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Breaking barriers: An education and contact intervention to reduce mental illness stigma among Indian college students

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ABSTRACT

This study assessed the effectiveness of an intervention designed to foster more positive attitudes towards persons with mental illness among college students in Delhi. A total of 50 young people participated in a one-time education and contact based intervention. Attitudes towards persons with mental illness were assessed before the intervention, immediately after it and at a one week follow-up. Results indicated increased feelings of benevolence, community mental health ideology and less authoritarianism at the post-intervention assessments. Reduction in endorsement of social restrictiveness was also observed but only in the case of the immediate post-assessment. We also observed a greater recognition of needs, increased positive descriptions, decreased negative descriptions and reduced labelling after the intervention. These results support the efficacy of education and contact-based strategies for reducing mental illness stigma. Implications of the findings for low-middle income countries like India are discussed.

Rompiendo barreras: una intervención educativa y de contacto para reducir el estigma de los trastornos mentales en los estudiantes universitarios de la India

Palabras clave:
Trastornos mentales
Estigma
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RESUMEN

El estudio valoró la eficacia de una intervención diseñada para favorecer unas actitudes más positivas hacia las personas con trastornos mentales entre los universitarios de Delhi. Un total de 50 jóvenes participaron en una intervención educativa y de contacto. Se evaluaron las actitudes hacia las personas con enfermedades mentales antes, justo después y una semana después de la intervención. Los resultados aumentaron los sentimientos de benevolencia, y la ideología de salud mental comunitaria y redujeron el autoritarismo en las evaluaciones después de la intervención. También se apreció una disminución del apoyo de la restricción social, pero solo en el caso de la evaluación inmediatamente posterior. Asimismo, se observó un mayor reconocimiento de las necesidades, más descripciones positivas, menos descripciones negativas y se redujeron las etiquetas después de la intervención. Estos resultados respaldan la eficacia de las estrategias de educación y contacto para reducir el estigma de los trastornos mentales. Se discuten las implicaciones de estos hallazgos para países de ingresos bajos-medios como la India.

Mental illness stigma can be comprehensively defined as the "devaluing, disgracing, and disfavouring by the general public of individuals with mental illnesses" (Abdullah & Brown, 2011). Stigma encompasses three inter-related constructs: stereotypes (for e.g., persons with mental illness are aggressive), prejudice (for e.g. I do not want to be friends with someone who has a mental illness) and discrimination (for e.g., refusing to give a job to a person with mental illness) (Corrigan, 2004). The cluster of negative beliefs, attitudes and resultant behaviours that surround mental health problems can be debilitating for people effected by them. Due to widespread misconceptions and stigmatization, families tend to conceal members with mental illnesses. Social exclusion

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takes other forms as well. For example people report being unwilling to spend an evening socializing, work next to, or have a family member marry a person with mental illness (Martin, Pescosolido, & Tuch, 2000). Lack of direct contact caused by different forms of social exclusion further perpetuates negative attitudes. Stigma can reduce access to health care (Desai, Rosenheck, Druss, & Perlin, 2002), inhibit persons at risk from using mental health services (Leaf, Bruce, Tischler, & Holzer, 1987) and decrease adherence to treatment regimes (Sirey et al., 2001). Research has suggested that many people choose not to pursue mental health services because they do not want to be deemed a "mental patient" or suffer the prejudice and discrimination the label brings (Ben-Zeev, Young, & Corrigan, 2010). Further, the internalization of negative views has been linked to low self-esteem, negative emotional states and self-blaming (Link, Cullen, Frank, & Wozniak, 1987).

Stigma can also lead to adverse economic effects for persons with mental illness by negatively impacting employment, income and public views about resource allocation and healthcare costs (Sharac, McCrone, Clement, & Thornicroft, 2010). Public funding for research on mental illnesses typically falls well below what is provided for other disabling conditions. Attitudes towards mental illness also create fund-raising challenges for voluntary organizations, making it extremely difficult for agencies to attract funds at the level seen for conditions like cancer and heart disease (Stuart, Arboleda-Florez, & Sartorios, 2012).

As in other parts of the world, mental illness stigma is highly prevalent in India. A cross sectional survey of Indian patients with psychiatric disorders indicated that 90% of the sample had experienced stigma and that stigma was perceived irrespective of age, mental status, rank and education (Pawar, Peters, & Rathod, 2014). Moreover stigma tends to be experienced in various domains. A study on patients with schizophrenia from an outpatient department of a psychiatric hospital in Mumbai revealed that stigma was perceived to be highest in the familial, social and personal contexts. Also prevalent were reports of being avoided due to their illness, discrimination suffered in the family, overhearing offensive comments about mental illness and discrimination at the work place. Close to half the respondents reported problems coping with their marriage and not receiving proposals for marriage due to their illness (Shrivastava et al., 2011). In a study on the experiences of stigma and discrimination of people with schizophrenia in three diverse settings in India, Koschorke et al. (2014) found that more internalized forms of stigma such as a sense of alienation were even more common than experiences of negative discrimination.

