



Reducing Mental Health Stigma:

A Case Study

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Abstract

The purpose of this study was to evaluate a contact-based educational symposium designed to reduce mental health-related stigma in journalism students. Repeated surveys conducted before ($n = 89$) and again after the intervention ($n = 53$) were used to assess change. The estimated average response rate for each survey was 90%. The instrument, adapted from prior research, contained items pertaining to stereotypical content, attitudes toward social distance and feelings of social responsibility (Cronbach's $\alpha = .74$).

There was a statistically significant reduction in stigma (reflecting a 5% reduction in the aggregated scale score). A large, item-specific change was noted pertaining to attributions of dangerousness and unpredictability (reflecting a 26% improvement). The majority of students reported that the symposium had changed their views of people with a mental illness. Half of these students considered that they would change the way they would report stories involving someone with a mental illness. A potential unexpected negative side effect was that 14% fewer students reported post-test a willingness to go to a doctor if they experienced a mental illness.

Though it is difficult to draw firm conclusions from an uncontrolled study, it would appear that this relatively brief, contact-based intervention changed journalism students' views of people with a mental illness. More controlled investigation is needed to rule out alternative explanations that could account for this change.

In the two years leading up to its final report, *Out of the Shadows at Last*, the Standing Senate Committee on Social Affairs, Science and Technology (2006) reviewed the state of mental health and addictions in Canada – the first national review. As part of its investigation, the committee received several thousand testimonials from Canadians who shared stories about the profound stigma and discrimination they face. The committee recommended that a Mental Health Commission be created to provide national leadership in mental health to begin to address the many problems the committee had uncovered. In 2007, the commission was funded by the federal government with a 10-year mandate. One component of the commission's mandate is to diminish the stigma and discrimination experienced by Canadians living with mental illness. In 2009, the launch of the commission's 10-year Opening Minds anti-stigma, anti-discrimination initiative marked the largest systematic effort to combat mental illness-related stigma and discrimination in Canadian history.

The Opening Minds program is approaching stigma reduction in a highly focused way: targeting specific groups and areas for change; supporting interventions that are based on the best available evidence; developing and building upon grassroots networks of individuals and agencies already engaged in anti-stigma programming; developing tools that can be used to broadly disseminate best practices; and contributing to the best practice literature through systematic evaluation and research. Since the inception of the program, two evaluation networks have been created, both of which are now actively engaged in field work. One focuses on youth, and the other focuses on health professionals. A third network, focusing on stigma in workplaces, is under development.

This article presents the evaluation results of a contact-based educational intervention that was undertaken as part of the youth initiative to reduce stigma among journalism students. The intervention was a half-day symposium that brought students into direct contact with three presenters who had personal experience with mental illness. They shared their stories and described the impact of stigma (including the impact from negative media portrayals) on their everyday lives. Two media specialists – one mass media expert and one journalist – talked about the media's pivotal role in the creation and maintenance of stigma, particularly in adopting story lines that portray people with a mental illness as violent and unpredictable, or using negative and disrespectful language to sensationalize story content. Although the media are a major source of stigmatizing images, to our knowledge, this is the first time contact-based education has been targeted to this important group. The complete symposium can be viewed on line at the Mental Health Commission of Canada's website (<http://www.mentalhealthcommission.ca>).

Background

*I would do anything to have breast cancer over mental illness.
I would do anything because I [would] not have to put up
with the stigma.*

–Helen Forristall

The term *stigma* has been variously used to refer to an undesirable trait (such as a mental illness) that marks the bearer (Goffman 1963); a cognitive-emotional process that results in negative stereotypes, prejudicial feelings and discriminatory behaviours (Corrigan 2000); and a complex social process involving individual, group and structural elements that intersect to disempower, marginalize and disenfranchise (Link and Phelan 2001). In the colloquial use of the term, *stigma* has become equated with a negative attitude, leaving human rights advocates feeling that the discourse has become too narrow and incapable of drawing attention to the central issues of social injustice and discrimination (Everett 2004). However, as the opening quotation suggests, the conceptualization that appears to resonate best with the lived experiences of those who have a mental illness is the one that defines *stigma* in its most pervasive sense, as a social force that perpetuates social injustices, diminishes life chances, jeopardizes recovery and impinges on self-esteem. It is within this broader understanding that *stigma* is used in this article, and it is within this broader understanding that young journalist students were targeted for this anti-stigma intervention.

