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A Mixed Methods Approach to Challenging Stigma at a Faculty of Education

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Abstract

This dissertation investigates the stigma of mental illness in schools. In today's Canadian classrooms, at least one in five students is experiencing a mental disorder, which without treatment or support can severely impede students' academic performance and can reinforce stereotypical beliefs about: (a) these students' ability to be successful in the classroom, and (b) their teachers' abilities to meet their needs. While mental health awareness about these issues is steadily increasing, stigmatizing attitudes – which present a major barrier to help-seeking – are not decreasing at a comparable rate. Therefore, I used mixed methods to explore the experience of mental illness stigma at school from two perspectives: (1) youth living with mental illness, and (2) teacher candidates at a Faculty of Education. In particular, I investigated whether personal contact with youth self-identifying as having a mental illness influenced teacher candidates' perceptions of students with mental illness. I asked: *What is the impact on the stigma of mental illness when youth share their stories with teacher candidates?* Using two quantitative measures of stigma – the Attribution Questionnaire-9 and the Opening Minds Scale – I found that youth stories about their experience with mental illness at school were not significantly associated with a decrease in stigma among teacher candidates. Using semi-structured interviews and short-answer questions, the majority of teacher candidates who heard youth's stories at a mental health literacy professional development day specifically named these stories as having the “biggest impact” on them. During the design studio and focus groups, youth revealed that reflecting on the specific messages they wanted to send to teacher candidates allowed youth to discover new insights about what they had learned and how they had grown from their experiences living with mental illness at school. This study offers educators firsthand perspectives from youth and teacher candidates about how they and other mental health stakeholders can work together to challenge the stigma of mental illness in educational contexts.

Keywords: mental health, youth, stigma, mental illness, young adults, teacher, teacher candidates, mental health literacy

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A Mixed Methods Approach to Challenging Stigma at a Faculty of Education

Research Context: The Stigma of Mental Illness

Much attention has been paid to reducing mental illness stigma in schools (Stuart, 2012; Froese-Germain & Riel, 2012; Meldrum, Venn, & Kutcher, 2009). While mental health *awareness* in schools is steadily increasing, stigmatizing *attitudes* towards mental illness are not decreasing at a comparable rate (Arboleda-Florez & Sartorius, 2008; Pescosolido et al., 2010). In an attempt to learn more about what may influence those stigmatizing attitudes, I designed a mixed methods study to explore the experience of mental illness stigma at school from two perspectives: (1) youth living with mental illness, and (2) teacher candidates at a Faculty of Education. In particular, I investigated whether personal contact with youth self-identifying as having a mental illness can influence teacher candidates' perceptions of students with mental illness. I ask: *What is the impact on the stigma of mental illness when youth share their stories with teacher candidates?*

I begin by defining two key terms: *mental illness* and *stigma*. Mizock and Russinova (2013) define mental illness as “a mental disorder that interferes with at least two of the following– social functioning, vocational functioning, and self-care” (p. 229). The Mental Health Commission of Canada (2009) defines stigma as “beliefs and attitudes about mental health problems and illnesses that lead to the negative stereotyping of people living with mental health problems and illnesses and to prejudice against them and their families” (p. 82). The Commission recognizes that stigma is a major problem in Canada, and “believes that the work to reduce stigma and eliminate discrimination must be actively taken up by everyone across the country. Only then will it become possible for people living with mental health problems and illnesses to be fully included as valued members of Canadian society” (Mental Health Commission of Canada, 2009, p. 81).

Stigma resides at multiple levels: from the attitudes we hold towards people with mental illnesses, to the beliefs we have about the legitimacy and feasibility of mental health care, to the policies and practices that create barriers that inhibit “access to financial, interpersonal, spiritual, and political resources that are available to all adults seeking to accomplish personal goals” (Corrigan, Powell, & Michaels, 2013, p. 180).

Arboleda-Florez and Stuart (2012) add that “people with a mental illness are marginalized, disenfranchised, excluded, and denied the human rights and social entitlements that others take for granted” (p. 459). From their study of over 3,900 Canadian teachers, Froese-Germain and Riel (2012) concluded that most teachers also “believe that stigma and discrimination pose a major barrier to the provision of mental health services for students” (p. 19). Youth may perceive this barrier to be even greater when seeking help: In a small study, Bowers, Manion, Papadopoulos and Gauvreau (2013) found that Canadian youth, regardless of whether or not they had a mental illness, were significantly more likely than school-based mental health service providers to perceive stigma as a significant barrier to seeking help. These youth also perceived their teachers “as inadequately equipped to deal with and address mental health and substance abuse problems” (p. 165).

The impact of mental health problems at school. Mental health problems that significantly interfere with the ability to function on a daily basis present a major challenge for children and youth in schools across Canada (Froese-Germain & Riel, 2012). Meldrum, Venn, and Kutcher (2009) call mental disorders “the most common and disabling condition affecting young people”, reporting that “[a]t any given time in Canada, approximately twenty percent of young people may be suffering from some form of mental disorder, which translates to one in five students in the average classroom” (p. 3). Waddell (2007) adds “mental disorders are arguably the leading health problems that Canadian children face from infancy onwards” (p. 7). This claim is supported by Statistics Canada (2004), which reports that when compared to all other age groups, youth ages 15-24 were the group most likely to report suffering from major depression, mania disorder, panic disorder, agoraphobia, social anxiety disorder, alcohol dependence, and illicit drug dependence. This may be because of the age of onset for the majority mental illnesses: 50% of people with mental illness will experience its onset by age 11, and 75% before the age of 25 (Kessler et al., 2005; Kutcher, 2014). Therefore, the overwhelming majority of people who experience mental illness will do so while they are in school.

Experiencing emotional distress or multiple symptoms of poor mental health impedes students' academic performance through a number of factors. In particular, students struggling with externalizing symptoms often find their academic performance and social functioning eroding (Flett & Hewitt, 2013). For example, Breslau, Lane, Sampson, and Kessler (2008) found that students with at least one mental disorder with externalizing behaviours (i.e., inner feelings of anger or frustration expressed outwards towards other people, rather than turned inward) were more likely than their peers without a mental disorder to drop out of school before graduating from primary school, high school, and college (Esch et al., 2014). These students were also less likely than their peers to enter college. This breakdown in the ability to function at school can then reinforce stereotypical beliefs about these students' ability to be successful in the classroom and their teachers' abilities to meet their needs.

Esch and his colleagues' (2014) meta-analysis found that girls' educational attainment was most affected when they experienced symptoms of poor mental health that caused a loss of motivation, cognitive slowness, and social inhibition. Boys were more likely to have their academic achievement inhibited by "non-cognitive" (p. 10) behaviours including aggressiveness and restlessness in the classroom (Esch et al., 2014). Substance use in particular is associated with decreased academic achievement and an increased risk of secondary school dropout, and the cycle of poor mental health continues after dropping out of school, as students who drop out of secondary school are more likely to develop mood disorders and are at a higher risk of suicidal ideation (Esch et al., 2014; McLeod, Uemura, & Rohrman, 2012).

DeSocio and Hootman (2004) found the same pattern for younger children in their review of the literature linking mental health to school outcomes. They reported that academic and social difficulties in elementary school often preceded mental illness diagnoses in adolescence. At the elementary school age, children experience and communicate emotional distress through somatization, or "the frequent reporting of aches, pains, and medically unexplained physical symptoms" (DeSocio & Hootman, 2004, p. 191). DeSocio and Hootman report that when these physical symptoms keep these students from attending school, they fall behind in class and social activities at

school, and become more likely to experience academic difficulties. Despite the large number of youth in distress – and the dire consequences of struggling with poor mental health at school – only one in four youth struggling with their mental health “report that they have sought and received services and treatment” (Mental Health Commission of Canada, 2012).

Stigma impedes seeking support for mental health problems. One of the most significant barriers to seeking help and continuing with treatment is the stigma associated with mental illness (Alvidrez, Snowden, & Kaiser, 2008; Angermeyer & Dietrich, 2006; Bowers, Manion, Papadopoulos, & Gauvreau, 2013; Boyd, Katz, Link, & Phelan, 2010; Corrigan, 2007; Corrigan, Druss, & Perlick, 2014; Couture & Penn, 2003; Froese-Germain & Riel, 2012; Matteo & You, 2012; Mental Health Commission of Canada, 2009; Moses, 2009; Pescosolido et al., 2010; Pinto, Hickman, Logsdon, & Burant, 2012; Rusch, Angermeyer, & Corrigan, 2005; Spagnolo, Murphy, & Librera, 2008; Vogel, Bitman, Hammer, & Wade, 2013). Corrigan (2014) argues that anti-stigma efforts “need to target the educational system so classroom supports help students with mental illness to achieve their academic goals” (p. S6). The threat of stigma resulting from a diagnosis of mental illness deters both teachers and students from seeking social and professional support during mental distress, and continuing with treatment once help is sought. The social exclusion and self-isolation that often results when individuals try to cope with mental illness on their own can lead to the exacerbation of troubling symptoms of mental illness, which further prohibit recovery and fuel negative stereotypes about the capacity and potential of people with mental illness. This may help explain why, in a climate where knowledge and awareness about mental illnesses continue to steadily increase, stigmatizing attitudes and behaviours have not shown a commensurable decrease (Arboleda-Florez & Sartorius, 2008; Pescosolido et al., 2010).

Challenging Stigma with Personal Contact

Research shows that one of the most effective ways to decrease mental illness stigma is to have personal contact with an individual who self-identifies as having a mental illness and who also disconfirms commonly-held negative stereotypes about mental illness (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012; Corrigan, Roe, &

Tsang, 2011; Couture & Penn, 2003; Dalky, 2012; Froese-Germain & Riel, 2012; Spagnolo et al., 2008). Personal contact may decrease the stigma of mental illness by allowing people to better understand and recognize the humanity, diversity, and capacity of individuals with mental illnesses (Corrigan, Roe, & Tsang, 2011). In fact, Boyd, Katz, Link, and Phelan (2010) note that people who have direct experience or have family members or friends who have had experience with psychiatric hospitalization “possess a more egalitarian, welcoming attitude, making them viable advocates for dispelling the myths associated with the mentally ill” (p. 1069). Couture and Penn (2003) hypothesize that personal contact is effective because “it potentially combines information provision (i.e., education) with the opportunity to directly interact with someone with [a serious mental illness]” (p. 293).

Personal contact has long been proposed to help change “prejudicial attitudes and improv[e] tensions among various racial and ethnic groups” (Couture & Penn, 2003, p. 293): Couture and Penn explain that when members of the general public “encounter instances of the stigmatized group that are inconsistent with their stereotypes of that group” (p. 293), they are left with a discrepancy between what they previously believed and what they have now experienced. To resolve this discrepancy, they generalize the positive attitudes they now have about the person they had meaningful contact with to all members of that stigmatized group. The same theoretical mechanism might apply to contact with people with mental illness in particular.

Challenging stereotypes. Although mental health awareness has been increasing, attitudes towards mental illness have not been improving at a comparable rate. In this study, I investigate whether personal contact with youth self-identifying as having a mental illness can influence teacher candidates’ perceptions of students with mental illness. My overall research question is:

Overall Research Question:

What is the impact on the stigma of mental illness when youth share their stories with teacher candidates?

As a result of the recent increase in mental health awareness campaigns, I propose that teacher candidates are successfully receiving the message that mental illness should not be stigmatized. However, despite these encouraging messages, teacher candidates may continue to associate the experience of mental illness with a permanent loss of competency, social standing, and opportunities for success. The disconnect between what teacher candidates *hear* and what they *believe* may come from a lack of meaningful personal contact with students who identify as having a mental illness, have sought help for their struggles, and have experienced positive outcomes as a result.

We all encounter individuals on a daily basis who disconfirm negative stereotypes, but only a small percentage publicly self-identify as having a mental illness (Boyd, Katz, Link, & Phelan, 2010). Many individuals successfully managing a mental illness may choose not to reveal their diagnoses of mental illness or experiences of psychiatric hospitalizations for various reasons, including the consequences of stigma and individuals' right to privacy (Boyd, Katz, Link, & Phelan, 2010). After all, no one is entitled to know another person's story. How have teacher candidates reacted when faced with the opportunity to ask – or tell – about a story of mental illness? How might this process be intensified in youth populations, where youth must contend with a power differential between the student revealing a diagnosis of mental illness and the teacher receiving the story? In Chapter 4, I describe how youth in this study responded to the tension between the benefits and drawbacks of 'coming out' about their mental illness.

What are the characteristics of a contact experience that successfully challenges stereotypes to decrease stigma? In her review of youth personal contact anti-stigma programs, Stuart and her colleagues (2014) found that:

The best storytellers shared a story with a recovery theme and without lengthy digressions into the signs and symptoms of their illness, were psychologically ready to share their experiences to help students learn (rather than to achieve a personal therapeutic goal), were able to engage their audience, managed active participation through questions and discussion, and modelled recovery. The most effective programs recognized that this takes considerable training and support, which they provided on an ongoing basis. (Stuart et al., 2014, p. S15)

Couture and Penn (2003) and Reinke, Corrigan, Leonhard, Lundin, and Kubiak (2004) agree that the storyteller must challenge or disconfirm public stereotypes about people with mental illness, but not “so much that the target person is viewed as the ‘exception to the rule’” (Couture & Penn, 2003, p. 293). Reinke et al. (2004) explain that the focus of the story must not be on the storyteller’s experiences unsuccessfully self-managing symptoms of mental illness because this confirms long-held stereotypes about people with mental illness – I will discuss these stereotypes in depth in Chapter 2. The importance of sharing a story that disconfirms stereotypes is particularly important when the target audience includes people who regularly come in contact with individuals in crisis. Indeed, Reinke et al. (2004) argue that mental health professionals tend to endorse stigmatizing attitudes because their daily work involves interacting with people who confirm stereotypes about people with mental illness. Therefore, Couture and Penn (2003) propose that the most effective contact experiences happen when “people encounter instances of the stigmatized group that are inconsistent with their stereotypes of that group” (p. 293).

The role of youth. Imagine if you had the power to change lives just by talking. Imagine if you knew you could save lives by simply telling your story. (Landsberg, 2012)

Challenging stigma through telling your story. Research supports the notion that individuals with lived experience benefit from sharing their stories. However, the great majority of this research has focused on adults sharing their story. Corrigan and Rao (2012) discuss how individuals with lived experience can experience feelings of empowerment and decreased personal stigma when they are able to rewrite and re-tell their own stories about their recovery from serious mental illness. Fisher and Freshwater (2014) see the act of telling and constructing one’s own story of mental illness and health as a form of decolonization, where people who have experienced mental illness “represent themselves rather than being spoken for” (p. 202). People with lived experience can reclaim their own sense of identity from dominant, patriarchal models of mental illness pathology where the doctor is the only expert on all aspects of the patient’s

welfare, care, and recovery (Corrigan, Roe, & Tsang, 2011; Fisher & Freshwater, 2014; Schon, 2010; Wang, 2011; Young, 2009).