Stigma originates from multiple and interacting sources including lack of education, lack of perception, and the nature and complications of the mental illnesses (Arboleda-Flórez, 2002). A strikingly large percentage of participants (97%) in Shrivastava et al.'s (2011) study believed that persons with schizophrenia are stigmatized due to lack of awareness. This lack of awareness is pervasive (Salve, Goswami, Sagar, Nongkynrih, & Sreenivas, 2013) and outmoded beliefs about mental conditions continue to prevail in the country leading to the stigmatization of patients and their families. Mental illness tends to be attributed to supernatural causes and the pathway to care is often shaped by doubts about mental health services and treatments options (Lauber & Rossler, 2007). In a study on myths, beliefs and perceptions about mental disorders and health-seeking behaviour in India, Kishore, Gupta, Jiloha, and Bantman (2011) found a large number of participants to believe that prayer could alleviate mental illness and that ghosts could be removed by a '*tantrik*' or '*ojha*'. The attitude towards psychiatrists, particularly in participants from rural areas was negative. Cultural factors further influence people's beliefs and attitudes. In Asian cultures the emphasis on conformity to norms and emotional self-control leads mental illnesses to be seen as a source of shame (Abdullah & Brown, 2011). Mental illness may be explained as a manifestation of spiritual or moral transgressions and thus be regarded with a sense of guilt. For a nation such as India which grapples with multiple economic, social and political challenges, mental illness does not appear to be a high priority issue. In developing countries, national budgetary allocations for the treatment and management of mental conditions are minimal or none (Stuart et al., 2012). In India, mental health expenditures by the government health ministry are 0.06% of the total health budget (WHO, 2011). Fewer resources being allocated to the area inhibit efforts to alter the existing state of affairs.

Addressing stigma is essential to ensuring that persons with mental illness are able to lead lives of dignity and gain access to resources they need. Despite the prevalence of stigma in Indian samples and the implications it has for the lives of persons who have mental illness, the scarcity of anti-stigma programmes in the country is conspicuous. In comparison with campaigns conducted in affluent countries, the development of anti-stigma programmes is still insufficient in low and middle income countries (Mascayano, Armijo, & Yang, 2015). The present study attempted to address this gap. The objective of the study was to develop, implement and assess an intervention programme designed to foster more positive attitudes towards persons with mental illness among college students.

A review of past studies brought to the fore three types of strategies common among interventions that target mental illness stigma-contact, education and protest (Corrigan & Penn, 1999). Of these, the first two have been found to be successful (Pinfold et al., 2003; Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004). Educational programmes have been directed at several kinds of audiences and tend to produce positive effects at least in the short-term (Corrigan & Penn, 1999; Essler, Arthur, & Stickley, 2006). Some benefits of educational interventions have been established specifically for undergraduate students (Boysen & Vogel, 2008; Masuda et al., 2007). Contact is likely to have an even greater impact on attitudes than education (Corrigan et al., 2001). However the intergroup contact hypothesis first proposed by Allport (1954) holds that positive effects of contact occur in situations characterized by four key conditions: equal status, common goals, intergroup cooperation and support by social and institutional authorities. Allport's formulations have received support from research conducted across a variety of situations and groups (e.g., Ellison and Powers, 1994; Smith, 1994). Research over the years has also illuminated other conditions that improve the outcomes of contact. For instance, studies within the field of mental illness have shown direct contact to be more beneficial than video-based contact (Corrigan, Morris, Michaels, & Rafacz, 2012). Given the well-established efficacy of both the strategies, we designed an intervention involving education as well as direct-contact to address negative attitudes towards persons with mental illness. We discuss the intervention in greater detail below.

Method

Participants and procedure

A total of 50 college students (27 females, 23 males) participated in the study. They ranged in age from 18 to 21 years and were recruited through convenience sampling from different colleges across the Delhi-National Capital Region. The participants were pursuing various academic courses such as History, English, Business and Journalism. However none had a background in psychology or psychiatry. The sample belonged predominantly to the upper-middle income category.

The intervention was conducted in a single two-hour session. On the day of the intervention, all the participants were seated

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