News and entertainment media create and maintain public stereotypes of the mentally ill. Because they make a living from *selling* the news, journalists often use stigmatizing images to frame news stories and grab audience attention. A catchy news story is one that presents conflict or controversy or raises issues of public safety. News stories often convey vivid, sensationalized and inaccurate portrayals of people who have a mental illness, ones that emphasize violent and bizarre behaviour. A single dramatic event may be reshaped and repeated to provide a steady flow of negative information that has the power to overshadow positive depictions and reinforce deep-seated cultural stereotypes and fears. Stereotypical images are consolidated with each negative report. The frequency and intensity with which news media cover a violent incident can give the mistaken impression that dangerousness and unpredictability are part and parcel of being mentally ill, and heavy exposure to such images cultivates misinformation, misconception, fear, hostility and intolerance (Stuart 2006a).

Even very young children (as young as five years old) can project elements of mental illness stigma by using negative stereotypes or derisive terminology. This is because media socialization begins early. Television occupies more of children's time than any other structured activity, including school. It has

been estimated, for example, that children have already received the equivalent of three years of television instruction by the time their formal schooling begins (Wahl 2003). With regular reinforcement from news and entertainment media, children's thinking about mental illness follow a developmental path, with prejudices eventually becoming fully engrained and deeply resistant to change (Adler and Wahl 1998; Spitzer and Cameron 1995).

Because news media are a major source of mental health information, they have been the targets of several different anti-stigma approaches. For example, there are a number of media-monitoring projects that have been initiated by members of advocacy groups and the mental health community in an attempt to create reporting guidelines (Kisely and Denney 2007; Pirkis et al. 2008). However, journalists may view reporting guidelines as an imposition; if guidelines are seen as an attempt to restrain journalists' freedom, this may cause a backlash and engender charges of censorship.

There is also some evidence that engaging reporters and providing them with appropriate background materials and storylines can improve the number of positive media images of mental illness, though it may have little effect on the number of negative images (Stuart 2003). When an appropriate rapport has been established between journalists and mental health experts, even violent incidents can be presented in a balanced manner, used to educate the public about the difficulties faced by people who experience a mental illness and contextualize acts of violence as rare events (Mayer and Barry 1992).

A third approach is to educate journalism students – before their opinions have crystallized – to raise their awareness about the role of media in creating and perpetuating negative stereotypes. Campbell and colleagues (2009) offered an interdisciplinary, active educational experience to five journalism students and 14 psychiatric residents. After a workshop led by medical and journalism faculty, interdisciplinary teams of students were charged with designing an anti-stigma intervention. Following the project, journalism students reported a greater awareness of the impact of stigma and the media's role in creating it. However, they were also less likely to consider that they had the ability to improve society's ideas about mental illness.

TABLE 1.
Pretest and post-test characteristics

Characteristic	Pretest % (n = 89)	Post-Test % (n = 53)
Gender*		
Male	31.3 (25)	30.2 (16)
Female	68.8 (55)	69.8 (37)
Not stated	(9)	
Age group†		
19–21	51.3 (41)	39.2 (20)
22–24	27.5 (22)	31.4 (16)
25+	21.3 (17)	29.4 (15)
Not stated	(9)	(2)
Contact (multiple responses possible)‡		
Close friend ^A	30.4 (24)	37.7 (20)
Family member ^B	46.8 (37)	49.1 (26)
Any close friend or family member ^C	67.1 (53)	67.9 (36)

* χ^2 (df = 1) = 0.017, $p = .897$.

† χ^2 (df = 1) = 1.97, $p = .372$.

‡A = χ^2 (df = 1) = 0.77, $p = .379$; B = χ^2 (df = 1) = 0.06, $p = .802$; C = χ^2 (df = 1) = 0.01, $p = .920$.

Numerous studies have shown that people who have had interpersonal contact with someone who has had a mental illness hold more positive and less stigmatizing attitudes (Kolodziej and Johnson 1996). Creating opportunities for positive interpersonal contact in the context of educational programs (termed *contact-based education*) has become one of the most promising anti-stigma practices (Corrigan et al. 2001). For example, undergraduate university students were randomly assigned to a contact-based educational intervention consisting of a video depicting the personal stories of nine people who had been treated for a mental illness, followed by active discussion. Knowledge scores improved by 8.8%, attitude scores by 5.5% and scores reflecting a willingness to accept a person with a mental illness by 9.5%. There were no changes in the control group (Wood and Wahl 2006). Such results provide strong evidence that contact-based education can bring about small but important reductions in stigma.

