Destigmatizing Mental Illness
An Innovative Evidence-Based Undergraduate Curriculum
Stacey M. Carroll, PhD, ANP-BC

ABSTRACT
Stigma toward individuals with mental illness is prevalent, not only in society but also among nurses caring for this population. Such stigma contributes to health disparities, discrimination, and a lack of providers working with those who experience mental illness. An evidence-based anti-stigma curriculum innovation in a mental health nursing course in an undergraduate program is described. The curriculum change, undertaken over 2 years, included two elements: (a) contact-based education, and (b) reflective activities. For the contact-based education element, volunteers with varying mental illnesses modeling a recovery focus spoke with students and reinforced the content of that day’s lecture. For the reflective element, students engaged in reflective activities regarding stigma, personal biases, and changed perceptions at three points: before, during, and after the contact-based education series. Implications related to nursing and nursing education are presented. [Journal of Psychosocial Nursing and Mental Health Services, xx(x), xx-xx.]

Stigmatizing attitudes toward those with mental illness are common. Stigma is defined as “having some condition or characteristic that is perceived by others as a particular token of shame, disgrace, and social unacceptability” (Charles & Bentley, 2016, p. 149). Stigma causes a perception of difference and lack of value (Abbey et al., 2011) and can lead to discrimination (Sartorius, 2006) and health disparities (Parsloe & Carroll, in press). These negative attitudes may dissuade nursing students from pursuing this field (Jansen & Venter, 2015), when in fact the need for mental health nurses
is greater than ever due to the increase of individuals with mental illness. In addition, even if a student does not work in the mental health field, mental illnesses are prevalent as comorbidities in any area of nursing. Given that stigma has worse consequences than mental illness itself (Thornicroft et al., 2016), creative ways to counteract stigma more effectively are needed.

PROVIDER ATTITUDES REGARDING MENTAL ILLNESS

One might expect that mental health care providers, specifically nurses, would have more positive views than the general population toward those with mental illness due to exposure. However, nurses have demonstrated a stereotypical rather than person-centered approach toward patients with mental illness (MacNeele, Scott, Treacy, Hyde, & O'Mahony, 2012), and this medical model orientation was similarly found among nursing students (Temple & Mordoch, 2012). Nurses’ exposure is often during the most acute phases of illness (Ungar, Knaak, & Szeto, 2016), which means that the recovery element is missing and stereotypes of poor prognosis are confirmed. Likewise, nursing students’ clinical rotations are typically in more acute situations where they see patients in psychiatric crises. Nursing students may miss the whole recovery process and not see individuals living full, functional lives with mental illness. In fact, Linden and Kavanagh (2012) found that mental health nurses and nursing students practicing in inpatient settings had less positive attitudes toward mental illness than those working in community settings, where recovery is more evident.

CONTACT-BASED EDUCATION IN MENTAL HEALTH

Having contact with individuals with mental illness has repeatedly been shown to decrease negative attitudes toward that population (Charles & Bentley, 2016; Corrigan, Morris, Michaels, Rafacz, & Rüschi, 2012). Interactions with individuals with mental illness as a means to educate mental health students, including nursing students, resulted in students having improved attitudes toward mental illness (Perry, Watkins, Gilbert, & Rawlinson, 2013; Schneebeli, O’Brien, Lampshire, & Hamer, 2010). However, the type of contact requires careful consideration; if exposure is to individuals with mental illness who have behaviors consistent with the stereotypical view of that mental illness, stigma is likely to increase rather than decrease. Reinke, Corrigan, Leonhard, Lundin, and Kubiak (2004) found that the stereotypes held needed to be disconfirmed by the individual with mental illness to challenge stigma and lead to positive attitude change. Barczyk (2015) found that among the general public, if individuals did not believe in the recovery potential of a person with mental illness, social distance increased. If the contact demonstrated the recovery model, defined by Abbey et al. (2011) as “the process by which people with lived experiences with mental illness participate, work, learn, and live fully in their communities” (p. 7), stereotypes were challenged and stigma was therefore decreased (Barczyk, 2015). Recovery does not necessarily mean symptom-free but rather focuses on coping (Abbey et al., 2011) and living well with the illness (Chen, Koller, Krupa, & Stuart, 2016). For example, when positive stories were presented by those who abuse substances, stigma was effectively reduced (Livingston, Milne, Fang, & Amari, 2012).

In-person contact was generally deemed more effective than video representations, which do not allow for dialogue or interaction (Corrigan et al., 2012). Thornicroft et al. (2016) reviewed studies examining effectiveness in reducing stigma and found that education combined with contact was effective in reducing medium- and long-term stigma. Henderson et al. (2014) found that health professionals, although still demonstrating stigma toward individuals with mental illness, were less stigmatizing than students in those same professions. Thus, targeting stigma at the student level is essential, and in-person contact with a recovery focus is one way to achieve this goal.