Carless and Douglas (2008) explain “the experience of serious mental illness can in itself deny individuals both the ability and the opportunity to author their own life story” (p. 579). Because it is traditionally the mental health professional who makes the psychiatric diagnosis of mental illness, who dictates the course of treatment, and who predicts the likelihood of recovery, mental health consumers can suffer a loss of agency as their identity becomes subsumed under the will of the ‘professional’ (Carless & Douglas, 2008; Corrigan, Roe, & Tsang, 2011; Wang, 2011; Young, 2009). Fisher and Freshwater (2014) argue that this loss of agency has influenced the cultural templates that people with mental illness have traditionally used to construct, understand, and tell their story. They explain that in the 1950s and 1960s, this template was “based on a story of mental illness as loss, loss of life and loss of opportunities”, where “the hope for restitution [was] firmly placed in submitting oneself to the authority of nurses and doctors” (Fisher and Freshwater, 2014, p. 203). This kind of negative personal narrative about the future life losses that follow a diagnosis of mental illness can promote further symptoms of poor mental health: MacDougall, Vandermeer, and Norman (2015) found that people who imagined a negative future for themselves as a result of their mental illness were significantly more likely to be depressed than people who imagined a positive future self.

In contrast, Fisher and Freshwater (2014) explain that after the 1980s, ‘patients’ became ‘service users’, while their cultural template “transmute[d] into an explicitly political story of survival and resistance, with the narrator newly cast as hero” (Fisher & Freshwater, 2014, p. 203). Young (2009), who analyzed four memoirs written by individuals with lived experience, found that these memoirs “refute culturally dominant ideas about severe mental illness as personal weakness, as something shameful, and as a condition that necessarily leads to isolation and disenfranchisement” (p. 52). She argues that act of telling about one’s experiences with mental illness helps change “our social attitudes toward people with mental illness” (Young, 2009, p. 52). Similarly, Fisher and Freshwater (2014) propose that when people hear and experience new cultural templates

that construct stories of mental illness and health through a lens of resistance to negative stereotypes, “new heroic stories of survival and of human diversity arise, influencing how mental disorder is experienced” and how mental illness is perceived (p. 203).

What we do not yet know is what this process looks like for *youth* who choose to tell their story. How might this process differ from what has already been investigated with adults with lived experience? Neither the process by which youth with lived experience formulate and share their experiences of mental illness and health, nor the impact of these stories on the stigma of mental illness in teacher candidates, has been widely investigated in the existing mental illness stigma research literature. Therefore, my second research question is:

Research Question 2:

What is the process and result when youth co-create curriculum to share their story with teacher candidates?

Why study youth in particular? There is a dearth of research investigating the process by which youth decide whether and how to share their story about their experience with mental illness. The lack of research in this area is especially troubling since youth are consistently recruited to share their stories. I choose to work alongside youth with lived experience in this study to highlight the importance of their voices being at the centre of discussions surrounding the stigma of mental illness in schools. When adult caregivers – e.g., doctors, parents, teachers – traditionally hold the power to make key decisions and pronouncements about the welfare and capacity of a young person with mental illness, the act of youth taking control of their own story – including exposing the barriers and system gaps that inhibit their recovery and growth – can support youth in reclaiming their identity as the expert in their own life, refuting culturally dominant perceptions of individuals with mental illness, and recognizing their unique strengths and potential to effect real change in the lives of other mental health stakeholders (Fisher and Freshwater, 2014).

Corrigan (2014) argues “research on stigma requires an active team that partners scientists and people with lived experience of mental illness” (p. S7). Therefore, in this

study I partnered with participants from a Canadian youth mental health advocacy organization. Five of these participants aged 18-25, self-identified as having a mental illness and chose to tell their story to teacher candidates. My choice of this age group was purposeful: to be just past – rather than in the midst – of experiences with stigma in school. These youth were close enough in age to high school students, but over the age of majority so that they could consent to the research themselves. Furthermore, youth participants in this study who had particularly difficult experiences with mental illness stigma during high school had enough distance from their experiences in high school to reflect on their experiences in a way that felt empowering to them. My choice of the method with which I worked with youth participants was also purposeful: it reflected key characteristics of anti-stigma practices, which I discuss further in Chapter 2.

The role of teacher candidates. Corrigan, Powell, and Michaels (2014) remind us “evaluating stigma is not sufficient; absence of stereotypes does not promote social inclusion” (p. 466). Therefore, they argue that stigma change programs must “target stereotypes and their discriminatory consequences.” (p. 466) Teacher candidates are the next generation of teachers who can be mental health champions in their schools and can approach their practice through an affirming, anti-discriminatory lens.

Stigma in the classroom. Stuart (2012), writing in the context of Canadian schools, reports that the stigma of mental illness

is often described as more disabling than the illness itself. It prevents individuals and families from seeking early identification and treatment for a mental illness; it tarnishes their reputation and social standing, and it results in serious inequities in educational, economic, health, and other social entitlements that non-disabled people take for granted (Stuart, 2012, p. 1).

In the classroom, stigma affects everyone. When teachers do not have the opportunity to learn about how they can help support the mental health of their students – or when they are told that it is beyond the scope of their teaching role – students struggling with mental illness may receive the message that they do not belong in the classroom. Their peers may also learn that the classroom is not a safe space to address

mental health concerns, and teachers may learn that their own mental health is not a priority for their working environment.

The reality of the pervasive nature of stigma makes it more likely that teacher candidates will encounter stigmatizing attitudes about mental illness from other teachers, school administration, and their own students (Froese-Germain & Riel, 2012; Rothi, Leavey, & Best, 2008; Stuart, 2012). For example, 21% of teachers in Froese-Germain and Riel's (2012) study of teachers reported that they had *frequently* "seen a student being treated unfairly, bullied, or teased as a result of having a mental health problem.[...] Only 17% of teachers could say that they had 'never' witnessed unfair treatment because of a mental health problem" (p. 14). Teacher candidates can help push back against stigma and be an asset to the emotional development and empowerment of their students when they participate in cultivating a healthy classroom environment for all students. When today's teacher candidates become tomorrow's education policy drivers, they will determine the role of mental health education in the next generation of Canadian classrooms. Teacher candidates who choose to pursue careers outside education can have an equally important impact, since the workplace is one of the Mental Health Commission of Canada's four main target groups for reducing the stigma of mental illness. These teacher candidates who are educated about ways to combat the stigma of mental illness can contribute to safe and healthy workplaces and can influence mental health-affirming policies beyond educational institutions.

Why study teacher candidates in particular? I chose to study teacher candidates because they must contend with periodically conflicting identities of 'student' and 'teacher' during their preservice training. They must take care of their own emotional health as students, but also find ways to support their students' emotional needs when acting as teachers during their practicum (Chang, 2009; Koller & Bertel, 2006; Rothi, Leavey, & Best, 2008; Walter, Gouze, & Lim, 2006). So what do we expect from the next generation of classroom teachers? While a teacher's role in caring for students with mental illness remains distinct from a mental health professional's role, researchers are increasingly recognizing the reality that teachers play a significant role in the early identification of students developing emotional difficulties and the support of students'

emotional development (Knight & Knight, 2011; Kutcher, Wei, McLuckie, & Bullock, 2013; Liljequist & Renk, 2007; Rothi, Leavey, & Best, 2008; Meldrum, Venn, & Kutcher, 2009). Knight and Knight (2011), Rothi, Leavey, and Best (2008), and Loades and Mastroyannopoulou (2010) add that parents and students also look to teachers for guidance for mental health support and referral. Koller and Bertel (2006) explain that because the teacher is “the first adult role model” for students in their classroom, teachers “must be able to apply basic mental health principles to foster positive personal, social and emotional growth” (p. 201).

It is logical to assume that, based on the amount of research-based calls for better teacher preparation to promote mental health, schools and faculties of Education would have reformed their course offerings to educate teacher candidates in mental health. After all, over a decade ago, Koller, Osterlind, Paris, and Weston (2004) wrote:

teachers are routinely sent into public schools with increasing student mental health problems, completely untrained, which leaves many of them frustrated, disappointed, and discouraged. This disconnect between training and practice, coupled with the fact that teachers are rarely trained to recognize and manage their own mental health needs, such as stress and burn-out, may contribute to the high rate of attrition [...] among teachers in their first five years of teaching. (Koller, Osterlind, Paris, & Weston, 2004, p. 41)

However, over a decade later, not enough has changed. At the time of the study described in this dissertation, the Faculty of Education in this study had recently begun a mental health course for a limited number of students in the intermediate-senior program. The University of British Columbia was also “the first in North America to offer a social and emotional learning cohort for the pre-service teachers” (SEL T-Ed, n.d.). In contrast to these two promising initiatives, Froese-Germain and Riel found that in 2012, over two-thirds of Canadian teachers “reported that they had not received any professional development such as knowledge acquisition or skills training to address student mental illness” (p. 16). Regardless of whether teachers in this survey had prior training in mental health issues, “[v]irtually all teachers surveyed (97%) reported an important need for additional knowledge and skills training in recognizing and understanding mental health

issues in children” (p. 17). Interestingly, this number was higher than the 84% of teachers who reported the need for more classroom management training.

In most teacher education programs, educational psychology classes are mandatory, where teacher candidates learn about ‘normal’ and abnormal social and emotional development of children and youth. However, Rothi, Leavey, and Best (2008) argue that “[t]here is limited guidance [during teacher training] beyond an expectation that teachers are able to demonstrate an understanding of how pupils’ learning may be affected by their physical, intellectual, linguistic, social, cultural and emotional development” (p. 1219). After an extensive review of all preservice teacher courses across Canada, Rodger et al. (2014) determined that “[a]t most, teacher [candidates] may complete a basic general educational psychology course which focuses on instructional theory but which excludes mental health principles and their relationship to learning” (p. 4).

Within the last five years, the Faculty of Education in this study has recognized and responded to the increasingly complex challenges of new teachers by developing a new mandatory classroom management course. Walter et al. (2006) say that “[c]lassroom management strategies are particularly pertinent for students with disruptive behavior, and a number of effective techniques that can be implemented by teachers have been catalogued in recent publications” (p. 67). However, Rothi, Leavey, and Best (2008) argue “much of the emphasis [in teacher training initiatives] dwells on the management of disruptive behaviour rather than on an investigation of the underlying emotional or psychological problem” (p. 1219). Classroom management alone is incomplete because it can neglect underlying emotional difficulties that can present as disruptive behaviour that challenges the teacher. Without explicit instruction on how to promote mental health in the classroom, a focus on correcting disruptive behaviour can rob teacher candidates of the opportunity to examine of the roots of these challenging behaviours from an anti-discriminatory perspective that breaks the cycle of stigmatizing assumptions about students with mental illness.

As mental health awareness increases in the public sphere through mental health campaigns (e.g., *Bell Let’s Talk*, *Time To Change*, *Opening Minds*, *Not Myself Today*)

and celebrities are beginning to speak about their personal experiences with mental illness (e.g., *Off The Record*, Catherine Zeta-Jones, Clara Hughes, Demi Lovato, Carrie Fisher, Brooke Shields, Sheryl Crow, Jean-Claude Van Damme), teachers are also starting to recognize that addressing mental health at school is important, but they feel underprepared to do so (Kutcher, Wei, McLuckie, & Bullock, 2013). For example, Walter, Gouze, and Lim (2006) found that teachers “did not feel confident about their ability to manage mental health problems in their classroom” (p. 64), and cited “lack of information/training” as “the greatest barrier to surmounting mental health problems” (p. 61). Similarly, Rothi et al. (2008) found that “teachers feel incompetent to the task of recognition [of mental health problems] and that schools generally lack policy or strategies on the management of these problems beyond ‘punishment’” (p. 1221) .

Therefore, teachers recognize the areas in which they feel underprepared, and are willing to learn (Froese-Germain & Riel, 2012). Teachers in Rothi et al.’s 2008 study “demanded (a) expert advice on recognition and sources of support, (b) information on appropriate referral agencies and (c) practical training on how to manage children with mental health problems in the classroom” (p. 1223). However, Rothi et al. (2008) also found that in-service teachers cited a lack of time as a major barrier to devote to learning these strategies. A better time for this could be during preservice training. Koller, Osterlind, Paris, and Weston (2004) recommend that

pre-service teachers should know and be able to demonstrate, upon completion of their certification requirements:

- the role that they have in the prevention of mental health problems (such as creating positive classroom environments, promoting healthy peer relationships, and enhancing students’ self-concept)
- how to identify students who may have, or are headed toward, a mental health problem such as depression or anxiety
- how to create a positive, strengths-based learning environment where learning academic content can occur, but where a positive self-image in the learner is also reinforced. (Koller, Osterlind, Paris, & Weston, 2004, p. 43)

To this end, Weston, Anderson-Butcher and Burke (2008) have proposed a comprehensive curriculum framework of “teacher dispositions and competencies” as a “first attempt to provide guidance to teacher training and pre-service preparation programs” in the United States (p. 32). Despite these recommendations for preservice education, tension exists in balancing the number of already mandatory classes that teacher candidates are required to take. Knight and Knight (2011) add that for inservice teachers, the tension continues

between meeting the needs of all learners on the one hand and that of academic performance benchmarks and standards assessed through national testing on the other.[...] In essence, there is less time to devote to a pastoral care role of enhancing students’ personal and social development which can’t be measured but is essential for overcoming barriers and achieving learning outcomes (Knight & Knight, 2011, p. 93).

Professional development days may offer a compromise between need and efficiency to help teacher candidates feel more confident in supporting their students’ mental health (Rothi, Leavey, & Best, 2008).

Mental health literacy. What should teachers learn about during their professional development? The Faculty of Education at the institution in this study was the first to offer a completely online mental health literacy course for a limited number of teacher candidates. It also offered a Mental Health Literacy Day, a mandatory one-day professional development workshop for all teacher candidates. In a report for the Canadian Alliance on Mental Illness and Mental Health, Bourget and Chenier (2007) write that “mental health literacy has been defined as the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems. Enhanced mental health literacy appears to confer a range of benefits: prevention, early recognition and intervention, and reduction of stigma associated with mental illness.” (p. 4) This is the definition teacher candidates were asked to respond to during their interviews.

Wei, Kutcher, Hines, and MacKay (2014) have brought their framework to school by educating Nova Scotia students and teachers. Wei et al. define mental health literacy

as “the capacity to understand what constitutes positive mental health and learning about strategies to obtain and help maintain positive mental health; knowledge about mental disorders and their treatment based on best available evidence, improved attitudes towards those living with mental disorders (decreased stigma) and enhanced personal capacity to seek mental health care from appropriate health care providers should that be required” (p. 1158). Both of these definitions include the reduction of stigma in their mental health literacy framework. This suggests that an anti-stigma strategy can be a key component of mental health literacy education initiatives.

It is encouraging to hear from Froese-Germain and Riel (2012) that “[i]n general, teachers support the need to continue and broaden the important emerging conversation about child and youth mental illness and mental health in order to raise awareness, and reduce and ultimately eliminate harmful stigma” (p. 19). The study in this dissertation investigates one way for both teacher candidates and youth with lived experience to contribute to this conversation and challenge stigma at school.