Contact-based education has been shown to reduce prejudice and social intolerance in high-school (Pinfold et al. 2005; Stuart 2006b), undergraduate (Corrigan et al. 2001; Corrigan et al. 2002; Reinke et al. 2004), psychology (Holmes et al. 1999; Wallach 2004), social work (Shera and Delva-Tauiliili 1996; Shor and Sykes 2002) and medical students (Altindag et al. 2006). To our knowledge, there are no examples of contact-based education used to reduce stigma among journalism students. Toward this end, we provided a two-hour symposium that gave students an opportunity to have direct personal contact with three people who had different experiences with mental illnesses – two had

personally experienced a serious mental illness and one had a seriously ill parent. In addition, we included two media experts to help link the speakers' personal experiences of stigma to journalism practices. In keeping with previous research with university students (e.g., Wood and Wahl 2006), we expected to see small but statistically significant changes reflecting a 5–10% improvement in our aggregated scale score. In addition, because a key focus of the symposium was on media images of dangerousness and unpredictability, we also expected to see a large reduction in the proportion of students who subscribed to this stereotype. Finally, we expected students to provide qualitative reports indicating ways in which they would change their behaviours as a result of their participation in the session.

Methods

Design

We surveyed students before and after the symposium. Because all journalism students were targeted to receive the intervention on a given day (and classes had been released only for that day), there was no possibility of developing a comparison group. Surveys were anonymous.

Study Sample

Though the symposium was targeted to journalism students, faculty members from other health- and social service-related classes requested permission for their students to attend, and class time was released for this purpose. Interested teachers and members of the general public also attended. The pretest response rate based on the broader sample of students was 87% (122 of 141 were returned). The post-test response rate based on all attendees was 92% (254 out of 276). Because the content of the symposium was targeted to journalism students, our analysis is restricted to this group.

Measures

We adapted items from a questionnaire used by several program sites that participated in the World Psychiatric Association's global anti-stigma program to evaluate contact-based high-school programs (Pinfold et al. 2005; Stuart 2006a). Our Stigma Evaluation Survey contained 20 self-report items. We assessed changes in attitudes (six items), expressions of social acceptance (eight items) and feelings of social responsibility (six items). All items were scored on a five-point agreement scale, ranging from strongly agree to strongly disagree. To avoid potential response sets, we varied the wording so that some items were positively worded and others were negatively worded. We reverse scored items so that higher scores would reflect higher levels of stigma. Cronbach's alpha was .74, indicating that the scale had good reliability in this sample. We also measured gender, age (based on year of birth) and prior contact with someone with a mental illness (a close friend or family member). Finally, we included

open-ended questions on the post-test survey asking respondents what they liked and disliked about the symposium and what they thought they would do differently having heard the presentation. The terms *mental illness* and *the mentally ill* were used throughout to frame the survey questions as these are known to be well understood and to prompt stereotypical responses.

Results

Eighty-nine journalism students completed the pretest survey, and 53 completed the post-test survey (60% of the original cohort). Table 1 describes the characteristics of the pretest and post-test groups. There were 12% fewer younger students (aged 19–21) in the post-test sample, and 7% more people who reported that they had a close friend with a mental illness. To minimize the possibility of bias, we weighted the post-test sample to be proportionally equivalent to the pretest sample with respect to age group and gender. We did not weight on the basis of contact because students' willingness to disclose personal contact may have changed as a result of the intervention.

Table 2 shows the item-specific proportions for the pre- and post-test groups. For ease of presentation, scores were re-coded into agree, neutral and disagree. Items that were reverse coded are marked with (*R*). Because weighted *n*-sizes do not correspond to the original data, only percentages have been shown.

Considering the pretest scores, the journalism students reported positive and non-stigmatizing attitudes in a number of important areas. For example, they tended not to subscribe to common stereotypes that portray people with a mental illness as being able to "snap out of" their illness, too disabled to work, or untrustworthy. They also agreed that people with a mental illness are often treated unfairly. However, only about half (55%) disagreed with the stereotype that people with a mental illness are dangerous, unpredictable and untreatable. In hypothetical social interactions, they reported feeling mostly comfortable interacting with people who have a mental illness in situations involving casual or less intimate social interactions (e.g., where they could control the level of social proximity and engagement), such as living next door to, sitting in class next to or giving a job to someone with a mental illness. They were less comfortable making close friends with someone who had a mental illness or engaging in professional relationships requiring a high level of competency and trust, such as going to a physician who had been treated for a mental illness or letting someone with a mental illness babysit their children or teach schoolchildren. Most stated that they themselves would be comfortable going to a doctor if they had a mental illness, and that they were generally socially conscious when it came to causes that did not require a close, interpersonal commitment, such as donating to a charity to support people with a mental illness, signing a petition to support better programming or supporting more tax dollars to improve services. They were less likely to want to volunteer their time or

