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Challenging the Stigma of Mental Illness Among College Students

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A B S T R A C T

Purpose: This study investigated the impact of contact- and education-based antistigma interventions on mental illness stigma, affirming attitudes, discrimination, and treatment seeking among college students.
Methods: Data were collected from 198 students of a Chicago University campus in spring of 2014. Participants were randomly assigned to one of three conditions: a contact-based antistigma presentation, education-based presentation, or control condition. Measures of stigma, discrimination, affirming attitudes, and treatment seeking were administered at preintervention and postintervention.
Results: A 3 × 2 analysis of variance was completed for each measure to examine condition by trial interactions. Both contact- and education-based interventions demonstrated a significant impact on personal stigma, perceptions of empowerment, discrimination, attitudes towards treatment seeking, and intentions to seek treatment from formal sources. No difference in effect was demonstrated between the contact- and education-based conditions.
Conclusions: These findings suggest that these two approaches should be considered for challenging mental illness stigma among college students.

IMPLICATIONS AND CONTRIBUTION

Study findings suggest both education- and contact-based stigma reduction strategies are effective at reducing stigma and improving beliefs about empowerment, attitudes towards treatment seeking, and intentions to seek treatment for mental health among young adults. Results have implications for addressing barriers to mental health care for young adults.

Data suggest college campuses are a place where many students find themselves struggling with mental illnesses. Recent estimates of the prevalence of mental illness among college students estimate depression at 17.3%, panic disorder at 4.1%, and generalized anxiety disorder at 7% [1]. The experience of mental illness in college is a significant predictor of lower grade point average [2] and greater risk for dropout [2–4], and poorer economic [5,6] and social outcomes [7,8] in later life.

Research in the general population indicates stigma, including stereotypes, prejudice, and discrimination, is a significant barrier individuals with mental illness face in achieving life goals [9]. The college mental health literature discusses public stigma as being composed of two separate constructs: perceived stigma and personal stigma [10–12]. Perceived stigma includes one's beliefs about how members of their community view individuals with mental illness; personal stigma involves one's own endorsement of stereotypes, corresponding prejudice, and discrimination. Label avoidance involves avoiding contexts (i.e.,

Conflicts of Interest: None to report.

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mental health services) that may prime the label of mental illness, subjecting one to stigma [13].

Treatment participation is an important factor contributing to recovery; however, stigma causes many individuals to avoid treatment [14]. A systematic review on barriers and facilitators to help seeking in young people found that the number one reported barrier was stigma [15]. The National Alliance on Mental Illness conducted a survey of 765 college students with mental illness reporting that 36% of students cited stigma as the number one barrier to seeking care [16]. Existing literature suggests that perceived stigma [11,17–19], personal stigma [9–11,17–19], and label avoidance [10,11,17–19] may be associated with college student attitudes towards treatment seeking.

Decreasing stigma is not the only outcome of interest for stigma change programs [20]. Changing stereotypes needs to be accompanied by promoting affirming attitudes—beliefs regarding recovery and empowerment—about people with mental illness [21,22]. The importance of increasing affirming attitudes is substantiated by findings suggesting that these attitudes are significantly, negatively related to stigma [23].

Common approaches to addressing mental illness stigma are contact (interactions with individuals with mental illness who tell their stories of challenges and successes) and education (contrasting myths and facts about mental illness). Meta-analyses of studies with the general public suggest that contact seems to be the most effective, followed by education, and that in vivo or face-to-face interactions with people with mental illness are more effective than video-based interventions [24,25]. Intervening at the level of public stigma may also reduce label avoidance [14]. Yamaguchi et al. [26] completed a literature review of interventions to reduce stigma among college students, concluding that social contact interventions were most effective in improving attitudes towards individuals with mental illness and reducing desired social distance with this population.

This study aimed to evaluate the impact of in vivo contact- and education-based interventions on college students' public stigma, label avoidance, attitudes towards mental health treatment seeking, intentions to seek treatment, affirming attitudes, and discrimination. To our knowledge, this is the first study to compare the impact of these two approaches on this set of outcomes. It was predicted that participants in both conditions would experience a reduction in stigma, label avoidance, and discrimination towards individuals with mental illness, and improvement in attitudes towards treatment seeking, intentions to seek treatment, and affirming attitudes. In addition, it was predicted that changes would be significantly greater for the contact-based condition.

Methods

Adults enrolled at a 4-year private university in metropolitan Chicago were recruited for this study. In fall 2013, total enrollment at this university was 7,829 students, including 4,907 graduate students and 2,922 undergraduates [27]. International students make up 45.7% of the student body. Of full-time undergraduates, 30% were female during fall 2013, and 22% were minorities.

Approval for this study was obtained from the Institutional Review Board of the university at which the study was conducted. Required sample size for this study was calculated based on findings from a previous meta-analysis of the literature [24]. Participants were recruited through advertisements in the university newsletter, psychology student subject pool, and recruitment from campus fraternities and sororities. Language in recruitment materials advertised the study as a survey on attitudes towards mental illness. Interested students either completed an online form to indicate their availability or directly emailed the research team. As participants enrolled in the study, they were randomly assigned to one of three conditions: contact, education, or control groups. Randomization was achieved through a randomized block design using a random number generator. Once participants were randomly assigned, they were emailed the time and location for their study section. Participants were blinded to the study, and we have no known violations to blinding procedures to report. All participants provided informed consent to participate. Participants completed measures of stigma, affirming attitudes, desired social distance (a proxy of discrimination), label avoidance, attitudes towards treatment seeking, and intentions to seek treatment prior to participating in the intervention and immediately after. Surveys were completed in the session on a laptop, smartphone, or tablet via a Qualtrics online survey, eliminating concerns about bias being introduced by data collectors.

Interventions were delivered in a classroom on campus, with between 4 and 30 participants in each session. Programs included two parts: a 15-minute presentation followed by 5 minutes for questions. Presentations were kept brief to minimize participant burden. The control presentation consisted of a Ted Talk video on beatboxing, which discussed no issues related to mental illness or any other type of disability.

The contact-based condition consisted of a student with a mental illness telling his or her story. Students were sought from several postsecondary institutions throughout the city. Students providing the contact-based intervention identified as having a diagnosed mental illness and were willing to share their personal stories surrounding mental illness with current college students for the purpose of the study. These students were all currently enrolled in college and taking a medication for their mental illness. The structure of the contact-based intervention involved speakers sharing their experiences of symptoms, their challenges and success, and their experiences with stigma and concluded with a message to the audience about what they can do to address stigma. This format is in line with key ingredients for contact-based approaches to stigma reduction [28]. Analyses of outcome data showed that research participants did not differ by contact group leader. Data were therefore collapsed across contacts for subsequent analysis.

The education-based intervention consisted of a PowerPoint presentation delivered by a graduate student that began by defining stigma and mental illness and concluded with contrasting myths and facts surrounding mental illness specific to the college population. The key myths and facts surrounding mental illness specific to the college population were obtained through earlier focus groups with key campus stakeholders. An example of a key myth included the belief that mental illness is rare among college students. The slide meant to address this myth first stated this common belief and then provided statistics from recent research on the prevalence of mental illness among college students. A checklist was used to document fidelity in both conditions, and adequate fidelity was demonstrated.

Dependent measures

Dependent measures included the Social Distance Scale (SDS) [29], the Attribution Questionnaire (AQ) [23], the Perceived