison, 11 of the present study's participants have been living in the United States for less than a year, while the other 34 have been for more than a year. So it is unclear what the exact average of years lived in the United States is, but it is reasonable to assume that it would be lower than 10 years. Therefore, this sample needs to be compared with Chinese participants with similar years lived in a Western culture in order to better assess whether a higher level of education in associated with more positive attitudes toward help-seeking.

The collapsed category format also made the pre-existing positive attitudes toward the helpfulness of professionals and activities associated with treatment of depression more apparent. In the present study, zero participants marked doctors, counselors, psychologists, or close friends as harmful for help with depression. Similarly,

zero participants marked physical activity, counseling, cognitive behavior therapy, or psychotherapy as harmful to treat depression. A lack of strong negative opinions in the pre-test made it more difficult to attain statistically significant increases in positive attitudes as there was less room for improvement. Since the literature indicates an underutilization of counseling services by Chinese international students, but the present study suggests generally positive attitudes towards seeking professional help, it is necessary to understand the disconnect to decrease that gap between attitude and action.

Our insignificant results could also indicate that these interventions were not adequate to produce the intended change in stigma against help-seeking. Some of the stigma-prevention factors that the literature indicates would have increased the likelihood of success are multiple forms of social contact and an enthusiastic facilitator (Knaak, Modgill, & Patten, 2014). Due to time constraints and lack of personal access to international students, the present study did not incorporate these factors. As such, for future studies, combining these videos with introductions to international center and counseling center staff may prove more effective than the videos alone.

Attitudes did significantly improve towards treating depression with medicine, which can be interpreted as a type of formal help. The previous research on the experience of depression with Chinese culture (Lee, Kleinman, & Kleinman, 2007) led to the creation of our videos with a delivery that equated mental health with physical health as there appears to be less stigma associated with physical illness. Focusing on the physical attributes of depression may have allowed for an increased tolerance of accepting medication for depression to treat its physical symptoms. This is a way that

individuals can still seek help for a problem in their life without encountering the stigma that is associated with major depressive disorder.

Limitations and Implications for Future Research

There were several significant limitations with this study. First, the sample size was smaller than desired (n = 45), which reduced both its degree of external validity and the power to achieve statistically significant results with this short of an intervention. The means mostly moved in the projected direction, so it is reasonable to expect a more significant change with more participants. Also, the study is geographically isolated to three Midwestern institutions, so it is unknown how the results would represent students around the U.S. Further studies should network with many universities or with universities with higher Chinese international student populations in order to attain more access to the target population. With a higher number of participants, we also suggest studies with a control group to confirm post-test differences in social distance stigma were not caused by confounding variables like practice effects or social desirability bias.

Another element of anti-stigma effectiveness that needs to be measured is long-term change. As noted in Dalky's review (2012), many studies lack the important measure of stigma changes over time after the intervention. Adding a follow-up survey 3-6 months after viewing these videos would be our first recommended step of continued research. If the social distance stigma is still significantly lower in the months following, it would especially support this intervention's worth in aiding with orientations for Chinese international students.

Additionally, it would be worthwhile to explore stigma against depression in other international student populations to provide more culturally sensitive materials and reduce underutilization of counseling services for other cultures. Lindsey et al.'s (2009) study indicates that international students from African countries report a higher level of acculturative stress and depression prevalence than Asian students, perhaps because of greater language and cultural isolation in the U.S. Studies have shown that they also have a high rate of depression stigma and underutilization of counseling services (Yakushko, Davidson, & Sandford-Martens, 2008) as well, so it is a population that might benefit from similar interventions. If it is too difficult to find pre-existing measures in different languages, it would be interesting to see if similar or different effects were found if the study were conducted in a students' second language, English.

Conclusion

Although much of the results were not statistically significant, this study does provide unique insight into the attitudes of Chinese international students toward both stigma against depression and help-seeking professions and treatments. Two short, informative videos can significantly decrease students' desire for social distance from individuals with depression, while not affecting their attributions of negative qualities to those same individuals. Baseline attitudes toward helpfulness are relatively high in this population, and videos with a medical approach to treating depression significantly increased attitudes of helpfulness toward medicinal treatment. More clarity of these results should occur when future studies are conducted with higher statistical power.

Chinese international students are a population that can experience a high level of acculturative stress once in the United States, so it is vital that international offices and

counseling centers continue to find the best ways to help these students with their transition. Since this was the first anti-stigma intervention conducted with international students, there were many hurdles in attaining the necessary scales, creating the intervention videos, and recruiting participants. Our hope is that this study can be a stepping stone for future studies that now have access to these materials to further the research, so that Chinese international students can have a more navigable transition to the U.S. in the future.