TABLE 2.
Self-report stigma items*

Stereotyped Attribution Items	Pretest %	Post-Test % (Weighted)
(R) Most people with a mental illness could snap out of it if they wanted to		
• Disagree	90.9	93.9
• Neutral	6.8	6.0
• Agree	2.3	—
(R) People who are mentally ill are too disabled to work		
• Disagree	80.7	88.3
• Neutral	15.9	7.1
• Agree	3.4	4.6
(R) People with mental illnesses are untrustworthy		
• Disagree	85.1	93.8
• Neutral	9.2	6.2
• Agree	5.7	—
People with mental illnesses are often treated unfairly		
• Agree	85.2	91.7
• Neutral	8.0	1.4
• Disagree	6.8	7.0
(R) People with mental illnesses tend to be dangerous and unpredictable		
• Disagree	55.1	81.1
• Neutral	34.8	8.7
• Agree	10.1	10.1
(R) There are few effective treatments available for the mentally ill		
• Disagree	56.2	51.7
• Neutral	22.5	36.5
• Agree	21.4	11.8
Social Distance Items	Pretest %	Post-Test % (Weighted)
I would not mind if someone with a mental illness lived next door to me		
• Agree	92.0	96.8
• Neutral	4.6	1.8
• Disagree	3.5	1.3
(R) I would be upset if someone with a mental illness sat next to me in class		
• Disagree	87.5	95.4
• Neutral	10.2	4.6
• Agree	2.3	—
(R) If I was an employer, I would not give someone with a mental illness a job		
• Disagree	70.1	79.1
• Neutral	24.1	12.5
• Agree	5.8	8.3
I would make close friends with someone who had a mental illness		
• Agree	53.4	65.9
• Neutral	39.8	31.4
• Disagree	6.8	2.7
(R) I would not go to a physician if I knew that he or she had been treated for a mental illness		
• Disagree	51.7	67.7
• Neutral	25.3	21.1
• Agree	23.0	11.1

Table 2 Continued.

I would let someone with a mental illness babysit my children		
• Agree	25.0	30.7
• Neutral	39.8	40.9
• Disagree	35.2	28.4
(R) I would not want someone with a mental illness to be a schoolteacher		
• Disagree	51.1	64.3
• Neutral	33.0	28.8
• Agree	15.9	6.9
I would go to the doctor if I thought I had a mental illness		
• Agree	88.5	74.3
• Neutral	9.2	18.4
• Disagree	2.3	7.4
Social Responsibility Items	Pretest %	Post-Test % (Weighted)
I would sign a petition to support better programs for the mentally ill		
• Agree	94.3	92.7
• Neutral	3.5	7.0
• Disagree	2.3	1.3
I would make a one-time donation to a charity to support mentally ill people		
• Agree	80.5	73.4
• Neutral	13.8	19.8
• Disagree	5.8	7.0
I would make a regular donation to a charity to support mentally ill people		
• Agree	49.4	53.1
• Neutral	37.9	34.1
• Disagree	12.6	12.8
I would support spending more tax dollars to improve services for the mentally ill		
• Agree	71.3	84.9
• Neutral	23.0	7.6
• Disagree	5.8	7.6
I would join an advocacy program to improve the rights of the mentally ill		
• Agree	51.1	46.8
• Neutral	34.1	36.2
• Disagree	14.8	17.0
I would volunteer my time to work in an agency for the mentally ill		
• Agree	43.2	45.4
• Neutral	44.3	33.3
• Disagree	12.5	19.3

*(R) signifies an item that was reverse coded in the scale calculation. Higher-scale scores reflect higher levels of stigma. Post-test results are weighted to pretest results for gender and age group.