Building on the previous mental health literacy professional development day at this Faculty of Education, I used this study to investigate the impact of adding an anti-stigma component to the day in the form of youth stories. In addition to hearing from mental health literacy experts, teacher candidates attending Mental Health Literacy Day I in the fall term of 2014 heard from youth firsthand about what it was like to go to school as a student experiencing mental illness. Some teacher candidates had personal contact with these youth, hearing their story live and asking them questions. Other teacher candidates watched a video of one youth telling his or her story, then worked with a facilitator to discuss questions designed to build empathy, reflect on their assumptions and practices, and plan for the integration of students with mental illnesses into their classrooms. Still others served as the control group, listening to an anti-stigma lecture from a professor. These teacher candidates all had the opportunity to listen to one youth’s story during Mental Health Literacy Day II in the winter term of 2015. I used quantitative methods to answer my third research question:

Research Question 3:

Is a contact-based intervention involving teacher candidates hearing from youth with mental illness significantly associated with a decrease in public or private stigma?

After Mental Health Literacy Day I, eleven teacher candidates participated in individual semi-structured interviews to share their perceptions of Mental Health Literacy Day I, their practicum experiences supporting their students' mental health, and their own experiences with mental health and the stigma of mental illness. Their answers contributed to my fourth research question:

Research Question 4:

How did teacher candidates' new knowledge from Mental Health Literacy Day inform their teaching practices?

Mutual effects of youth and teacher candidates challenging stigma at school.

So far, we have explored how sharing personal stories about mental illness may benefit youth with lived experience, and how hearing from youth may benefit teacher candidates. However, are there any mutual effects of researchers, teacher candidates, and youth with lived experience working together to challenge the stigma of mental illness?

From a relational-cultural theoretical perspective, the ultimate benefit of personal contact lies in the mutual effects of engaging in a growth-fostering relationship. Duffey and Somody (2011) say "people develop more fully through connections with others. Relationship, rather than autonomy, is the cornerstone of growth." (p. 224) This kind of growth is mutual, where all partners in the relationship "contribute and grow or benefit; development is not a one-way street" (Duffey & Somody, 2011, p. 226). As partners in the relationship grow towards each other, they develop mutual "empathy and mutual empowerment" (Duffey & Somody, 2011, p. 226). Similarly, Darling-Hammond (2000), writing about teacher education, argues that "[a] commitment to open inquiry, the enlargement of perspectives, and the crossing of boundaries are critical features of the ideal university education." (p. 171) In Chapter 6, I discuss how the exercise of teacher candidates listening and responding to youth stories served as one way to accomplish

these goals. It is my hope that the description of the *mutual effects* in this study prompts more teacher education programs to pursue research partnerships with youth with lived experience.

Summary

In summary, this dissertation focuses on an urgent health concern that affects students and teachers alike in today's Canadian classrooms – in fact, for some students the stigma of mental illness becomes a matter of life or death. In this study, I cooperatively developed a platform alongside youth with lived experience where they could speak for themselves, telling their own stories about their experiences with mental illness stigma and their road to recovery while pointing out persistent barriers that inhibit their growth and development. I use Kassam et al.'s (2012) definition of recovery as “a process which occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness” (p. 1). In Chapter 2 I discuss theories about the formation and impact of public and self-stigma, with an emphasis on theories from Weiner (2000) and Corrigan et al. (2003) that make up my theoretical framework. In Chapter 3 I discuss my methodology, including how pragmatism led me to choose mixed methods to best answer my research questions. In Chapters 4 and 5 I present the quantitative and qualitative data results from youth and teacher candidate participants, and in Chapter 6 I summarize my findings and offer implications for future research.

Chapter 2: Literature Review of Mental Illness Stigma Theory

Stigma and discrimination have a huge negative impact on people living with mental health problems and illnesses, affecting all aspects and stages of their lives – dealings with friends, family, communities, educators, employers, mental health service providers, and the justice and health care systems. (Mental Health Commission of Canada, 2009, p. 81)

Pinto, Hickman, Logsdon, and Burant (2012) define mental illness stigma “as the culmination of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and enact behaviours of discrimination against people with mental illness”(p. 49) Within this definition, we see three components: (1) negative attitudes, or *stereotypes*, (2) belief in these negative attitudes, or *prejudice*, and (3) behaviours that limit the rights and opportunities of people with mental illness, or *discrimination*. These are the three components that encapsulate Corrigan and Watson’s (2002) framework of mental illness stigma. In this chapter, I will use this framework to structure a literature review of current research in the field of mental illness stigma theory.

I begin by discussing the public dimension of stigma, including its three components: stereotypes, prejudice, and discrimination. I then introduce the work of Holley, Stromwall, and Bashor (2012) to contrast *cultural* and *institutional* stigma with *interpersonal* stigma, the focus of this study. Next, I discuss the mechanism of interpersonal stigma from the perspective of theorists Bernard Weiner and Patrick Corrigan. To end my discussion of public stigma, I review three strategies commonly used to decrease public stigma. Next, I discuss the personal dimension of stigma: *self-stigma*. I introduce two major theories used to describe self-stigma: *modified labelling theory* and the *stage model of self-stigma*. I end by describing the goal of anti-stigma work: *affirming attitudes* towards people with mental illness, which promote their *empowerment, self-determination, and social inclusion*.

Conceptual Framework: Stigma Has Two Dimensions and Three Components

The framework used to structure this literature review of mental illness stigma research is based on the work of Corrigan and Watson (2002). I chose this framework for three reasons: (1) It is the framework most commonly cited in the mental illness stigma research literature, (2) it best encapsulates multiple diverse perspectives about the nature of mental illness stigma, and (3) unlike most other frameworks and theories about stigma, it is specifically designed for *mental illness* stigma.

As summarized in Figure 1, Corrigan and his colleagues propose that mental illness stigma has two dimensions (*public* and *personal*) and three components (*stereotypes*, *prejudice*, and *discrimination*). The public and personal dimensions of mental illness stigma share the same three components, but public and personal responses to stigma follow distinct theoretical mechanism pathways. We will begin by examining public stigma, the focus of this study.

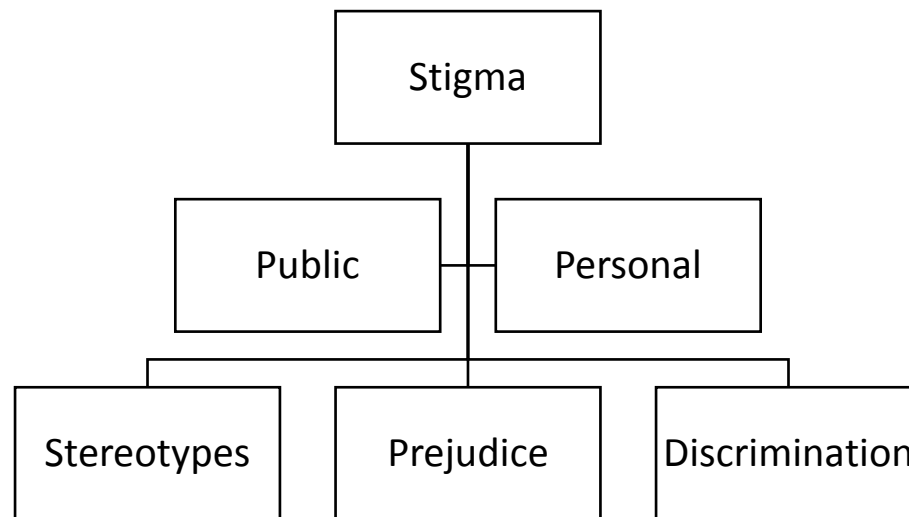


Figure 1. Stigma has two dimensions and three components. Stigma's two dimensions are public and personal. Stigma's three components are stereotypes, prejudice, and discrimination (Corrigan & Watson, 2002; Corrigan et al., 2002).

Public Stigma

Stereotypes. Stereotypes are commonly-held societal beliefs about a social group which provide people with quick categorizations of individuals (Angermeyer & Dietrich, 2006). People use these quick categorizations to help them know what to expect from individuals categorized in that group, and to predict their behaviours (Corrigan &

Watson, 2002; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). The stereotypes that members of the general public commonly report about individuals with mental illness can be divided into three categories: their personal characteristics, the origins of their illness, and their prospects for recovery from mental illness after treatment.

The characteristics of individuals with mental illness are often stereotyped as unpredictable, socially disruptive, dangerous, incompetent, and therefore incapable of making their own (or good) decisions (Angermeyer & Dietrich, 2006; Corrigan, 2004; Couture & Penn, 2003; Covarrubias & Han, 2011; Martin, 2010; Thachuk, 2011). Individuals with mental illness are often stereotyped as being personally responsible for their mental illness, which has been caused or prolonged by “a personal weakness, improper lifestyle, or moral transgression” (Alvidrez, Snowden, & Kaiser, 2008, p. 876). In other words, these individuals could cure their mental illness if they activated their willpower to remove serious flaws in their character (Couture & Penn, 2003; Corrigan, 2004; Fisher & Freshwater, 2014; Froese-Germain & Riel, 2012). When these individuals are treated for their mental illness, they are stereotyped as difficult to treat or unable to recover from their mental illness despite professional treatment (Couture & Penn, 2003; Covarrubias & Han, 2011; Froese-Germain & Riel, 2012; Thoits, 2011).

Thachuk (2011) argues that these stereotypes “create a context that many of those diagnosed with mental illness describe as more painful and debilitating than the illness itself.” (p. 141) Why? Because stereotypes influence beliefs, which in turn influence actions. Martin (2010) agrees, explaining “the stigma of mental illness can cause even more negative impacts than the mental illness itself, with disempowerment occurring on social, cultural, economic and political levels” (p. 261).

Prejudice. A person is prejudiced when he or she believes a negative stereotype about a stigmatized group (Corrigan & Watson, 2002). These beliefs can influence our actions towards the stigmatized group. For example, when we believe that people with mental illness are unpredictable, unreliable, or incoherent, we assume that they cannot be trusted to make their own decisions – we must make decisions about their capacity, care, and well-being for them (Couture & Penn, 2003; Rusch, Angermeyer, & Corrigan, 2005). When we believe that people with mental illness are dangerous, out of control, reckless,

or irresponsible, we tend to endorse measures that exclude these people from the rest of society, such as forced hospitalization, segregated schools, and lifetime prison sentences (Corrigan & Watson, 2002). When we believe that people with mental illness are difficult to treat or that most cannot truly recover after professional treatment, we tend to endorse measures that make these exclusions permanent (Couture & Penn, 2003).

Perpetuating the belief that individuals with mental illness lack capacity and wellness even after professional treatment can easily lead to an argument against allocation of funding dollars for mental illness research and treatment, since there seems to be no hope of positive outcomes after treatment that allow individuals with mental illness to contribute meaningfully to society (Couture & Penn, 2003). In fact, in a review of population studies about “[p]ublic beliefs about and attitudes towards people with mental illness” (p. 163), Angermeyer and Dietrich (2006) found that believing that people are personally responsible for their mental illness was associated with “approving of structural discriminations” (p. 171) including allocating financial resources to healthcare and research.

Couture and Penn (2003) point out that members of the general public often believe that individuals with mental illness are responsible for their illness *and* that they are unlikely to improve when they seek help. Couture and Penn (2003) characterize this as “an impossible standard to live up to” (p. 292) for individuals with mental illness because if these individuals choose to get better by seeking professional help, they will not get better. If they choose not to seek professional help because they do not believe they will get better, they are causing or perpetuating their own illness. What, then, is the solution for these individuals besides permanent exclusion from the rest of society? This may also explain how stigma can lead to decreased help-seeking in individuals who have recently received a diagnosis of mental illness and who *also* believe common stereotypes about their chances for recovery. If they believe the stereotype that individuals with mental illness cannot get better, they will be unlikely to seek help for their own mental illness because they assume the same will be true for themselves.

Discrimination. “First, ending discrimination is the goal. As an advocate with lived experience once told me, “It would be nice if people respected me; but at the

end of the day, I don't want them to block my opportunities." Attitude change is important but the real proof of stigma programs is tearing down the discriminatory behaviours that undermine a person's life goals." (Corrigan, 2014, p. S6)

While stereotypes and prejudice describe attitudes and beliefs, *discrimination* is a behavioural response that results in harm or oppression of the stigmatized group (Corrigan & Watson, 2002; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Overton and Medina (2008) describe discrimination as the "behavioral response to the emotions and beliefs generated by prejudice" (p. 145). Corrigan, Markowitz, Watson, Rowan, and Kubiak (2003) remind us that 'harm' can refer to anything that undermines an individual's chances for success. Therefore, it can come in active forms (e.g., verbal or physical abuse) or passive forms (e.g., social avoidance or withholding help) (Corrigan et al., 2003). Individuals with mental illness are often refused opportunities for housing, and falsely accused of violent crimes. Thachuk (2011) adds that the stigma of mental illness "undermines their consideration as eligible candidates for employment, threatens job security, and limits possibilities for professional advancement" (p. 141). These are some of the dimensions that Stuart (2005) is referring to when she defines discrimination as "inequitable or unfair treatment of people with mental disorders, which amounts to denial of the rights and responsibilities that accompany full citizenship" (p. 22).

When researchers in psychology investigate the causes and effects of discrimination towards people with mental illness, they primarily research *interpersonal* discrimination, or how a person views and responds to a person perceived to have a mental illness. Angermeyer and Dietrich (2006) describe this as "the behaviour of individuals that is directed straight against the members of a stigmatized group" (p. 170). From Corrigan's (2007) point of view, people become prejudiced when they believe stereotypes about people with mental illness. This prejudice leads to at least three discriminatory behaviours: withholding help, social avoidance, and endorsement of segregation and coercion. Many of the real-life consequences of stigma are captured in these three discriminatory behaviours. However, the influence of *power* on both the stigmatizer and the stigmatized is only implied in this discussion, but rarely explored.

Link and Phelan (2001) explain that it is power that allows stigma to result in discrimination: “Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination” (p. 367). To make the connection between discrimination and power more explicit, I introduce the work of Holley, Stromwall, and Bashor (2012) on oppression and transformative research in the area of mental illness stigma research. This work describes how people with mental illness experience oppression as a result of power differentials that make discrimination possible. Holley et al. also describe recommendations for the types of research that should be done by researchers seeking to eradicate discrimination towards people with mental illness. Corrigan (2014) has also begun to explicitly discuss the influence of power, and now recommends that anti-stigma efforts “target groups in positions of power” (p. S6) over people with mental illnesses.

Oppression. Dominelli (2008) defines oppression as “a system of domination that denies individuals dignity, human rights, social resources and power” (p. 10). It involves exercising individual choices or enacting systemic policies that restrict the freedom of certain groups of people (Corneau & Stergiopoulos, 2012). It is important to discuss oppression in the context of mental illness stigma because it illuminates the experience of power enacted onto the lives, choices, and freedom of many people who live with mental illness. Holley, Stromwall, and Bashor (2012) argue that people with mental illness experience at least three *faces of oppression* (Young, 1990): marginalization, powerlessness, and cultural imperialism. They explain that people are *marginalized* when they are “excluded from the labour market”, and then “dehumanized” when they attempt to access social services (Holley, Stromwall, & Bashor, 2012, p. 54). People are rendered *powerless* when decisions are made for – rather than by – them. Rusch, Angermeyer, and Corrigan (2005) explain that this is the consequence of the way that we view people with mental illness.