CURRICULAR CHANGES BASED ON EVIDENCE

The prior undergraduate mental health curriculum at a New England baccalaureate nursing program involved lectures and clinical rotations in acute care psychiatric/substance abuse settings, as is the typical model. In addition to the traditional mental health clinical rotations, an observational experience at a community mental health agency was added so students could interact with more patients in the recovery phase. In an effort to reduce stigma, a curriculum innovation of the didactic portion of the mental health nursing course was undertaken over the past 2 years. The curriculum innovation approach was two-pronged: (a) contact-based education with a recovery focus, and (b) reflective activities prior to, during, and after the contact-based education program.

INTEGRATING CONTACT-BASED EDUCATION INTO CURRICULUM

Contact-based education with a recovery focus has been identified as one of the most effective ways to reduce stigma; therefore, a series of guest speakers comprising individuals who live and function well with mental illnesses was arranged. Speakers were scheduled on the same day as the lecture on their corresponding mental illness; for example, if the lecture was on anxiety and obsessive-compulsive disorder (OCD), the speaker that day was someone who experiences that condition. Speakers came in for the end of class after the lecture was completed and stayed for 30 minutes to 1 hour (average = 45 minutes).

Speakers were located using social media, the instructor’s contacts, and a call for volunteers, explaining that the goal was to help educate mental health nursing students about the perspective of individuals experiencing various psychiatric conditions, as well as to reduce stigma about mental illnesses.
The response was overwhelming and over the course of 2 years, speakers with the following conditions or experiences were arranged: anxiety/OCD, depression/suicidality, child psychiatric illnesses (from the parent perspective), substance abuse, bipolar disorder, and abuse/trauma/posttraumatic stress disorder (PTSD). Careful planning was required so that speakers’ experiences correlated with the day’s lecture topic. Sometimes one speaker presented and other times two presented. For example, two speakers shared the different types of abuse they experienced, which demonstrated to students that although the type of abuse can vary, the underlying issue of control and the resulting consequence of trauma can occur regardless. During the first year, speakers were all non-nurses. However, Pinto-Foltz and Logsdon (2009) hypothesized that contact and education by a nurse with a mental illness would decrease stigma. Thus, during the second year, a nurse with a mental illness was added to the speaker roster. By varying the speakers and presenting different mental illnesses, the generalist model of mental illness as one entity (Ungar et al., 2016) was avoided and students came to learn about and understand differences among mental illnesses.

Students were informed of confidentiality requirements and speakers were introduced by first names only, unless they wished to give last names as well. When describing speakers’ backgrounds, person-first language (e.g., “person who has schizophrenia” rather than “a schizophrenic”) was modeled by the course instructor to avoid feelings of separation. Speakers told their stories, including the history of their mental illness, how the illness has affected their lives, how they live with the mental illness, any treatments/medications they have used, and what approaches by health care providers were helpful/not helpful. The information presented by speakers reinforced what students learned during the lecture. For example, students were educated about not interrupting the compulsive behaviors exhibited by a patient during lecture, and this concept became much clearer when the speaker with OCD gave an example of how she could not stop scrubbing a spot on the wall and that trying to get her to stop would greatly increase her anxiety. If the instructor sensed there were certain concepts with which the students were struggling, these were discussed with the speaker so the concept could be reinforced through the narrative.

Because individuals (in this case, students) may not be comfortable knowing what to say to someone with mental illness (Szeto, O’Neill, & Dobson, 2015), and because contact-based education needs to be engaging to be effective (Chen et al., 2016), speakers who were receptive to questions were chosen. Students were free to ask questions while speakers were telling their stories, and additional time was allotted at the end for a question-and-answer session. As students saw how receptive the speakers were, they gained confidence to ask questions.

Having individuals who experience mental illness in the role of “client educators” (Ungar et al., 2016, p. 263) helped shift the power differential. Rather than being patients, these individuals with mental illness were now educators and sources of information; this changed power relations and resulted in students being more reflective and empathetic (Perry et al., 2013). Corrigan, Kosyluk, and Rüsch (2013) suggested that self-stigma, which is applying a stereotype to oneself, can be decreased among individuals with mental illness through public disclosure. Similarly, Mittal, Sullivan, Chekuri, Allee, and Corrigan (2012) found that increased empowerment helped individuals with mental illness cope with self-stigma. Although the goal of contact-based education via those with lived experience of mental illness is to provide education (Chen et al., 2016) and reduce stigma among students, several speakers noted that it was cathartic and helpful for them to share their experiences. One speaker said, “Trust me when I say it was just as beneficial for me as it may have been for them.”