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APPENDICES

Appendix A: Depression Literacy Questionnaires (Wong, Lam, & Poon 2010)

Note: Chinese Version uses Xiaojuan instead of Mary.

Part I: Case Discussion

The following section concerns a hypothetical person called Mary. The description below outlines how she has been recently.

Mary is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary's boss who is concerned about her lowered productivity.

1. From the information given, what, if anything, is wrong with Mary?

2. Do you think Mary needs professional help?

Yes❑ 1
No❑ 2

3. *If Mary were to seek help from any of the following people, is it likely to be helpful, harmful or unknown for her (Tick one response for each line)* ?

a. A GP or family doctor	very helpful❑	1	b. A chemist or pharmacist	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
c. A counselor	very helpful❑	1	d. Social Worker	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5

e. Telephone counseling service	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5	f. A psychiatrist	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5
g. A clinical psychologist	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5	h. Help from her close family	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5
i. Help from some close friends	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5	j. A naturopath or a herbalist	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5
k. The clergy, a minister or a priest	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5	l. Mary tries to deal with her problems on her own	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5
m. A Chinese Medicine Doctor	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5	n. A Sorcerer	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5

4. *If Mary were to take one of the following medications, is it likely to be helpful, harmful or unknown for her? (Tick one response for each line)*

a. Vitamins and minerals	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5	b. St John's wort	very helpful❑ helpful❑ no help or harm❑ harmful❑ very harmful❑	1 2 3 4 5
c. Pain relievers	very helpful❑ helpful❑ no help or harm❑	1 2 3	d. Antidepressants	very helpful❑ helpful❑ no help or harm❑	1 2 3

	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
e. Antibiotics	very helpful❑	1	f. Sleeping pills	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
g. Anti-psychotics	very helpful❑	1	h. Tranquillizers	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
i. Chinese Medicine	very helpful❑	1			
	helpful❑	2			
	no help or harm❑	3			
	harmful❑	4			
	very harmful❑	5			

11. 5. *If Mary were to undertake any of the following, is it likely to be helpful, harmful or unknown for her? (Tick one response for each line)*

a. Becoming more physically active such as playing more sport, or doing a lot more walking or gardening	very helpful❑	1	b. Read about people with similar problems and how they have dealt with them	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
c. Getting out and about more	very helpful❑	1	d. Courses on relaxation, stress management, meditation or yoga	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
e. Cutting out alcohol altogether	very helpful❑	1	f. Counseling	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
g. Cognitive-behavioral therapy	very helpful❑	1	h. Psychotherapy	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3

	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
i. Hypnosis	very helpful❑	1	j. Admission to a psychiatric ward of a hospital	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
k. Electroconvulsive therapy (ECT)	very helpful❑	1	l. Having an occasional alcoholic drink to relax	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
m. A special diet or avoiding certain foods	very helpful❑	1	n. Qigong healing	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5
o. Consulting a fortune teller	very helpful❑	1	p. To ask the gods for an oracle	very helpful❑	1
	helpful❑	2		helpful❑	2
	no help or harm❑	3		no help or harm❑	3
	harmful❑	4		harmful❑	4
	very harmful❑	5		very harmful❑	5

6. Have you ever had a problem similar to Mary's?	Yes❑	1
	No❑	2

7. Has anyone in your family or close circle of friends ever had a problem similar to Mary's?	Yes❑	1
	No❑	2

Appendix B: Social Distance Scale (Angermeyer & Matschinger, 2003))

How willing are you to…?

1. Become a neighbor of Xiaojuan
2. Share the weekend with Xiaojuan
3. Become friends with Xiaojuan
4. Worked with Xiaojuan as a working partner
5. Let Xiaojuan marry your family

1 – Completely willing
2 – Willing
3 – Probably not
4 -- Never want to

Appendix C: Social Distance Scale (Angermeyer & Matschinger, 2003))

Do you agree with the following description of Xiaojuan?

a. Xiaojuan is an unpredictable person.
b. Xiaojuan is a person lacking self-control
c. Xiaojuan is a violent person
d. Xiaojuan is an aggressive person
e. Xiaojuan is a dangerous person
f. Xiaojuan is a person who depends on others
g. Xiaojuan is a helpless person

1 – Fully agree
2 – Partially agree
3 – A little bit of approval
4 – Do not agree
5 – Never agree

Appendix D: Achievement Goal Questionnaire (Sun, H. & Hernandez D., 2012)

English Version

Using the scale below, indicate to what extent each of the following items corresponds to your goals in class.