For example, when we view people with mental illness as irresponsible or reckless, we react with *authoritarianism* – we assume that they need to make decisions

for them (Rusch, Angermeyer, & Corrigan, 2005). In contrast, we might think that a more compassionate way to view people with mental illness is with *benevolence*, where people with mental illness are like children who need always to be cared for and protected (Rusch, Angermeyer, & Corrigan, 2005). However, the result is the same – we assume we must make decisions for them. This is why Corrigan advocates for empowerment, where people with mental illness “have power over life decisions and mental health services” (Corrigan et al., 2010, p. 262). In fact, people who believe that they have power over their decisions are less likely to believe that they are stigmatized (Corrigan et al., 2010). We will return to this topic when we discuss self-stigma.

If our goal is to help students living with mental illness feel empowered in their classrooms, mental health literacy for teachers must involve a balance between increasing teachers’ knowledge base about mental illnesses *and* instilling the notion that knowledge is never enough. Rather than reacting with authoritarianism or benevolence, we must encourage our teachers to lead with a spirit of curiosity into the “values, challenges, and the resources available” to each of their students (Davidson, Ridgway, Wieland, & O’Connell, 2009, p. 39). Davidson, Ridgway, Wieland, and O’Connell (2009) argue that the person living with mental illness has the “most intimate knowledge” (p. 39) of his or her capacity. Therefore, rather than being satisfied with making appropriate decisions for students with mental illnesses based on the limitations ascribed to them by their diagnosis, anti-stigma interventions should involve opportunities for teachers to decrease their social distance from students with mental illness in order to uncover each student’s capacity and personal potential (Davidson, Ridgway, Wieland, & O’Connell, 2009).

Finally, “[g]roups that experience *cultural imperialism* are judged by the norms of the dominant group” (Holley et al., 2012, p. 54, emphasis added). Specifically, people who are perceived to have mental illness “are socially constructed as “Other” rather than normal through stereotypes that present them as violent, untrustworthy, and incapable” (Holley, Stromwall & Tavassoli, 2015, p. 398). In Chapter 4, I will explore how youth described their relationship with ‘normal’ through their experiences with mental illness, and how they used their stories to complicate and challenge stereotypes about the capacities of people with mental illness.

Holley, Stromwall, and Tavassoli (2015) add a fourth face of oppression: *violence*. They explain that people with mental illness are often the “targets of violence in the form of physical and verbal attacks that have the purpose of ridiculing, intimidating, degrading, or stigmatizing them” (p. 398). Mizock and Russinova (2015) add that due to intersectional stigma, “women with mental illness experience elevated rates of victimization [...]. It is estimated that as many as 51% to 97% of women with mental illness have a physical and sexual assault history” (p. 16). Corneau and Stergiopoulos (2012), writing about ways to “address racism and oppression embedded in mental health and social services” argue that using an anti-oppression framework can be “a counter-discourse to the medical or bio-psycho-social model” (p. 267) because it “stipulates the importance of connecting all forms of oppression as a struggle strategy for equality within social structures and institutions” (p. 267).

Corneau and Stergiopoulos (2012) conclude that “[t]he main ingredients” (p. 276) in an anti-oppressive framework should include “empowerment, education, alliance building, language, alternative healing strategies, advocacy for social change, and fostering reflexivity” (p. 276). Some of these ingredients were reflected in this study in order to respond to the future research direction that Corneau and Stergiopoulos (2012) propose when they caution that “there is still a need to document how these frameworks and approaches interact with one another to bring about individual well-being and the betterment of society” (p. 276). For example, in Chapter 3 I discuss the negotiation process I undertook to build a research alliance with members of a youth advocacy organization. In Chapter 4 I describe how youth felt empowered through their decision to educate teacher candidates using their stories. In Chapter 6, I discuss the reflexive relationship of the impact on stigma for both youth and teacher candidates.

The message of Corrigan and his colleagues has begun to shift to this direction: Corrigan, Powell, and Michaels (2014) now say that diminishing stereotypes about people with mental illness and improving attitudes towards people with mental illness are no longer sufficient. They argue that social change is needed, and Corrigan’s later writings have begun to include theorizing about how to promote the *empowerment*, *self-determination*, and *social inclusion* of people living with mental illness, with the goal of

replacing stigmatizing attitudes with *affirming attitudes* towards people with mental illness. I will describe these concepts at the end of this chapter, after I have also discussed self-stigma.

The research goal in this study was to use an educational psychology lens to investigate youth and teacher candidates' perceptions of and experience with mental illness stigma. As such, I used the quantitative strand in this mixed-methods study to test the theoretical mechanism of *interpersonal* discrimination, when “people are socialized to accept stereotypes and internalize messages of inferiority and superiority about their own and others' social groups” (Holley, Stromwall, & Bashor, 2012, p. 53). I will return to the concept of internalizing messages of inferiority when I discuss modified labelling theory.

Therefore, the focus of this study was not on the policies and practices that contribute to stigma at school. A full investigation of “the imbalances and injustice inherent in social structures, political decisions and legal regulations” that impact people living with mental illness is a much-needed area for future research (Angermeyer & Dietrich, 2006, p. 171). This study does, however, include examples of interpersonal, *cultural*, and *institutional* discrimination towards people with mental illness. Corrigan (2004) argues that “[s]tigma change is most effective when it includes all the components that describe how a specific power group impacts people with mental illness” (p. 113). Therefore, in Table 1, I provide a preview of examples from this study that illustrate Holley, Stromwall, and Bashor's (2012) conceptualization of the three levels of stigma.

Table 1

Areas for Transformative Research (Holley, Stromwall, & Bashor, 2012, p. 55)

Level of Oppression		“Possible Areas for Transformative Research”, from Holley et al. (2012)	Examples from this study
CULTURAL	Language	<i>Examine how people with mental illnesses actively resist stereotypes in manifest in oppressive language</i>	Youth participants uncovering and rejecting assumptions about the language of “secrets” in relation to disclosing a diagnosis of mental illness.
	Traditions/ Practices	<i>Examine strategies used by people with mental illnesses and their allies to overcome [oppressive] traditions/ practices. Examine contexts and actors involved in NIMBY actions and effectiveness of interventions designed to decrease NIMBY.</i>	Youth Joan’s experience with a teacher who counseled her to drop out of school after Joan disclosed her experience with depression and panic attacks. Teacher candidates were asked to respond to this story, explaining what they would do in that teacher’s place, and how they would respond differently.
	School System*	<i>Document and evaluate interventions that focus on consciousness-raising and strategies for institutional-level change.</i> *Holley et al (2012) classified this area of research as the mental health system, but I examined it at the school system level.	This study used mixed methods to evaluate the impact of Mental Health Literacy Day on teacher candidates.
INSTITUTIONAL	Workplace	<i>Examine organizational culture and practices that limit and support employees’ abilities to be ‘out’ as persons with mental</i>	During individual interviews, teacher candidates described how past employment cultures of

	<i>illness. Examine the effects of oppressive policies and practices on those with and without mental illnesses.</i>	transparency or secrecy about mental health and mental illness compared to their experience as teacher candidates in the school environment.
Mental Health System	<i>Document and evaluate strategies aimed at developing positive group identities among people with mental illnesses.</i>	Youth participants Sandra and Raina's naming of strengths that resulted from their experiences with mental illness.
Research Institutions	<i>Collaborate with people with mental illnesses in designing and carrying out research projects, focusing on asking research questions that are important to people with mental illnesses.</i>	Youth participated in the research project during the first part of this study. During the second part, certain teacher candidates who identified as having a mental illness also participated in planning workshops for the second mental health literacy day.
INTERPERSONAL	<i>Examine contexts and actors involved in teaching individuals about oppressive language, practices, and roles. Examine effects of intersections of oppression/privilege related to multiple social group memberships on physical health, mental health, and other domains.</i>	In response to one teacher candidate who described his disappointment in not hearing more about intersectionality, I worked with subject experts to plan sessions including this for the second Mental Health Literacy Day.
	<i>Document/develop and evaluate anti-oppressive interventions to address individual-level oppression.</i>	The development of teacher candidates' ideas and assumptions about people with mental illness during the individual interviews and in response to survey questions.

Holley, Stromwall, and Bashor (2012) explain that discrimination at the *cultural* level involves “beliefs, symbols, and underlying cultural rules of behaviour [that] produce and reproduce oppression” (Holley, Stromwall, & Bashor, 2012, p. 53). We also find discrimination at the *institutional* level, where “the practices and policies of media, legal, health care, religion, and other institutions negatively affect members of oppressed groups while simultaneously privileging members of more powerful groups” (Holley, Stromwall, & Bashor, 2012, p. 53). This explains why Major and O’Brien (2005) argue that a discussion about stigma must include the influence of power: Both powerful and powerless groups may hold negative stereotypes about each other, but it is the people and institutions that have the power to grant and deny access to resources that can “prevent people with mental illnesses from obtaining the simple things that others take for granted” (Stuart, 2005, p. S22).

Furthermore, Holley, Stromwall, and Bashor (2012) argue that we must also take notice of the benefits that powerful groups continue to obtain as a result of upholding practices and policies that stigmatize people with mental illness. In other words, who benefits when the status quo of stigmatizing people with mental illness is maintained? Holley, Stromwall, and Bashor (2012) argue that it is the “individuals who are members of dominant groups” who “receive unearned privileges, such as being assumed to be capable, receiving priority in hiring, and being elected to leadership positions that are less available to members of subordinated groups” (Holley, Stromwall, & Bashor, 2012, p. 53). This privilege can extend to individuals with ‘invisible’ mental illnesses that can be concealed at times. These individuals have the privilege of choosing whether to publicly identify with an oppressed group.

As I discuss further in this chapter when I describe modified labeling theory, we can understand why the stigma associated with the ‘mentally ill’ label causes some individuals with invisible mental illnesses to choose not to ‘come out’ about their mental illness: Whatever benefits they imagine gaining by disclosing their mental illness – including commendation for successfully managing their life while living with a mental illness, acceptance from peers who also identify as having a mental illness, or even relief from symptoms of emotional distress when deciding whether to seek treatment – are

seriously tempered by the consequences of losing the privilege of being considered part of the dominant group (Corrigan, 2007).

Theoretical mechanism of interpersonal discrimination. The theoretical mechanism under investigation in the quantitative strand of this study is proposed by Patrick Corrigan (2002), and influenced heavily by Bernard Weiner's (2000) interpersonal attribution theory of motivation. Weiner's (2000) theory describes the causal attributions that lead to certain behavioural reactions towards an individual with a stigmatizing condition. Corrigan's (2002) work focuses on *mental illness* specifically as the stigmatizing condition, and distinguishes between the personal and public dimensions of mental illness stigma. While Weiner's theory identifies causal controllability as the only antecedent to personal responsibility beliefs and consequent behavioural reactions, Corrigan adds the perception of the dangerousness of the individual with mental illness as an independent antecedent to a separate behavioural reaction – fear.

When reviewing the literature on public stigma, it appears that the literature is divided on what constitutes the larger influence on discriminatory behaviour. Both Weiner and Corrigan agree that the pathway to stigma starts with a *cue* that signals the possibility that an individual has a mental illness (Corrigan, 2007; Overton & Medina, 2008). This cue can take the form of a mental illness diagnosis or label (e.g., schizophrenia), “something physical or observable, for instance, a psychiatric symptom, a deficit in social skills, or a difference in physical appearance” (Overton & Medina, 2008, p. 144). This cue leads to a judgment of whether or not an individual has a mental illness. However, after people judge the cue to be indicative of a mental illness, Weiner and Corrigan diverge on the cause of stigmatizing reactions (see Figure 2).

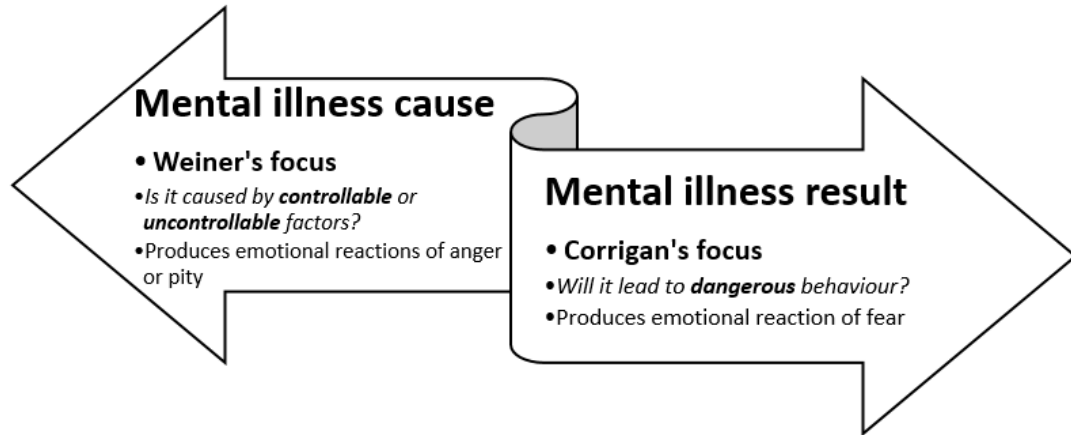


Figure 2. Weiner's focus is on how the general public perceives the *cause* of the mental illness. Corrigan's focus is on how the general public perceives the *result* of the mental illness.

From Weiner's perspective, the determinant of stigma is what came *before* the cue – that is, the intention or the causality of the cue. People's stigmatizing reactions result from what they believe to be the *cause* of the person's mental illness. In contrast, from Corrigan's perspective, most people stigmatize based on what is likely to come *after*, or as a result, of the cue they have observed. Here, people's stigmatizing reactions result from what they believe is the *result* or *outcome* of the person's mental illness – dangerous behaviour.

Weiner's Attribution Theory of Interpersonal Motivation. Weiner's (2000) theory predicts how people will respond to individuals with a stigmatizing condition. Weiner theorizes that behavioural reactions such as giving or withholding a reprimand, condemnation, neglect, retaliation, or help are predicted by *causal controllability* – the extent to which people judge that the *cause* of the stigmatizing condition is *controllable* by the individual with the stigmatizing condition. As summarized in Figure 3, Weiner and other theorists have expanded on the theory to explain people's behavioural reactions specifically towards individuals with mental illnesses. Here, genetic predispositions and biochemical imbalances are often described as *uncontrollable* causes of mental illness, while an individual's lack of a healthy lifestyle, willpower, 'mental toughness', 'resilience', or moral character are characterized as *controllable* causes (Alvidrez, Snowden, & Kaiser, 2008).