INCORPORATING REFLECTIVE ACTIVITIES INTO CURRICULUM

Students’ personalities, experiences, and individual differences can affect their level of stigma (Szeto et al., 2015). In addition, increased empathy and the ability to think about a situation from another person’s perspective can decrease stigma (Szeto et al., 2015); therefore, reflection is an important exercise for self-awareness. Reflective activities were incorporated into the curriculum before, during, and after the contact-based education series.

Reflection Prior to Contact-Based Education Series

Reflective activities included having students, on their first day of the course before any of the guest lectures occurred, write anonymously whether they have had exposure to or personal experience with any mental illness, including substance abuse. After being given the definition of stigma, students were asked to describe in writing whether they have a stigma against mental illness and why, and whether they believe society has a stigma against mental illness and why. These responses were consolidated by the instructor and reviewed with students to facilitate dialogue. Such upfront assessment of student learners regarding attitudes is consistent with the anti-stigma guide suggested by Ungar et al. (2016). Most students indicated that they had either personal experience with mental illness or exposure to various mental illnesses among their family and friends. Some had exposure only through patients and some, of course, had no exposure at all.

In general, those who had some exposure or considered themselves older and more experienced believed that they did not have a personal stigma against mental illness, with one student noting, “I know people with mental illness and they are great people.” Being raised in a household that talked freely about mental illness was noted as a way to reduce stigma. Common themes expressed were related to understanding that individuals with mental illness do not have control over the condition.

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and probably wish they did not have the mental illness, and that they deserve respect and proper treatment. As one student stated, “We all have struggles and difficulties.” Another student noted, “You have to see past that side of them and know that they are a person who lives equally in society but has a hard time.”

Students who believed they had stigma toward mental illness generally cited having no exposure or a negative experience with someone who has a mental illness. One student noted, “Even though they can’t help their condition, I feel they are not a normal person,” and others stated that the media portrayal of people with mental illness as “crazy” or dangerous has contributed to their own stigma. Discomfort was a common reaction: “I don’t know how to approach, behave, or handle a situation where I’m interacting with someone with a severe mental illness and I admit it makes me uncomfortable,” and “I don’t know how to react…when I should just treat them like everyone else.” The stigma was generally deemed unintentional and students hoped that through education their stigma would lessen. As one student stated, “I’m in between being fearful but still understanding the circumstances.”

Students almost unanimously believed that society has a stigma against mental illness. One student stated, “Society labels people with mental illness. The stigma portrayed is that people with mental illness are unfit to function properly, making people with mental illness hesitant to come forward.” Contributing factors to societal stigma identified were: media portrayals, mental illnesses not being fully understood, the primacy placed on physical illness over mental illness, difficulty connecting with those who have mental illness, believing that individuals with mental illness are unpredictable, jokes about mental illness, and labels such as “crazy.” One student remarked, “It’s our human nature to judge others,” whereas another student stated that mental illness is “viewed as being apart from normal society.” Addiction issues being perceived as a lifestyle choice rather than a disease were identified as contributors to stigma. Cultural issues can be a factor as well, as one student stated, “Society in my native country [not the United States] has a stigma because these patients are considered wicked and are being punished by some higher power.” Another student noted, “As someone with a mental illness, I feel I am constantly stigmatized.”

Reflection During Contact-Based Education Series

Another reflective activity involved having students identify—verbally and in writing—any biases they have toward certain situations and populations. This activity was performed during the second half of the course, after several lectures had occurred. At this point, students had some exposure to mental illness and could address remaining biases. This exercise had three goals: (a) to acknowledge that everyone has biases and fears, and that expressing those is part of self-reflection and growth; (b) to allow misconceptions to be clarified; and (c) to discuss strategies to deal with the biases.

Biases identified by students often related to an ongoing personal battle. Examples included a bias toward those who abuse substances if a student had experienced a family member who did not successfully recover from substance abuse, or a bias toward caring for individuals who have hurt others if a student experienced past personal trauma. Certain situations scared students, which caused them to feel biased. Students shared clinical and personal stories, using no names, which demonstrated these concepts and allowed them to reflect and learn from each other. One student admitted having negative feelings toward patients who are addicted to drugs, causing an aversion toward working with this population, whereas another student shared experiences with a family member’s history of addiction, which fueled a desire to work with this population. These stories allowed students to see a different perspective. Students shared stories of loved ones who had attempted or completed suicide and the effect it had on them and the people around them, and stated that it can be emotionally devastating to process suicide.

Students attempted to be aware of their biases and find strategies to overcome or deal with them. Education—specifically obtaining more knowledge about mental illnesses and what it is like to live with these conditions—was identified as a way to understand and work with these biases. One student stated, “I would never treat a patient differently because of their issue but it is always in the back of my head that it bothers me.” Another student reflected, “I know I shouldn’t work with that population if I can’t overcome those biases.” Students focused on the need to not judge others. A strategy shared was: “I purposefully set myself up with patients who have conditions I’m biased against to heal myself.” Students noted that “taking a step back” and reflecting on their own biases helped them approach patients more positively.