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Comparing the pretest to the post-test findings, the largest item-specific change was with respect to students' views of dangerousness and unpredictability. In the post-test sample, 81% disagreed that people with a mental illness are violent and unpredictable, reflecting a 26% improvement. The remaining five attribution items all changed in the expected direction. For example, a greater proportion of students in the post-test sample disagreed that people with a mental illness were untrustworthy

(a 9% change), were too disabled to work (an 8% change), were often treated unfairly (a 7% change) or could snap out of it if they wanted to (a 3% change). In addition, there was a drop of 10% in the proportion of post-test students who agreed that few treatments are available for mental illness.

Seven of the eight social distance items also changed in the expected direction. A greater proportion of post-test students thought that they would not mind if someone with a mental illness lived next door to them (a 5% change) or sat next to them

TABLE 3.
Predicted mean scale scores in pretest and post-test groups*

	Pretest Model (CI)	Post-Test Model (CI)	Mean Difference (CI)
Mean scale score	43.6 (42.9–44.3)	39.5 (38.7–40.4)	-4.1
Gender			
Male	43.0 (41.7–44.2)	39.4 (38.7–40.6)	-3.6
Female	43.9 (43.1–44.7)	39.6 (38.5–40.8)	-4.3
Age group			
19–21	45.8 (45.1–46.5)	42.0 (40.8–43.1)	-3.8
22–26	41.5 (40.6–42.4)	38.8 (37.8–39.8)	-2.7
25+	41.2 (40.1–42.3)	37.1 (35.8–38.5)	-4.1
Close friend			
No	44.1 (43.3–44.9)	40.9 (39.9–41.9)	-3.2
Yes	42.5 (41.3–43.7)	37.2 (36.2–38.3)	-5.3
Family member			
No	45.8 (45.1–46.5)	41.7 (40.7–42.6)	-4.1
Yes	41.1 (40.5–41.8)	37.3 (36.5–38.2)	-3.8

CI = confidence interval.

*Mean values are predicted from a least squares regression assuming independent samples with all variables included in the model;

 $R^2 = .18$ ($n = 119$), $F(6, 112) = 4.13$, $p < .001$.

in class (an 8% change). Post-test students were also more likely to report that they would hire someone with a mental illness if they were an employer (a 9% change) or make close friends with someone who had a mental illness (a 12% change). With respect to professional relationships, a greater proportion of post-test students would agree to let someone with a mental illness babysit their children (a 6% change) or teach schoolchildren (a 13% change) or would go to a doctor who had been treated for a mental illness (a 16% change). Surprisingly, 14% fewer post-test students indicated they would be willing to go to a doctor for treatment if they thought they themselves had a mental illness.

With respect to social responsibility items, students in the post-test sample were less willing to make a one-time donation to a charity to support people with a mental illness (a reduction of 7%) but more willing to make a regular donation (a 4% increase). The proportion willing to sign a petition was high in both groups (93–94%). Fourteen percent more post-test students were willing to support spending additional tax dollars to improve mental health services. A small positive change was noted in the proportion of post-test students who would volunteer their time (2%), and a small negative change was noted in the proportion of post-test students who would be willing to join an advocacy group (-4%).

Table 3 presents the results of a least squares regression model estimating the total stigma scale score and 95% confidence

intervals for pre- and post-test groups adjusting for gender, age group and contact variables and assuming independent samples. Results show a statistically significant mean drop of 4.1 points from pretest to post-test, reflecting a 5% drop in the average scale score. The model was statistically significant and explained 18% of the variance. Table 3 also shows the estimated mean differences for each group based on the fitted model. All groups showed statistically significant changes in the expected direction. Mean differences ranged from 2.7 (for those aged 22–26) to 5.3 (for those having a close friend with a mental illness).

What Would Respondents Do Differently?

The majority of post-test students (72%) responded to an open-ended question, indicating

that they thought they would behave differently as a result of the symposium. Theme-based coding of their comments indicated that 61% of those who thought they would change said they would alter their views about people with a mental illness. Also, almost half (46%) said they would pay more attention to the way in which media stories are covered, such as being “more conscientious about covering the subject” or “very aware of the wording” they use when writing stories.