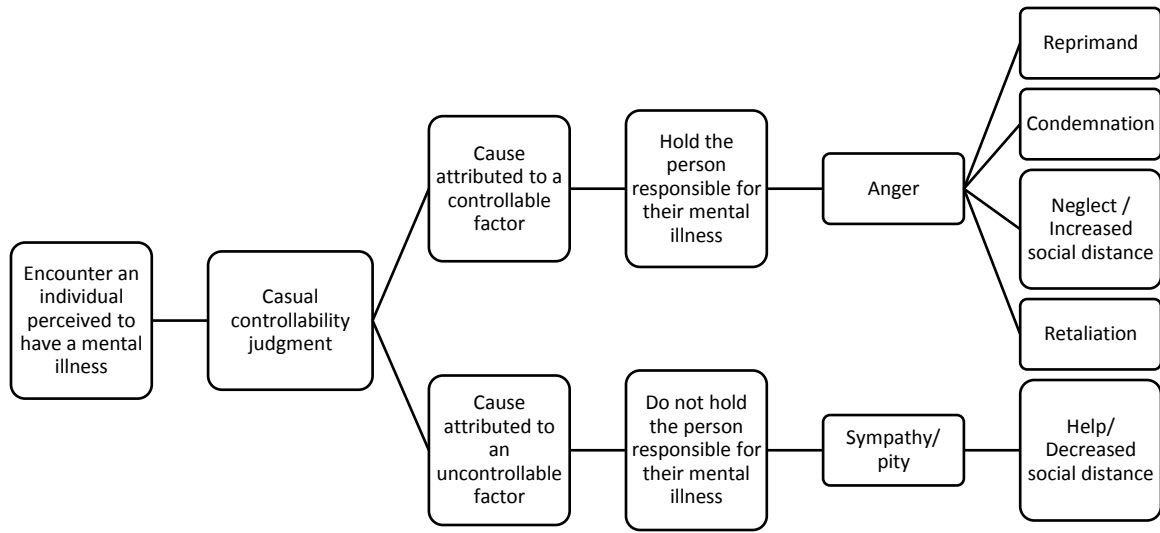


Figure 3. An attribution model of the motivation to help, harm, or neglect an individual perceived to have a mental illness, based on Weiner’s Attribution Theory of Interpersonal Motivation (2000).

Weiner’s theory predicts that when people attribute an individual’s mental illness to a controllable cause, they will hold that individual responsible for his or her mental illness (Weiner, 2012). This causes an emotional reaction of anger towards the individual, which results in behavioural reactions of condemnation, retaliation, reprimands, or neglect, where people increase their social distance – “an individual’s self-reported willingness to engage in relationships of varying levels of intimacy with a person who has a stigmatized identity” (Hartman et al., 2013, pp. 31-32; Weiner, 2012; Corrigan et al., 2003). These reactions decrease the likelihood that people will be motivated to help an individual perceived to have a mental illness. For example, people might attribute the cause of an individual’s mental illness to drug abuse, attention-seeking, or low self-control, and react with anger towards him or her because they believe that he or she has the ability to cure him or herself if he or she would only try harder (Boysen & Vogel, 2008; Thoits, 2011).

In contrast, when people attribute mental illness to a cause over which the individual has little or no control (e.g., brain injury, genetics), they do not hold that individual responsible for the mental illness. Consequently, they experience an emotional

reaction of sympathy or pity towards the individual with mental illness. Weiner predicts that people will respond by withholding reprimands, condemnations, and retaliations towards the individual. These behavioural reactions increase the likelihood that they will decrease their social distance and help an individual they perceive to have a mental illness (Weiner, 2012). From a relational-cultural theory perspective, decreasing social distance through personal interactions with people with lived experience might allow individuals to move past feelings of *sympathy* towards growth-fostering relationships characterized by mutual *empathy*.

While Weiner and his colleagues have found success validating each part of Weiner's theory, other researchers have been unable to replicate Weiner's findings. Corrigan and his colleagues (2002) did find evidence of the existence of the main constructs of Weiner's theory, but they did not find that personal responsibility judgments were significantly associated with emotional reactions of pity or anger. However, they did find that anger was negatively associated with helping behaviour. In contrast, Menec and Perry (1998) found significant associations between controllability judgments and emotional reactions, but failed to find a significant association between anger and helping behaviour.

According to Weiner's theory, attributing the cause of mental illness to an uncontrollable factor should decrease stigma. We can see examples of this attribution in popular anti-stigma campaigns that compare mental illness to physical illness (Figure 4).



Figure 4. Billboard advertisement from Glenn Close's anti-stigma campaign, *Bring Change 2 Mind*. Retrieved from http://oohforgood.com/store/images/BC2M_Poster2.jpg

Thachuk (2011) explains that “[p]roponents of the biomedical model contend that likening mental illness to physical illness legitimizes the individual’s experience of helplessness, undermines the assumption that those with mental illness are simply weak-willed, and increases accessibility to health-care services” (Thachuk, 2011, p. 144). This may explain why anti-stigma campaigns targeted towards the general public often promote comparisons of the similarities between mental illness and physical illness. For example, as illustrated in Figure 4, the 2012 anti-mental illness stigma campaign *Bring Change 2 Mind* asked people to imagine blaming an individual for having cancer. The goal was for members of the general public to see that it was equally shameful to blame an individual for having a mental illness. The underlying assumption was that a physical illness like cancer and a mental illness had enough in common to draw an equivalency between blaming individuals for both illnesses. However, researchers have found that when this idea is empirically tested, non-stigmatizing attitudes towards individuals with a mental illness do not always result from an uncontrollable attribution. Papish et al. (2013) explain that “framing [mental illness] as a neurological brain disease may perpetuate the stigma by suggesting to some that it is irreversible and creating wider social divisions” (p. 7).

For example, Boysen and Vogel (2008) found that attributing a biological (i.e., uncontrollable) basis to the cause of mental illness was associated with less blame for the mental illness, but the attribution of an uncontrollable cause did *not* result in a decrease in social distance. To explain this finding, the authors compared it to the differing social distance consequences of two *physical* illnesses: the Ebola virus and a “relatively harmless cold virus.” (Boysen & Vogel, 2008, p. 465). The general public attributes both illnesses to an uncontrollable cause, and there is little blame associated with the individual who contracted either illness. However, people evaluate the *consequences* of decreasing their social distance to a person with the Ebola virus to be much more harmful than decreasing their social distance to a person with a common cold.

Therefore, in Boysen and Vogel’s (2008) study, attributions of controllability had no impact on social distance – it was the conceptualization of the consequences of social distance to the person with the illness that determined stigmatizing attitudes. The same could be true for the general public’s attitudes towards individuals living with mental

illness: Those who consider the cost of associating with these individuals to be high might be more resistant to changing their attitudes about mental illness. This also provides an impetus for me to investigate the impact of personal contact on stigmatizing attitudes, since Boysen and Vogel's (2008) anti-stigma intervention only involved using educational (i.e., mental illness literacy) materials to decrease mental illness stigma.

Whereas Weiner might characterize both genetic and neurobiological causes of mental illness as uncontrollable, Rusch, Todd, Bodenhausen, and Corrigan (2010) found that the same attribution (i.e., an uncontrollable cause) was significantly associated with disparate effects, depending on the specific cause. For members of the general public without a mental illness, attributions of the cause of schizophrenia to "genetic and hereditary factors" were significantly associated with an *increase* in social distance from individuals with mental illness (Rusch, Todd, Bodenhausen, & Corrigan, 2010, p. 329). Similarly, people who had a diagnosis of mental illness who attributed another person's schizophrenia to genetics tended to endorse statements of fear of people with mental illnesses. In contrast, attributing schizophrenia to "a brain disorder, caused by biological changes in brain metabolism" (p. 329) was associated with decreased implicit guilt in members of the general public who did not have a mental illness.

The authors suggest that the difference might lie in their participants' construction of the meaning of each uncontrollable cause. People may view a brain disorder as a temporary affliction, but attributing mental illness to genetics may brand it as a core, "perhaps immutable" (Rusch, Todd, Bodenhausen, & Corrigan, 2010, p. 331), "fundamentally flawed" (Rusch et al., 2010, p. 331), or "deviant" (Phelan, 2005) part of a person with lived experience's identity. Similarly, Phelan (2005) found that when people believed that the cause of a mental illness was genetic, they considered the mental illness to be more serious, "less likely to change" (p. 316), and more likely to be transmissible, which can lead to increased social distance motivated by fears of contamination with the mental illness.

What conclusion can we draw from the conflicting views that characterize the research testing theories that claim to explain the causes of public stigma? I propose that the solution to changing public stigma cannot be wholly found in 'correcting' any one kind of attribution, because any attribution that we make towards people with mental

illness comes with both benefits and baggage. What we may need is a more holistic understanding of the person – the *lived experience* of the person – who has struggled through and come to a place of acceptance about their mental illness. We must understand why stigma is so common, persistent, and detrimental, and then work to dismantle its power in our own lives and the lives of those around us. How can we do this? The three most commonly used strategies are *protest*, *education*, and *contact*.

Three common strategies to decrease the public stigma of mental illness: protest, education, and contact. Larson and Corrigan (2008) describe *protest* as “a moral appeal for people to stop stigma” (p. 89) where the general public is instructed to suppress stigmatizing stereotypes, attitudes, and behaviours by not considering or thinking about them. Couture and Penn (2003) report that protest is not successful in changing the attitudes of individual members of the general public, but Arboleda-Florez and Stuart (2012) contend that this strategy has been successfully employed to change the actions of certain media groups. Corrigan, Morris, Michaels, Rafacz, and Rusch (2012) explain that this is because while protest does not tend to change attitudes, protest “may be useful in suppressing behaviors that promote stigma, especially in the media” (p. 970). For example, advocacy groups using the protest method have successfully campaigned for less stigmatizing portrayals of people with mental illnesses in movies (Arboleda-Florez & Stuart, 2012). However, Arboleda-Florez and Stuart (2012) and Larson and Corrigan (2008) caution that protest often leads to the opposite of the intent: people react with anger at being told what not to think. Worse, they respond by becoming more likely to endorse the very stereotypes protesters aim to suppress.

Corrigan (2004) describes *education* in this context as “replacing the emotionally charged myths of mental illness (e.g., “Most people with mental illness are highly dangerous!”) with facts that counter the myths (e.g., On average, people with mental illness are no more dangerous than the rest of the population)” (p. 115). Hartman, Michel, Winter, Young, Flett, and Goldberg (2013) argue that people who are more knowledgeable about mental illness are less likely to “stigmatize mental illness” (p. 31). Therefore, this strategy has been successfully employed to help the general public correct false information they may believe about mental illnesses and improve short-term attitudes towards people with mental illness. However, education that consists of

presenting facts alone does not tend to produce long-term changes in the general public's attitudes or discriminatory behaviours towards people with mental illness (Corrigan, 2004). Therefore, Hartman et al. (2013) propose that anti-stigma efforts should combine education with a contact strategy, where members of the general public can benefit from learn facts *about* mental illness, and have the opportunity to learn *from* a person living with mental illness. Papish et al. (2013) explain that “[a]ccurate knowledge can help correct misinformation, reduce ignorance and improve mental health literacy, especially when combined with contact strategies” (p. 6). In the next section, I describe how researchers have combined education and contact strategies to produce varying results.

Couture and Penn (2003) describe *contact* as “the attempt to dispel inaccurate and negative beliefs about mental illness by placing people in direct personal contact with the stigmatized group” (p. 293). Corrigan (2014) observes that “[u]nlike education, contact with people with mental illness has consistently been shown to be more effective in tearing down prejudice and discrimination” (p. S6). Here, the goal is the same as for education and protest, but the delivery is different. Rather than telling members of the general public what to think, contact allows people to make up their own minds based on an interaction with a person who is normally the object of their stigma. Hartman, Michel, Winter, Young, Flett, and Goldberg (2013) say that “personal contact has been identified as the single most influential factor in changing stigma” (p. 32). In a meta-analysis examining the effects of anti-stigma approaches, Corrigan, Morris, Michaels, Rafacz, and Rusch (2012) found that “[m]eeting people with serious mental illness seem[ed] to do more to challenge stigma than educationally contrasting myths versus facts of mental illness” (p. 969). They found that the mean effect sizes of the effect of personal contact on “attitudes and behavioral intentions were significantly greater than those found for education” (p. 969).

Contact has been measured indirectly and directly; indirect measures of contact are much more common than direct measures of contact. Researchers investigating the effect of contact *indirectly* commonly find that people who are more familiar with people who have mental illnesses tend to show less stigmatizing attitudes than those who are less familiar with people who have mental illnesses. For example, Corrigan, Markowitz,

Watson, Rowan and Kubiak (2003) measured familiarity by asking participants to report how much contact they had with people with mental illness. They found that personal contact was positively associated with pity and helping, and negatively associated with anger, fear, and avoidance.

Boyd, Katz, Link, and Phelan (2010) also found that reporting personal contact specifically with an individual who had been hospitalized for a mental illness was negatively associated with blame, anger, and both intimate and casual social distance towards a character described as having a mental illness in a vignette. Intimate social distance included asking participants whether they would be willing to have a child of theirs date, marry, and have a baby with the character in the vignette. Casual social distance included making friends and working closely with the character in the vignette. People who had personal contact also perceived the character's mental illness as more "serious" than people who did not report any personal contact. Unlike Corrigan et al.'s (2003) study, they did not find that contact was associated with sympathy, and Boyd et al.'s study did not measure fear.

Boyd, Katz, Link, and Phelan (2010) concluded "personal contact with mental illness is associated with having a less ostracizing, less critical attitude toward a stranger with mental illness" (p. 1068). Because they did not find any difference between contact and non-contact groups in their levels of sympathy and perceived persistence, Boyd et al. (2010) suggest that personal contact promotes a realistic yet compassionate view of mental illness: "people with contact have a sober view of the problem: they take it very seriously but still have a more respectful, welcoming attitude toward others with mental illness" (p. 1066). Covarrubias and Han (2011) found that in a sample of masters of social work students, having friends – but not family members – with a serious mental illness was associated with decreased social distance. They concluded that voluntary contact, rather than the involuntary contact that can occur with family members, was most effective at reducing the stigma of mental illness.

What about the argument that the general public is right to stigmatize individuals with mental illness because it is "a natural response to frightening, incomprehensible, or otherwise unattractive behaviour of people with mental illness" (Phelan & Link, 2004, p. 78)? Phelan and Link (2004) found that personal contact helped dispel this particularly

persistent stereotype as well: people who reported having more contact with individuals who have experienced mental illness were less likely to believe that individuals with mental illness were dangerous, compared to people who had limited contact. This finding also applied to people who had personally experienced being threatened or harmed by an individual with a mental illness – Phelan and Link found that “exposure to threat or harm [did] not result in greater perceptions of danger among people with more contact” with individuals with mental illness. Phelan and Link conclude “removing people with mental illness from public view or changing their behaviour, for example by controlling their symptoms with medication, will not be enough to eliminate rejection and discrimination” (p. 79). In other words, excluding individuals with mental illness from general society or seeking to change their behaviours to be more socially acceptable will not improve public attitudes about individuals with mental illness. Phelan and Link’s solution? Personal contact.

There is limited research that measures personal contact *directly*, where researchers design an anti-stigma intervention in which half of the participants experience personal contact (live or via video) while the other half experiences an education intervention or a control condition. However, Papish et al. (2013) did use this design to study stigma among medical students, and found that education and personal contact were equally effective at significantly decreasing mental illness stigma. Although contact was not more effective in decreasing stigma than education, medical students ranked contact-based education as the most effective “teaching method for learning about people with mental illness” (p. 6) and “having the greatest impact on increasing their confidence in working with people with mental illness” (p. 6).

Does having live personal contact improve attitudes more than watching a story via video? Clement et al. (2012) found that in a population of nursing students, watching a DVD of a person telling their story about mental illness and hearing the story live were equally effective at improving attitudes towards people with mental illness and at decreasing social distance. Similar to the intervention in my study, both of these stories were followed by a facilitator-led discussion. Attending a stigma and mental health lecture “presented by a mental health nurse researcher with lecturing experience, but no

specialised knowledge of stigma” (Clement et al., 2012, p. 58) also significantly decreased mental illness stigma among nursing students, but significantly less than the other two contact (live and video) groups.