1- Does not correspond at all
2- Corresponds a little
3- Corresponds moderately
4- Corresponds a lot
5- Corresponds exactly

1. It is important for me to do better than other students in my class.
2. I just want to avoid doing poorly in my classes.
3. It is important for me to understand the content of my classes as thoroughly as possible.
4. I worry that I may not learn all that I possibly could in my classes.
5. My goal in my classes is to avoid performing poorly.
6. I am often concerned that I may not learn all that there is to learn in my classes.
7. My goal in my classes is to get a better grade than most of the other students.
8. It is important for me to do well compared to others in my classes.
9. I desire to completely master the material presented in my classes
10. My fear of performing poorly is often what motivates me.
11. Sometimes I'm afraid that I may not understand the content of my classes as thoroughly as I'd like.
12. I want to learn as much as possible from my classes.

Appendix E: World Health Organization Quality of Life-Brief Version (WHO, 1997)

I have omitted questions 4, 11, 15, 17, 21, and 26 in order to shorten the length of the distractor survey and omit any potentially disturbing questions. This survey will not be analyzed in any way for the results of this study.

Question	1	2	3	4	5
How would you rate your quality of life?	Very poor	Poor	Neither poor nor good	Good	Very good
How satisfied are you with your health?	Very dissatisfied	Dissatisfied	Neither dissatisfied or satisfied	Satisfied	Very satisfied

For the following questions the scale is:

1- *Not at all*
2- *A little*
3- *Moderate amount*
4- *Very much*
5- *An extreme amount*

3. To what extent does physical pain prevent you from what you would like to do?
4. How much do you enjoy life?
5. To what extent do you feel you life is meaningful?

For the following questions, the scale is:

1- *Not at all*
2- *Slightly*
3- *A moderate amount*
4- *Very much*
5- *Extremely*

6. How well are you able to concentrate?
7. How safe do you feel in your daily life?
8. How healthy is your physical environment?

For the following questions, the scale is:

1- *Not at all*
2- *A little*

3- Moderately
4- Mostly
5- Completely

9. Do you have enough energy for everyday life?
10. Have you enough money to meet your financial needs?
11. How available is information you need in your daily life?
12. To what extent do you have the opportunity for leisure activities?

For the following question, the scale is:

1- Very satisfied
2- Satisfied
3- Neither satisfied or dissatisfied
4- Dissatisfied
5- Very dissatisfied

12. How satisfied are you with your sleep?
13. How satisfied are you with your capacity to work?
14. How satisfied are you with yourself?
15. How satisfied are you with your personal relationships?
16. How satisfied are you with support from friends?
17. How satisfied are you with the conditions of your living place?
18. How satisfied are you with your access to health services?
19. How satisfied are you with your mode of transportation?

Appendix F: "I had a black dog; his name was depression" Script (World Health Organization, 2015)

I had a black dog. His name was depression.
Whenever the black dog made an appearance, I felt empty and life seemed to slow down.
He could surprise me with a visit, with no reason or occasion.
The black dog made me look and feel older than my years.
When the rest of the world seemed to be enjoying life, I could only see it through the black dog.
Activities that usually brought me pleasure, suddenly ceased to.
He liked to ruin my appetite.
He chewed my memory and my ability to concentrate.
Doing anything or going anywhere with the black dog required super human strength.
At social occasions, he would sniff out what confidence and chase it away.
My biggest fear was being found out. I worried that people would judge me.
Because of the shame and stigma of the black dog, I was constantly worried that I would be found out.
So I invested vast amounts of energy into covering him up. Keeping up an emotional lie is exhausting.
Black dog could make me think and say negative things.
He could make me irritable and difficult to be around.
He would take my love and bury my intimacy.
He loved nothing more than to wake me up with highly repetitive and negative thinking.
He also liked to remind me how exhausted I would be the next day.
Having a black dog in your life isn't about feeling a bit down, sad or blue…
At its worst, it's about being devoid of feeling altogether.
As I got older, the black dog got bigger and he started hanging around all the time.
I'd chase him off with whatever I thought might send him running.
But more often than not, he would come out on top. Going down became easier than getting up again.
So I became rather good at self-medication… which never really helped.
Eventually, I felt totally isolated from everything and everyone.
The black dog had finally succeeded in hijacking my life. When you lose all joy in life, you can begin to question what the point of it is.
Thankfully, this was the time that I sought professional help. This was my first step towards recovery and a major turning point in my life.
I learned that it doesn't matter who you are, the black dog affects millions and millions of people; it is an equal opportunity mongrel.
I also learned that there was no silver bullet or magic pill. Medication can help some and others may need a different approach altogether.
I also learned that being emotionally and genuine to those that are close to you can be an absolute game changer.
Most importantly, I learned to not be afraid of the black dog and I taught him a few tricks of my own.