Summary and Conclusion

This article describes the results of a contact-based anti-stigma intervention provided to journalism students sponsored by the Opening Minds anti-stigma program of the Mental Health Commission of Canada. Three people with different personal experiences with mental illness shared their stories and discussed the impact of stigma on their daily lives. Two media experts discussed the role of the media in creating and maintaining stigma. Students completed surveys prior to the seminar and then again following the presentations. We assessed changes in attitudes, expressions of social acceptance and feelings of social responsibility using a 20-item scale (Cronbach's alpha = .74). A statistically significant decrease in scale scores from 43.6 to 39.5 points was noted, reflecting a 5% reduction in stigmatizing attitudes following the symposium. In addition, a large, item-specific change (reflecting a 26% reduction in stigma) was noted

with respect to students' stereotypic views of mental illness as connoting dangerousness and unpredictability – a stereotype that was specifically targeted during the symposium. The majority of students reported that the symposium had changed their views of people with a mental illness, and half of these indicated they thought they would change the way they would report stories involving someone with a mental illness. These findings suggest that the symposium was successful in reducing stigma, particularly with respect to stereotypes of dangerousness and unpredictability, and in raising awareness of how news media can contribute to this process.

A potential and unexpected negative side effect of the symposium was that 14% fewer post-test students reported a willingness to go to a doctor if they were experiencing a mental illness, perhaps because they became more aware of the stigma and discrimination that people with a mental illness face. Mental health-related stigma is widely considered to be a key barrier to seeking help and is considered to be the major cause of the large treatment gap (Corrigan 2004). By promoting a greater awareness of the level of stigma and discrimination faced by people with a mental illness, we may have inadvertently encouraged label avoidance as a coping strategy, where students would be less willing to go to a doctor for diagnosis. However, because our presenters also talked about the importance of having received treatment for their own recovery, this interpretation remains highly speculative, but worthy of more detailed future investigation.

Simple evaluation designs, such as the pretest/post-test survey used here, are useful precursors to more rigorous evaluation because they are less intrusive and more cost-effective than larger, more controlled studies. They can help determine the usefulness of a program by indicating whether program participants change in the desired direction (Posavac 2011). However, pretest/post-test designs are also subject to over-interpretation because they do not control for the many competing explanations that may account for observed changes.

In our study, we experienced 40% attrition from pre- to post-test. We understand that there was some confusion among students as to whether they should complete two surveys. Some did not complete a post-test survey because they thought they had *already completed* the study questionnaire. Also, as the symposium drew to a close, a number of students left the room before the evaluation instrument could be collected. Thus, it may be that attrition was unrelated to stigma. We statistically matched pretest and post-test groups on age group and gender, thereby minimizing any bias that may have been related to these variables.

An important difficulty we experienced was our inability to individually match students on pre- and post-test surveys. We did not receive ethics clearance to collect the identifying information that was required to undertake this level of matching. Consequently, we could not determine which students did not provide a post-test measure. Secondly, we were unable to

optimize our analysis by using statistics that would take the dependence of the samples into consideration. As a result, estimates of variance were inflated, resulting in wider confidence intervals. This makes it more difficult to detect statistically significant differences. However, because we did not report any null findings, this is less of a concern.

With one-group evaluation designs, it is also impossible to rule out the impact of external events as an explanation for change. In our case, the types of external events that typically occur would have been negative, such as a widely publicized violent incident involving someone with a mental illness. Research has shown that such events increase stigma (Angermeyer and Matschinger 1995). Because our pre- and post-test measures were taken on the same day, it is unlikely that any external event would be a credible explanation for our findings.

Finally, because we used self-report measures, we cannot know the extent to which the symposium created a social desirability response. Students may have been less willing to state their real attitudes and beliefs and more knowledgeable about what constituted a socially and politically correct response. Inclusion of a social desirability scale would have been helpful to rule out this possibility, but it would have increased respondent burden and rendered data collection too unwieldy. Thus, we are unable to rule out social desirability as a competing explanation for our findings.

Despite these limitations, our results are consistent with findings from contact-based education programs targeting other target groups (Holmes et al. 1999; Pinfold et al. 2005; Shera and Delva-Tauiiili 1996; Shor and Sykes 2002; Stuart 2006a; Wallach 2004), including experimental designs where participants were randomized to study and control conditions (Altindag et al. 2006; Corrigan et al. 2002; Reinke et al. 2004; Wood and Wahl 2006). Thus, while it is difficult to draw firm conclusions from a single uncontrolled study, placed within the context of the existing literature, it would appear that this relatively brief contact-based intervention changed journalism students' self-reported views of people with a mental illness. More controlled investigation is needed to rule out alternative explanations that could account for this change. However, in the mean time, these results are encouraging and suggest that those who administer journalism programs could consider including contact-based education to help students understand mental illness-related stigma and the role of the media in this process. The results also support the future planned work of the Opening Mind program in promoting contact-based education to de-stigmatize mental illnesses among various youth groups. **HQ**

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