Discussing the differences between emotional reactions in the contact groups versus the education (lecture) group, Clement et al. (2012) reported that “those in the combined social contact group (DVD or live) had a stronger emotional response than those in the lecture group” (p. 61) where “[h]ope, shock, motivation and surprise were almost exclusive to the social contact groups (DVD and live)” (p. 61). Nursing students in Clement et al.’s study rated the live session “as more interesting and useful than the DVD session” (p. 61), but the live session did not result in significantly better outcomes than the DVD session. Overall, both social contact groups were rated more highly than the lecture group, where nursing students were significantly more likely to “strongly agree that the training was interesting”, “confidence generating”, “useful”, “to believe their attitude to people with mental health problems had positively changed”, and “that their behaviour towards these individuals will be different” (p. 60).

Chan, Mak, and Law (2009) investigated the effects of using education about schizophrenia, personal contact via video with a person living with schizophrenia, and a combination of both. The education condition was a 30-minute “demythologizing lecture” that challenged “seven dimensions of illness perceptions based on the self-regulation model [of illness] (Leventhal, Nerenz, & Steele, 1984; Moss-Morris et al., 2002)” (p. 1523). The following are the seven dimensions with an example of the misperception that was corrected in the lecture:

identity (‘Schizophrenia is the same as split personality’), cause (‘Schizophrenia is caused by poor parenting’), timeline (‘People with schizophrenia can never get better’), consequence (‘People with schizophrenia cannot work’), control (‘Schizophrenia is not treatable’), emotional representations (‘People with schizophrenia are scary because they are dangerous and violent’), and illness coherence (‘Schizophrenia is an incomprehensible illness’) (Chan, Mak, & Law, 2009, p. 1523)

In addition to these seven dimensions, Chan, Mak, and Law (2009) added one additional myth to correct at the end of the lecture: “I do not have a role to play in affecting the life of people with schizophrenia” (p. 1523). This was used to expand on “two key advocacy messages, i.e. ‘The way you treat people with schizophrenia could make all the difference’ and ‘Understanding and respect are important forms of support that all of us can give’” (p. 1523). Chan, Mak, and Law found that in a sample of Grade 9 students in Hong Kong, a combination of education *and* a video was the most effective. However, the order in which the students experienced education and the video mattered: When participants experienced the education condition immediately followed by the video, they significantly improved their attitudes towards people with mental illness, decreased their social distance, and increased their knowledge about schizophrenia.

Chan, Mak, and Law concluded that “[t]he lecture on schizophrenia may have provided sufficient information and background to allow for deeper processing of the video content” (p. 1525). However, the stigmatizing attitudes of participants who viewed the video *before* attending the education session were no different from the stigmatizing attitudes of participants who *only* participated in the education condition. In the intervention under investigation in my study, the first Mental Health Literacy Day began with an education session in the morning, followed afterwards by live and video stories presented by youth.

Pinto-Foltz, Logsdon, and Myers (2011) compared the effect of education versus contact on mental health literacy in high school girls. The contact intervention used “a knowledge-contact intervention called, *In Our Own Voice*”, which is “administered by the National Alliance on Mental Illness” (p. 2012). Although Pinto-Foltz, Logsdon, and Myers would have preferred the speakers “to be of perceived equal status to participants” (p. 2014), the speakers chosen for the contact intervention were young adults over the age of 18, in accordance with the National Alliance on Mental Illness, which “does not train individuals under 18 years of age to be *In Our Own Voice* presenters” (p. 2014). The speakers’ stories each included five themes:

- (a) Dark Days, the person’s first experience with symptoms of mental illness; (b) Acceptance, how the person has accepted the mental illness; (c) Treatment, what

therapies and medications work for the person; (d) Coping, daily activities that help the person self-manage the mental illness; and (e) and Successes, Hopes, and Dreams, how the person overcomes the challenges associated with mental illness and progresses toward meeting his or her personal goals. (Pinto-Foltz, Logsdon, and Myers, 2011, p. 2014)

Pinto-Foltz, Logsdon, and Myers (2011) note that the presentations included “*both* biological and environmental factors that may contribute to developing and recovering from mental illness” (p. 2014, emphasis added) because learning about mental health from a biological perspective alone “may worsen attitudes about the ability to recover from mental illness” (p. 2014). Pinto-Foltz et al. found that immediately after the intervention there was no significant difference in mental health literacy scores for the contact group and the education group. However, when participants were retested at four and eight weeks after the intervention, participants who had been in the contact group had significantly higher mental health literacy scores than participants who had been in the education condition.

Looking at the variable results from these interventions, I propose that education (i.e., replacing myths with facts about mental illness) combined with personal contact may be the most successful approach to achieving mental health literacy goals. There seem to be some qualitative aspects to personal contact that the general public specifically responds to, but these aspects have not yet been consistently identified, nor do they seem to correspond to any existing measures that have been validated to accurately and reliably quantify mental illness stigma. In Chapters 4 and 5, I use mixed methods to illustrate the public and private aspects of stigma that were affected by the personal contact intervention.

Corrigan et al. (2002): The role of fear. Corrigan and his colleagues’ (2002) model describing the general public’s reactions to individuals with mental illness closely resembles Weiner’s model: Corrigan et al. (2002) agree that judgments about individuals with mental illness’ *personal responsibility* can predict pity or anger towards them. However, Corrigan et al. (2002) propose that in addition to anger and pity, *fear* is also a common emotional reaction towards individuals with mental illness. While anger and

pity are explained by attributions of causal controllability, which lead to personal responsibility judgments, fear is explained by the perception that individuals with mental illness are dangerous. Phelan (2005) also found that “factors such as fear (reflecting perceptions of the behavioral manifestations of mental illness itself, not its causes) strongly influenced social distance and restriction” (p. 319).

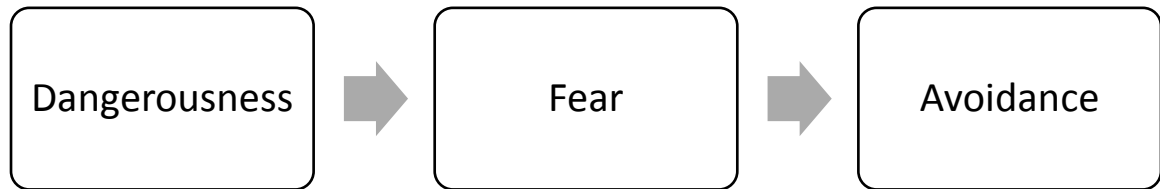


Figure 5. Corrigan's addition to Weiner's attribution theory proposes that when members of the general public perceive an individual to have a mental illness, they judge whether or not the individual is dangerous. If they judge the individual to be dangerous, they will experience fear, and will avoid the individual.

The influence of fear seems to be mediated by personal contact with individuals who have experienced mental illness. For example, Phelan and Link (2004) found that the frequency of personal contact with individuals with mental illness was inversely associated with perceptions of dangerousness, regardless of the level of threatening behaviour that they demonstrated. In other words, people who reported having more contact with individuals with mental illness were less likely to perceive individuals with mental illness as dangerous, compared to people who had limited contact with individuals with mental illness. In my own study, I included a question in my quantitative measure that asked about teacher candidates' personal contact experience.

Self-Stigma

There are powerful cultural, social, and economic forces that sustain the stigma of mental illness [...], and these can impinge on the lives of people with mental illnesses in ways that make coping efforts tenuous and difficult. Interventions like ours [to decrease self-stigma] would have a much greater chance of success if they occurred in a social context that reinforced rather than undermined them. (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002, p. 224)

Self-stigma, the *personal* dimension of stigma, occurs when an individual identifies with a stigmatized group and applies its negative stereotypes to him or herself (Eisenberg, Downs, Golberstein, & Zivin, 2009). In other words, self-stigma is self-prejudice. Self-stigma is not the focus of this study because the goal of this study was not to measure or change internalized stigma. This is a decision that is rooted in my orientation towards doing non-stigmatizing work that does not contribute to re-pathologizing a person with mental illness when we focus on the way he or she discriminates against himself. Such a study shifts the focus away from identifying and eliminating sources of cultural, institutional, and interpersonal discrimination. Focusing on the ‘problem’ of self-stigma among people who have experienced mental illness provides an easy justification for discrimination towards people with mental illness, where we are justified in ‘blaming the victim’ for his or her low self-esteem or negative behavioural reactions to discrimination. Corrigan and Rao (2012) acknowledge this predicament:

A caution needs to be sounded first. In trying to help people learn to overcome self-stigma, advocates need to make sure they do not suggest that the stigmatization is the person’s fault, that having self-stigma is some kind of flaw like other psychiatric symptoms that the person needs to correct. Stigma is a social injustice and an error of society. Hence eradicating it is the responsibility, and should be the priority, of that society. (Corrigan & Rao, 2012, p. 467)

This is a decision that I committed to beginning in my master’s degree research, where deficit models of another stigmatized group – black racial and Caribbean cultural identities – have often been used and abused to unwittingly perpetuate dangerous stereotypes about black students’ intelligence, work ethic, sense of self-worth, and chances for success in the classroom. In fact, Corrigan and Rao (2012) cite this faulty research assumption in their article about the self-stigma of mental illness: “Classic psychological models believed African Americans to have lower self-esteem than White Americans because the former internalized the biases and prejudices about them that dominated in the culture of the latter” (p. 468).

In my own experience, drawing on research from scholarly articles and having informal discussions with researchers in the field of social justice and equity, I learned that many black identity theorists – especially in Canada – were hesitant to apply quantitative measures to questions about black identity because of their historical misuse on marginalized populations of students. This led to two decisions for my own research: (1) To approach my own research from a strengths-based perspective to investigate what we could learn from students who had persisted through challenges with stigma, and (2) To use qualitative research to investigate individuals’ perspectives about their conceptualization of a stigmatized identity.

In the same way, I acknowledge that no quantitative measure can easily capture a sufficient range of the social nuances, interpretations, and personal meaning embedded in the stigma of mental illness. Rather than responding to the youth participants in my study with authoritarianism or benevolence where I make decisions about what they know or believe, I choose to approach this study with an affirming attitude towards youth who have experienced mental illness, where they can speak for themselves about their experiences with stigma. It is my goal that youth living with mental illness will use their own words to describe their own perspectives that may correspond to *or* complicate theoretical models of self-stigma. Using a qualitative method allows me to show respect for the dignity, story, voice, and perspective of each participant, where I acknowledge that they are the expert on their own experience.

What underlies self-stigma? In this section, I describe two theories that describe the experience of self-stigma. While both theories acknowledge that the root of self-stigma lies in public stigma, Corrigan and Watson’s (2002) *stage theory of self-stigma* describes the experience of self-stigma as one where people with mental illness “who live in a society that widely endorses stigmatizing ideas [internalize] these ideas and believe that they are less valued because of their psychiatric disorder” (Corrigan, 2007, p. 32). Here, the focus is on how the person living with mental illness answers the question: *Who am I?*

In contrast, the experience of self-stigma as explained by *modified labelling theory* (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989) involves trying to escape

the label of ‘mentally ill’ or ‘mental patient’ to avoid devaluation or discrimination from others (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Moses, 2009). However, recall our earlier discussion about the privileges afforded to people who can choose to conceal their mental illness (i.e., invisible mental illnesses). What happens when the label or diagnosis cannot be escaped, as is the case for people who experience symptoms of mental illness that cannot be concealed, or who are forced into treatment for a mental illness against their will? Here, people experiencing self-stigma will try to escape the devaluation and discrimination of other people likely to hold stigmatizing attitudes by hiding their diagnosis or withdrawing from interactions with them (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Here, the focus is on how the person answers the question: *How will others treat me?* Link, Struening, Neese-Todd, Asmussen, and Phelan (2002) point out that this question is not an undue concern on the part of the person living with mental illness: “This initial fear can be powerfully reinforced by objective realities as the person continues to be exposed to cultural stereotypes” (p. 203) that view people with mental illness negatively.

Modified labelling theory. Link, Cullen, Struening, Shrout, and Dohrenwend’s (1989) modified labelling theory explains how a diagnosis – or label – of a specific mental illness from a “mental health clinic or hospital” (Link et al., 1989, p. 400) causes people who have received that diagnosis to internalize negative beliefs about how their community will view and treat a person with a mental illness. Similarly, Fisher and Freshwater (2014) argue that “the labels that define people as mentally ill arguably have no reality independent of the discourse of the society in which they occur” (p. 204). Instead, these labels are “spoken into existence according to the values and beliefs that shape the discourse about what is ‘normal’ and ‘abnormal’” (Freshwater, 2006, p. 56). These values and beliefs about people with mental illnesses are developed from cultural sources such as “formal education, family lore, personal experience” (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002, p. 203), “jokes, cartoons, and the media’s reporting of mental patient status” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 402).

According to modified labelling theory, these cultural sources cause everyone to be socialized to believe that people who have received a diagnosis of a mental illness will experience discrimination (e.g., rejection “as a friend, employee, neighbor, or intimate partner” (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002, p. 203)) and devaluation (i.e., the loss of status in their community by being viewed as “less trustworthy, intelligent, and competent” (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002, p. 203; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989)). Therefore, Link et al. (1989) explain that the consequences of the label of ‘mentally ill’ involve decreased “self-esteem, social network ties, and employment” (p. 403), which “are regarded as major social and psychological risk factors for the development of psychopathology” (p. 404). Martin (2010) explains that the stress that results from frequent setbacks that people with mental illness experience when they are repeatedly discriminated against “can trigger an episode of mental illness or impede recovery” (p. 261). What’s more, the cycle of experiencing crisis and not seeking help continues, as “many people choose not to pursue mental health services because they do not want to be labeled a ‘mental patient’ or suffer the prejudice and discrimination that the label entails” (Corrigan, 2007, p. 31).

It is a *modified* labelling theory because Scheff’s (1966) original labelling theory contended that the label of the mental illness diagnosis was the primary cause of the symptoms of mental illness. According to this theory, people who exhibited symptoms of mental illness were unconsciously fulfilling societal expectations of what it meant to have a mental illness. Link, Cullen, Struening, Shrout, and Dohrenwend (1989) modified and tested this theory to acknowledge that all symptoms of mental illness cannot simply be explained by public stigma. However, they argue for the validity of modified labelling theory to respond to critics who claim that “any untoward effects experienced by mental patients are more likely to be caused by psychopathology” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 420). In other words, modified labelling theory validates – rather than dismisses – the real experience of stigma for people who have experienced the stigma associated with having been a patient in a mental health facility.

How do people who have experienced mental illness respond to stigma?

Modified labelling theory describes three responses associated with self-stigma: secrecy, withdrawal, and education (Alvidrez, Snowden, & Kaiser, 2008). *Secrecy* involves people with mental illness “conceal[ing] their treatment history from employers, relatives or potential lovers to avoid rejection” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 403). Link, Struening, Neese-Todd, Asmussen, and Phelan (2002) caution that the cost of secrecy involves “constant self-monitoring” (p. 204) to ensure that it is not apparent to others that the person is experiencing symptoms of mental illness. People who *withdraw* from the general public limit their “social interaction to those who know about and tend to accept one’s stigmatized condition” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 403) in order to protect themselves from “the rejection that might ensue if they ventured out to seek friends, jobs, and the like in the wider social environment” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 403). Link et al. (1989) found that people with mental illness who endorsed a withdrawal strategy tended to “rely extensively” on “insular support networks consisting of safe and trusted persons” (p. 419) often in their family.