Reflection After Contact-Based Education Series

At the end of the course, after the contact-based education program was complete, the final reflective activity occurred as part of a course evaluation. Students evaluated the speakers and reflected on whether their perception of individuals with mental illness changed as a result of this contact.

Students overwhelmingly believed that the speakers were a positive addition to the course as a whole. “All the speakers showed that recovery is possible,” commented one student. The majority of students believed that the speakers changed their own perceptions on mental illness and made them more empathetic. One student stated, “I used to judge people addicted to drugs and alcohol. I thought they were low-lives and bums. I now respect them for turning their lives around and trying to get help.” Speakers were noted to be “all nice and easy to talk to.” A student stated, “I had never met people with mental illness until this semes-
A common theme was that individuals with mental illness can be anyone: “They were your everyday people, which is not how most people with mental illness are viewed,” and “Often you think of people with mental illness as crazy but they are really just average everyday people.” One student noted that a speaker conveyed mental illness “in a more realistic way, instead of how it’s perceived in the movies.” They were surprised that the speakers were living normal lives, with one student stating, “She can hold a nursing job!” Students also came to realize that seeing the perspectives of individuals with various mental illnesses showed that each person has a unique lived experience: “not everyone with mental illness is the same,” and “they all had different coping skills.” Students realized it is not always easy to tell who is experiencing a mental illness and that “you never actually know what’s going on with a person.” Another student similarly noted, “My view has changed fully. I had no idea mental illness had that much impact. People you meet every day could be struggling.” Students believed that hearing about the different mental illness conditions from the speakers reinforced what they learned in their text books and class lectures, and made them more aware of resources for helping this population. Hearing the speakers “boosted my morale to work with [people with mental illness],” said one student. “I will always remember what they had to say,” noted a student, whereas another student who personally experienced a mental illness commented, “They made me feel less alone.”

IMPLICATIONS
Framing mental illness as a brain disorder and focusing on neurobiological causes was long thought to be the avenue to decreasing stigma. Pescosolido et al. (2010) analyzed a decade of data to examine whether the American public understood the neurobiological basis of mental illness and whether that understanding corresponded with decreased stigma. They found that although respondents increasingly attributed mental illness to neurobiological causes, there was no subsequent lessening of stigma and, in some cases, stigma actually increased. The researchers advocated an inclusion framework that focuses on the competencies and strengths of those with mental illness to decrease stigma. In 2014, Sayce examined evidence presented by various researchers including Pescosolido et al. (2010) and confirmed that conceptualizing mental illness as a brain illness similar to a physical illness perpetuated, rather than diminished, stigmatizing attitudes. Sayce (2014) reported that any illness—mental or physical—can in fact be subject to discrimination, so the preferable approach is for mental health providers to serve as allies to support the rights of those with mental illness.

Pinto-Foltz and Logsdon (2009) suggested that nurses be actively involved in anti-stigma organizations, be aware of inaccurate representations of those with mental illness, and advocate for fair treatment of this population. Decreasing nursing students’ stigma may lead them to later advocate for systemic—wide changes, thus contributing to more widespread mental health stigma reduction. Pescosolido, Medina, Martin, and Long (2013) suggested “efforts to influence larger cultural contexts of misunderstanding, inclusion or rejection, and tolerance or intolerance is essential” (p. e7). Thus, a political advocacy assignment could be another avenue to pursue with such curriculum innovation. Students could identify issues of concern to this population and write letters to legislators or newspapers. Another potential assignment could be to have students identify and discuss a positive or negative portrayal of mental illness in the media to raise awareness of the need to critically evaluate such situations.

CONCLUSION
In the revised curriculum presented, students learned about varying perspectives of mental illness and were able to reflect on those to recognize and decrease stigma. Based on narrative feedback, interacting with speakers representing the recovery model of mental illness combined with the reflective activities enabled students in this undergraduate nursing course to gain insight about and reduce their stigma. This curriculum innovation involved careful planning and coordination but did not add any expense, thanks to the generosity of individuals with mental illness who gave their time to fulfill a wider goal of educating future nurses. By desegregating mental illness, the hope is that these students will provide compassionate and effective mental health care during their clinical rotations and when they become RNs.

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Dr. Carroll is Assistant Professor, Anna Maria College, Paxton, Massachusetts.
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Address correspondence to Stacey M. Carroll, PhD, ANP-BC, Assistant Professor, Anna Maria College, 50 Sunset Lane, Trinity Hall, Paxton, MA 01612; e-mail: smcarroll88@gmail.com.
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