The more tired and stressed you are, the louder he barks. So it's important to learn how to quiet your mind.
It's been clinically proven that regular exercise can be as effective at treating mild to moderate depression as antidepressants. So go for a walk or a run and leave the mutt behind.
Keep a mood journal. Getting your thoughts on paper can be cathartic and often insightful.
Also keep track of the things you have to be grateful for.
The most important thing to remember is no matter how bad it gets,
If you take the right steps, talk to the right people, black dog days can and will pass.
I wouldn't say I'm grateful for the black dog, but he has been an incredible teacher. He forced me to reevaluate and simplify my life. I learned that rather than running away from my problems, it's better to embrace them.
The black dog may always be a part of my life, but he will never be the beast that he was. We have an understanding.
I've learned through knowledge, patience, discipline, and humor, the worst black dog can be made to heel.
If you are in difficulty, never be afraid to ask for help. There is absolutely no shame in doing so. The only shame is missing out on life.
World Health Organization.

Appendix G: "International Student Transitions" (Significant text from International Student Alliance, 2012)

There are many benefits for students who pursue a college degree abroad. It is an opportunity to improve your second language skills and experience another culture. This promotes your sense of independence and adaptability, which makes your job resume more competitive. Overall, studying in a different country can be really fun and memorable.

However, international students also experience unique stressors that can lower their health. Being away from family and a familiar culture can be difficult at times. Learning and being tested in your second language is also a challenge. Sometimes there is also a high pressure to perform well to make the most of studying internationally.

This stress can lower your immune system, which can lead to sickness. Talking to a doctor and getting treatment will help you with sicknesses. Just as it is important to take care of your physical body, it is also important to take care of your emotional and psychological well-being. Depression is one illness that negatively affects how you feel, how you think, and how you act. Often, people struggle with this illness without help, because they don't know what it is.

Here are some warning signs to look for:

- Loss of interest in things you enjoy
- Feeling of restlessness
- Sleep too much or aren't able to sleep
- Feel tired all the time or lack energy
- Gain or lose weight
- Lose your appetite
- Have a hard time concentrating or remembering
- Feel hopeless, guilty, worthless, or helpless
- Have headaches, stomach aches, bowel problems, or pain that does not get better with treatment

In some cases, it can lead people to want to harm themselves or others. If that is true for you, or if any of the other signs last more than two weeks, it is time to ask for help. A doctor can help you with physical symptoms, but a counselor can also treat these physical and mental symptoms.

The best place to find a counselor would be your on-campus counseling center. They are nearby and convenient, services are confidential, and they are usually free or provided at a discounted charge. Therapists and psychologists are professionally trained to help you deal with mental health issues. During therapy, you can have a private discussion about your symptoms and find ways to have a less stressful life. Medicine, such as antidepressants, can also be a helpful treatment for depression.

There are some myths that prevent people from seeking help from counselors.

1. "Counseling is for crazy people."
    i. False. People from all around the world get counseling, and studies show that most people who seek help for depression improve dramatically or recover completely. Taking care of your physical and mental health shows that you are motivated, self-aware and empowered.
2. "I can handle my own problems, if I can't, that means I'm weak."
    i. False. Seeking help for a mental health issue is similar to seeking help for any other medical problem. If you broke your leg, you wouldn't try to heal yourself - mental health is no different.
3. "Everyone will know I saw a counselor."
    i. False. In the United States, there are laws and professional ethics standards that prevent your doctor from sharing information with your parents, friends, and school faculty.
4. "If I talk about drinking alcohol or doing drugs, I'll get in trouble."
    i. False. Counselors and their offices are considered a safe place to discuss your experiences and what you are going through. All of your information will be kept confidential.
5. "The things we discuss will become part of my permanent record, and will be viewed negatively."
    i. False. The information you share with your counselor or other professional will remain confidential. It will not be a part of your school transcripts or any other school records.

If you are unsure about making a counseling appointment, you can meet with faculty at your international student center to discuss the difficulties you face. They want you to succeed both academically and personally!

As we mentioned earlier, being an international student can be a really fun experience. But because there are unique stresses as an international student, it is especially important to know and recognize the signs of depression. Treatments are available at your campus counseling center, and your international office can help with more resources.

Appendix H: Engagement Questions & Closing Question

1. What did the black dog represent?
    a. Depression
    b. Anger
    c. Love
    d. Speed
2. What was a major turning point in the narrator's life?
    a. Seeking professional help
    b. Running away from the black dog
    c. Hurting the black dog
    d. Sailing out to sea
3. How did the white cat interact with the black dog?
    a. They were enemies.
    b. They were friends.
    c. There was not a white cat in this video.
    d. They were neither friends nor enemies.
4. According to the video, which of these is a myth?
    a. "Counseling is for crazy people."
    b. "If I talk about drinking alcohol or doing drugs, I'll get in trouble."
    c. "Everyone will know I saw a counselor."
    d. All of the above

What is your favorite aspect of being an international student? Explain in three sentences. [Open Response]