A third strategy involves *education*, or “preventive telling” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 403). In this context, Link, Struening, Neese-Todd, Asmussen, and Phelan (2002) define education as: in order to reduce “the possibility of rejection” by others, people with mental illness try to improve attitudes about mental illness by correcting false information about people with mental illness (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002, p. 209). Link, Struening, Neese-Todd, Asmussen, and Phelan (2002) point out that this strategy may be effective in the long run, but comes with short-term costs: “challenging [stigma] might reduce stigma in the long run but expose the person to painful rejections in the short run” (p. 204).

What is the long-term cost or consequence of labelling? Link, Cullen, Struening, Shrout, and Dohrenwend (1989) conclude that “labeling and stigma may induce a state of vulnerability that increases their likelihood of experiencing repeated episodes of disorder” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989, p. 404). On the other hand, Moses (2009) points out that for some people living with mental illness, receiving

an official label or diagnosis of a mental illness comes with “positive effects that partially offset the stigmatizing and demoralizing impact of the label. Some psychiatric patients describe relief in having a label that can explain psychological symptoms, validate their experiences and guide them in knowing what to expect and how to cope” (p. 571).

Based on these conflicting views on the consequences of labelling, how should anti-stigma researchers proceed? Holley, Stromwall, and Bashor (2012) propose that focusing on whether or not to eliminate the label of ‘mentally ill’ distracts us from focusing on the problem of the continued oppression of people living with mental illness:

[G]etting rid of the label does not get rid of the group itself. Even without the label, people with mental illnesses will continue to be different in some ways than people without mental illnesses and will continue to be oppressed. If the existence of this group is denied, then the possibility of anti-oppression organizing by members of the group and their allies is hindered. People with mental illnesses would continue to be invisible when institutions develop policies and programs. (Holley, Stromwall, & Bashor, 2012, p. 59)

Instead, Holley et al. (2012) argue that we must work to disassociate the label from the discrimination that follows, so that people living with mental illness can experience “a society in which different social groups respect and affirm each other with full awareness of their differences” (Holley, Stromwall, & Bashor, 2012, p. 59). This represents another connection between my previous work in the field of racial identity: Rather than taking what racial identity theorists might call a ‘colourblind’ approach to people with mental illness (e.g., “I see absolutely no difference between a person with mental illness and a person who does not have a mental illness”), I propose that anti-stigma work should seek an approach that affirms differences (e.g., “As a person without mental illness, I recognize that I may be different in some ways from a person with mental illness. I respect and affirm that difference”). From this perspective, people living with mental illness would not need to constantly self-monitor to guard against unwittingly confirming a stereotype about people with mental illness. Whether they confirm or disprove a stereotype, they would be considered to be deserving of human dignity and respect.

Stage model of self-stigma. While Link et al.'s (1989) modified labelling theory primarily describes the behavioural consequences of self-stigma, the stage model of self-stigma, proposed by Corrigan and Watson (2002) and later modified by Corrigan, Watson and Barr (2006) describes both the behavioural and affective consequences of self-stigma on the person experiencing stigma. In particular, the stage model of self-stigma explains how self-stigma can affect a person's emotions and self-esteem. Similarly, Vogel, Bitman, Hammer, and Wade (2013) describe self-stigma as "the reduction in a person's self-esteem or sense of self-worth due to the perception held by the individual that he or she is socially unacceptable" (p. 312). The stage model of self-stigma is illustrated in Figure 6.

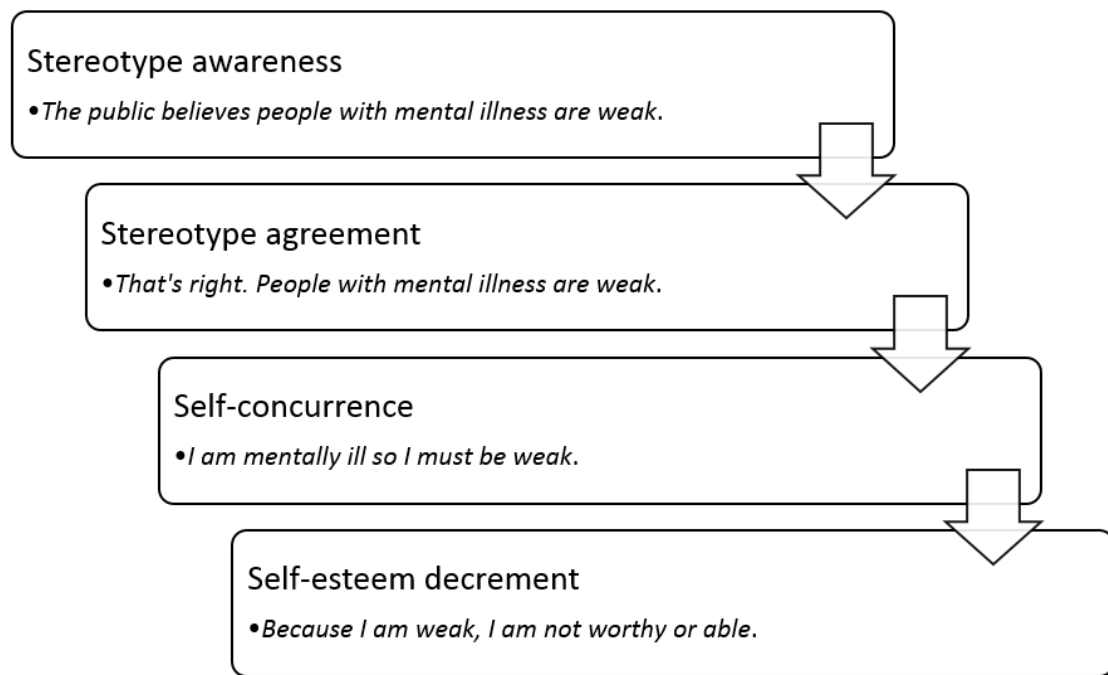


Figure 6. The stage model of self-stigma. As cited in MacDougall, Vandermeer, & Norman (2015) who cite Corrigan & Watson (2002) and Corrigan, Watson, & Barr (2006). The examples of each stage are taken from Corrigan & Rao (2013).

According to Corrigan et al.'s stage model, self-stigma occurs when a person who has experienced mental illness becomes aware of negative public perceptions or stereotypes about people with mental illness, and agrees with these stereotypes. Next, if the person decides that these stereotypes apply to him or her, he or she will experience a decrease in self-esteem (Corrigan, Druss, & Perlick, 2014; MacDougall, Vandermeer, &

Norman, 2015). Corrigan and Watson's (2002) original explanation of this theory described the experience of self-stigma as context-dependent. What determined whether a person with mental illness experienced self-stigma was the person's perception of the legitimacy of a particular discriminatory *event*. According to this theory, when an individual experiences a stigmatizing event or a discriminatory action by another person, the individual judges whether or not the discriminatory action was legitimate or warranted. If the individual perceives the action as legitimate, he or she experiences low self-esteem and self-efficacy (Corrigan & Watson, 2002).

On the other hand, according to the original theory, when the individual does *not* perceive the discrimination as a legitimate action, the individual's self-esteem remains intact, but the emotional reaction he or she will experience depends on whether he or she identifies with the stigmatized group (Corrigan & Watson, 2002). If an individual on the receiving end of a discriminatory action does not identify with the stigmatized group, he or she will be indifferent to the discriminatory action, believing it does not apply to him or her personally. If the individual identifies with the group, the unwarranted stigmatizing action will cause him or her to react with "righteous anger" (Corrigan & Watson, 2002, p. 35).

Newer citations of this model have shifted from examining the consequence of a particular discriminatory *behaviour* to the effect of the perceptions, beliefs, or *attitudes* that the public has about people with mental illness. This shift in focus could be explained by the fact that most research in psychology uses attitudinal measures that are understood to heavily influence behavioural intentions, which are meant to be reflective of actual behaviours. On the other hand, it could be because of the theoretical assumption that discriminatory behaviours are the natural result of prejudicial attitudes. Therefore, to change a behaviour, we must change an attitude first. This could explain why so many anti-stigma campaigns focus on the difficult task of changing attitudes before changing behaviours.

What is the emotional and behavioural result of self-stigma? According to Corrigan (2007), "[s]elf-stigma leads to automatic thoughts and negative emotional reactions" including "shame, low self-esteem, and diminished self-efficacy" (p. 32).

These negative thoughts and emotional reactions can have devastating behavioural consequences and feed into a vicious cycle of perpetuating negative stereotypes about people with mental illness. Corrigan, Druss, and Perlick (2015) call this the “‘why try’ effect” (p. 43), where people experiencing self-stigma do not pursue “opportunities at which they might otherwise succeed” (Corrigan, 2007, p. 32) because they assume that they are not worthy of the opportunity, or not able to succeed once they obtain the opportunity (Corrigan, Druss, & Perlick, 2014). Corrigan and his colleagues (2015) propose that the “why try” effect also discourages people from seeking and continuing with mental health care, because they internalize negative messages about their worth or abilities to participate in recovering from mental illness, such as “I am not worthy of treatment, or I am unable to really participate” (Corrigan, Druss, & Perlick, 2014, p. 44).

Martin (2010) contrasts personal responses to stigma that are *empowering* with responses that are *disempowering*. She notes that empowering responses require social support after a mental illness disclosure from people who are understanding, encouraging, and non-judgmental, and generally occur when the person living with mental illness externalizes the cause of stigma. Martin argues that when stigma is “externalised and viewed as a means of oppression” (pp. 261-262), people living with illness can “maintain, or regain, their confidence and self-esteem and achieve personal goals” (p. 261) because they feel empowered to develop strategies to respond to stigma. In contrast, she argues that it is only when stigma is internalized that people living with mental illness experience disempowerment, where they lose confidence and self-esteem, and lower their expectations for themselves.

Vogel, Bitman, Hammer, and Wade’s (2013) findings reinforce the connection between public and self-stigma. They found that public stigma was a “direct barrier to [...] people’s ability to form positive and healthy attitudes about themselves and their capabilities” (p. 314). Therefore, they characterize work to change “society’s attitudes toward mental illness and psychological help seeking” as “the ultimate goal” (Vogel, Bitman, Hammer, & Wade, 2013, p. 314). However, they caution that this work is difficult, which is reflected in the research that shows us that attitudes have indeed been slower to change than the rate of increased knowledge about mental health. As I

mentioned earlier, strategies designed to decrease the stigma of mental illness should promote the *empowerment*, *self-determination*, and *social inclusion* of people living with mental illness. The goal of decreasing stigma must be to replace stigmatizing attitudes with *affirming attitudes* towards people with mental illness. In this final section, let us briefly discuss these concepts.

Empowerment

How do we define empowerment? Rogers, Ralph, & Salzer (2010) explain that “[e]mpowerment is a key aspect of recovery and a common term in the mental health field, but there are few consistent definitions or validated measures of the construct” (p. 933). Still, Clark and Krupa (2002) observe that definitions of empowerment across “multiple domains including popular education, social psychology, community psychology, sociology, feminism, and theology” (p. 342) all share a certain number of characteristics. The definitions they examined all included the notion that “an individual or group participatory process that increases personal control by way of critical thinking, action and power sharing, that ensures dignity and equity through social change, and the mobilization of resources” (p. 342). In my study, I am examining empowerment from the perspective of teacher candidates and youth. From the perspective of teacher candidates, how can mobilizing mental health literacy resources empower teacher candidates to challenge stigma in their classrooms? From the perspective of youth, how are youth empowered through examining the costs and benefits of telling their story, and through the choices they make when preparing the story they choose to share with teacher candidates?

Corrigan and his colleagues (2010) argue that empowerment is “the opposite of self-stigma” because they found that “people who are high in personal empowerment are low in self-stigma” (p. 260). Corrigan et al. (2010) explain that the key to empowerment is self-efficacy, because “people who believe they have power over life decisions and mental health services are less likely to perceive and internalize stigma” (p. 262). However, this seems to be another “impossible standard to live up to” (Couture & Penn, 2003, p. 292): How can people living with mental illness experience empowerment if they do not have the opportunity to have power over their life decisions? After all, Davidson, Ridgway, Wieland, and O’Connell (2009) argue that “people with serious

mental illnesses, as people first and foremost, are active agents and citizens of their communities, who – like other citizens – need to be able to exercise their agency freely and autonomously in order to function as fully human” (p. 40). The answer might require people – including teachers – working with and caring for people with mental illness to adopt *affirming attitudes*, if they have not already done so. Affirming attitudes “include notions that people with mental illness recover, that they should determine for themselves life and treatment goals, and that they should have personal power over their life” (Corrigan, Powell, & Michaels, 2014, pp. 466-467). Davidson, Ridgway, Wieland, and O’Connell (2009) argue that affirming attitudes should be the goal of mental health care, where the health care system functions “to support people [with mental illness] in their own choices and pursuits and to offer them ‘tools’ to use for their own recovery, rather than to act as prerequisites or substitutes for the lives they desire to lead” (p. 41).

Affirming Attitudes

Affirming attitudes, then, may provide a counter-response to what Cohen and Cohen (1984) call *the clinician’s illusion*, or “the belief that people with [serious mental illnesses such as schizophrenia, bipolar disorder, and major depression] are always low functioning; cannot get along in society; and exhibit socially undesirable behaviors, like being violent” (Covarrubias & Han, 2011, p. 318). Papish et al. (2013) explain that “[m]edical students and physicians often work with individuals with severe and refractory illness, thus see a skewed sample of those with mental illness” (p. 7). Covarrubias and Han (2011), writing from the perspective of social work, add that “[s]ocial workers’ exposure to mentally ill individuals during periods of decomposition may lead to overgeneralizations and negative assumptions surrounding the functioning and behaviour of individuals living with [serious mental illness]” (p. 318). While teachers do not normally have students “experiencing the most severe symptoms of mental illness” (Covarrubias & Han, 2011, p. 318) in their classroom, they may look to medical professionals and social workers for information and advice about students experiencing mental illness. This is an example of how stigmatizing attitudes can be passively transmitted from medical professionals to teachers.

Instead, mental health literacy can be grounded in affirming attitudes towards people living with mental illness. However, this will be a challenge for mental health

educators if they do not believe that people living with mental illness are truly capable of achieving academic goals. In the context of the classroom, there is already an unequal power dynamic at play between teachers and students, which can make affirming attitudes difficult to carry out in practice. Writing from the perspective of a medical professional, Papish et al. (2013) explain that “there is an innate power differential that exists between a physician and a patient [...] which may contribute to stigma and to the notion of ‘us’ and ‘them’” (p. 7). Here, Papish et al. (2013) are referring to the tendency to ‘Other’ individuals, which makes it difficult to empathize and engage in growth-fostering relationships with people with mental illness. I will describe how we promoted affirming attitudes while working with youth and during Mental Health Literacy Day.

Self-Determination

According to Corrigan, Powell, and Michaels (2014), self-determination is “anchored in the belief that people with serious mental illness do have goals (e.g., want to go back to work, live independently, and/or enjoy intimate relationships) and in the notion that these goals should be pursued and are achievable” (p. 467). But what distinguishes self-determination from empowerment? Corrigan, Powell, and Michaels explain that it is the concept of independence. We can conceptualize empowerment as the first step in anti-stigma work, where we participate in removing internal and external barriers for people with mental illness, working towards *social inclusion*, or “a societal ideal of allowing access to financial, interpersonal, spiritual, and political resources that are available to all adults seeking to accomplish personal goals” (Michaels & Corrigan, 2013, p. 220). However, when we support self-determination for people with mental illness, we support their ability to pursue these goals *independently* (Corrigan, Powell, & Michaels, 2013). Davidson, Ridgway, Wieland, and O’Connell (2009) argue that “there is no way for members of [a] group to be made truly free other than for them to seize the reins and take control of their own situation. Otherwise, one oppressor has been replaced with another” (p. 39).

Corrigan, Druss, and Perlick (2014) explain that it is important to promote independence for people with mental illness because “human beings have a fundamental psychological need to be empowered and competent in seeking their goals with others” (p. 41). Davidson, Ridgway, Wieland, and O’Connell (2009) call this the *capabilities*

approach. Based on the work of Amartya Sen, a capabilities approach proposes “any legitimate approach to social justice must begin with the recognition that human beings are agents who need to be free to determine their own lives” (Davidson, Ridgway, Wieland, & O’Connell, 2009, p. 38). According to Corrigan, Druss, and Perlick (2014), when we promote independence, people become autonomously motivated. However, blocking people’s independent pursuit of their goals “promotes feelings of being controlled or amotivation” (p. 41). We can promote self-determination by addressing both the personal and public dimensions of stigma: Corrigan, Powell, and Michaels (2014) explain that we can help people experiencing self-stigma “grasp personal empowerment for themselves” and address public stigma by directing “the community not to erect barriers to the process” (p. 467).

Summary

In summary, the framework I used to describe the stigma of mental illness has two dimensions (*public* and *personal*) and three components (*stereotypes*, *prejudice*, and *discrimination*). This framework is based on the work of Corrigan and Watson (2002), but I also included the work of Holley, Stromwall, and Bashor (2012) and Holly Stromwall and Tavasoli (2015) to highlight four faces of *oppression* experienced by people with mental illness: *marginalization*, *powerlessness*, *cultural imperialism*, and *violence*. Next, I discussed the theoretical mechanism of *interpersonal discrimination*, drawing primarily on the work of Weiner and Corrigan. This theory predicts that people will be motivated to *help*, *harm*, or *neglect* an individual with mental illness based on how people evaluate the *cause* and *result* of the mental illness. People who perceive the cause of a mental illness to be *controllable* will react with *anger* towards the individual with mental illness, while people who perceive the cause to be *uncontrollable* will react with *pity*. People who perceive the result of interacting with the individual with mental illness to be *dangerous* will react with *fear*. A review of the research testing this theory revealed mixed results: Most studies were unable to validate all parts of this theory. Finally, I discussed three common strategies used to decrease public stigma: *protest*, *education*, and *contact*. A review of the research evaluating the impact of direct and indirect contact also revealed mixed results: While most studies found lower levels of

stigma among people who had contact with individuals with mental illness, the characteristics of the contact experiences and the types of stigmatizing attitudes, beliefs, and emotions that were influenced by contact varied greatly.

Next, I briefly discussed two prominent theories of private stigma, or *self-stigma*: *modified labelling theory* and the *stage model self-stigma*. The first theory describes the negative beliefs about how individuals with mental illness expect their community to view and treat them, while the second theory adds how individuals with a mental illness also perceive themselves. I concluded this chapter by describing three goals of initiatives designed to decrease public and private stigma: the *empowerment* and *self-determination* of individuals with mental illness, and *affirming attitudes* towards these individuals. In Chapter 3, I describe the methodology of my study.

Chapter 3: Methodology

In all research, collaborations should occur between individuals with research expertise (those with and without mental illness), community members with mental illnesses, and their allies. In these collaborations, research questions, methods, analyses, and reports derived from the life experiences of people with mental illnesses can lead to a transformative research agenda (Holley, Stromwall, & Bashor, 2012, p. 60)

In Chapters 1 and 2, I described how I derived my research questions and hypotheses from literature reviews about mental health in schools, mental illness stigma theory, and interventions designed to decrease the stigma of mental illness. The conclusion I reached in Chapter 2 was that anti-stigma work requires affirming attitudes towards people with lived experience. Therefore, in this study I invited the participation of and partnership with youth who identified as having a mental illness to develop an anti-stigma intervention for teacher candidates. As it turned out, youth were not the only participants with lived experience: several teacher candidates who disclosed a personal experience with mental illness also participated in developing mental health education curriculum for their teacher candidate peers.

Fisher and Freshwater (2014) argue “identification with the ill ultimately requires a commitment to research that does not foreclose people’s identities by attempting to pronounce the last word; the horizon of possibilities and the unanticipated should remain open.” (p. 204) These principles of non-foreclosure and anticipation of the unexpected guided the way I conducted the research and analyzed the quantitative and qualitative data collected in this study. In this chapter, I describe my methodological approach to this mixed methods study, including how the participation of individuals with the lived experience of mental illness and their allies influenced my methods. In Chapters 4 and 5, I describe the results of these decisions. I begin this chapter with a brief overview of the methodological design of this study. Next, I discuss the methodology of mixed methods. Finally, I describe the methods I used to collect and analyze the quantitative data (from teacher candidates) and qualitative data (from youth and teacher candidates) in this mixed methods study.

The purpose of this mixed methods study was to explore the experience of mental illness stigma at school from two perspectives: (1) youth living with mental illness, and (2) teacher candidates at a Faculty of Education. Why study youth and teacher candidates? As I described in Chapter 2, investigating youth perspectives responds to the dearth of research examining how youth living with mental illness respond to cultural, institutional, and interpersonal aspects of mental illness stigma. Youth participants and I used a qualitative method – a *design studio* – to discuss, challenge, and document these experiences with stigma using a workbook developed by Corrigan (2014) as a basis for our discussions. In Chapter 4, I demonstrate how these youth participants prepared stories about their experiences to share with teacher candidates.

Teacher candidates were the main focus of this study. I used quantitative and qualitative methods to investigate teacher candidates' stigmatizing *and* affirming beliefs, attitudes, and experiences with students living with mental illness. Some teacher candidate participants also wanted to share their dual perspectives as a teacher candidate *and* a student living with mental illness. In Chapter 1, I proposed that in an environment where there is an increased awareness of the prevalence of mental health problems in schools, teacher candidates continue to be underserved in opportunities to learn how to support students in their classroom who are living with mental illness. Two major roadblocks that prevent teachers from successfully implementing mentally healthy strategies in the classroom are: (1) lack of knowledge or skills in recognizing or understanding student mental health issues, and (2) the stigma associated with mental illness. It was my hypothesis that designing an intervention where teacher candidates had the opportunity to: (1) learn *about* mental health and mental illness in the classroom, and (2) learn *from* the experiences of youth with mental illness would improve teacher candidates' stigmatizing attitudes towards mental illness. I have outlined my study design in Figure 7.

Overall research question	What is the impact on the stigma of mental illness when youth share their stories with teacher candidates?			
Population	Youth with mental illness	Teacher candidates		
Population-specific research question	RESEARCH QUESTION 2 What is the process and result when youth co-create curriculum for teacher candidates based on their experience with mental illness?	RESEARCH QUESTION 3 Is a contact-based intervention involving teacher candidates hearing from youth with mental illness significantly associated with a decrease in public or private stigma?		
Methods	Design Studio + Focus Groups	Opening Minds Scale + Attribution Questionnaire-9 + two open-ended questions		
Sample	<i>n</i> = 7	<i>n</i> = 299	<i>n</i> = 112	<i>n</i> = 46
Time period	July-August 2014	Pre-intervention October 2014	Post-intervention October 2014	Post-waiting control intervention February 2015
Further research question, driven by results of quantitative analysis	<p style="text-align: center;">↓</p> RESEARCH QUESTION 4 How did teacher candidates' new knowledge from Mental Health Literacy Day inform their teaching practices?			
Method	Semi-structured interviews			
Sample	<i>n</i> = 11			
Time period	December 2014			

Figure 7. The overall mixed-methods study design, including the populations studied and the methods used to answer each research question.

In the next section, I describe the methodology of this study – mixed methods – based on my worldview as a pragmatic researcher. I then introduce my participant groups, and describe the methods used to answer the research questions and analyze the data associated with each group.

Methodology

I used a pragmatic approach to investigate the impact of youth living with mental illness sharing their story with teacher candidates on the stigma of mental illness, combining quantitative and qualitative methods to provide a more thorough answer to my overall research question: *What is the impact on the stigma of mental illness when youth share their stories with teacher candidates?*

Mixed Methods

The methodological approach that informs my research is mixed methods. Combining quantitative and qualitative methods allows me to identify where findings from the qualitative and quantitative strands of my research both converge and diverge (Grafton, Lillis, & Mahama, 2011; Greene, 2008). The quantitative aspect of my study allows me to isolate, quantify, and test certain variables in Corrigan’s (2002) and Weiner’s (2000) theories that predict stigmatizing attitudes and behaviours. Using a large sample of teacher candidates offers me the potential to generalize my research findings to a larger population. However, using quantitative research alone limits the depth and explanatory power of my research (Creswell & Plano Clark, 2011). Therefore, my study also includes qualitative research, where both youth and teacher candidate participants speak for themselves, interpreting their own experiences, while I as the researcher gain a better understanding of their perspectives (Creswell & Plano Clark, 2011).

Johnson, Onwuegbuzie, and Turner (2007) state that “[w]e currently are in a three methodological or research paradigm world, with quantitative, qualitative, and mixed methods research all thriving and coexisting” (p. 117). Therefore, my choice of mixed methods as a *methodology* represents my understanding that mixed methods encompasses more than just a combination of quantitative and qualitative *methods* – instead, mixed methods is a distinct *methodological* approach (Collins, Onwuegbuzie, & Johnson, 2012; Denscombe, 2008; Grafton, Lillis, & Mahama, 2011).

Mixed methods research has been described as an “intellectual movement” that developed “[i]n reaction to the polarization between quantitative and qualitative research” (Johnson, Owuegbuzie, & Turner, 2007, p. 117). It is “an approach to knowledge (theory and practice) that attempts to consider multiple viewpoints, perspectives, positions, and standpoints” (Johnson, Owuegbuzie, & Turner, 2007, p. 113). Often, mixed methods is positioned between the extreme viewpoints associated with quantitative and qualitative paradigms, because it attempts “to respect fully the wisdom of both of these viewpoints while also seeking a workable middle solution for many (research) problems of interest” (Johnson, Owuegbuzie, & Turner, 2007, p. 113). Mixed methods as a research paradigm necessarily accommodates diverse ideas and practices because in order to obtain a thorough understanding of a phenomenon under study, multiple perspectives are needed (Denscombe, 2008).

I am drawn to mixed methods research because it recognizes the human element of how a researcher comes to understand the world and chooses a research question. I recognize mixed methods as a third research paradigm because it encompasses distinct “belief systems and practices” (Morgan, 2007, p. 60) that honour diverse perspectives by following the principles of methodological eclecticism, paradigm pluralism, and “iterative, cyclical” research practices (Teddlie and Tashakkori, 2012, p. 781; Denscombe, 2008; Johnson & Onwuegbuzie, 2004). Mixed methods’ emphasis on diverse perspectives also facilitates communication between disciplines, which can encourage interdisciplinary collaboration (Johnson & Onwuegbuzie, 2004; Morgan, 2007).

This relates to my own research area, since the study of mental illness stigma has a number of different facets and stakeholders outside the field of education. For example, Dr. Heather Stuart at Queen’s University holds the Bell Canada Mental Health and Anti-Stigma Research Chair, yet unlike my background in neuroscience, education, and psychology, her background is in community health and epidemiology. The discrimination of persons with mental illness is also certainly a social justice issue, and researchers studying how social structures contribute to the marginalization of individuals with mental illness might approach the issue of mental illness stigma from quite a different perspective than, for example, studies that follow a pathological model of

mental illness which might employ the ‘gold standard’ in positivist research – the randomized control trial.

Some researchers might see these multiple perspectives as a disadvantage – indeed, it can be difficult to reconcile conflicting viewpoints and findings. Still, mixed methods researchers can embrace the ‘messiness’ of interdisciplinary research with its complications and contradictions because they understand that facilitating communication between seemingly disparate fields can also encourage collaboration, which can lead to a deeper understanding of an enduring, multifaceted issue.

I agree with Creswell and Plano Clark’s (2011) assertion that mixed methods is a more intuitive and practical way to do research because it more closely resembles the way that we already go about understanding the natural world: We observe and record (or recall) others’ behaviours, we solve problems with both numbers and words, and we employ both inductive and deductive reasoning (Creswell & Plano Clark, 2011). Mixed methods as a paradigm is “sufficiently flexible, permeable, and multilayered to reflect the reality of social research in the 21st century.” (Denscombe, 2008, p. 271)

Mixed methods researchers “come from a variety of philosophical orientations” where they “subscribe to different conceptual frameworks.” (Teddlie & Tashakkori, 2012, p. 779) My particular study is guided by a *pragmatic* philosophical orientation. Teddlie and Tashakkori (2012) observe that a mixed methods researcher’s preferred paradigm often grows out of a researcher’s “personal history” (p. 779) and is influenced by their coursework and mentorship by “scholars who are themselves methodologically bilingual and willing to search for innovative combinations of methods” (p. 777). This is certainly true for me: As a science major during my undergraduate training, I used quantitative methods and followed a postpositivist paradigm. During my master’s degree, I came to appreciate the benefits of including participants’ own words in an investigation where I was introduced to qualitative research that followed a constructivist paradigm. If I were to have done mixed methods at that time, I would have used a transformative paradigm. In my doctoral research, I am supported by a ‘methodologically bilingual’ supervisor who uses mixed methods in innovative ways, and I use a pragmatic paradigm to guide my research. (Teddlie & Tashakkori, 2012)

Pragmatism

Mixed research actually has a long history in research practice because practicing researchers frequently ignore what is written by methodologists when they feel a mixed approach will best help them to answer their research questions. It is time that methodologists catch up with practicing researchers! It is now time that all researchers and research methodologists formally recognize the third research paradigm and begin systematically writing about it and using it. (Johnson & Onwuegbuzie, 2004, p. 22)

Mixed methodology is most often guided by a pragmatic approach, where the primary focus is the research question (Creswell & Plano Clark, 2011). Once the research question is established, a pragmatic researcher selects the methods that best allow the question to be answered (Creswell & Plano Clark, 2011; Grafton, Lillis, & Mahama, 2011; Johnson & Onwuegbuzie, 2004). Teddlie and Tashakkori (2012) remind us that “multiple paradigms can be associated with any given method.” (Teddlie and Tashakkori, 2012, p. 779; Hesse-Biber, 2010; McEvoy & Richards, 2006) Therefore, a pragmatic researcher is not forced, for example, to choose between a postpositivist and constructivist worldview based on the method he or she employs in his or her research (Creswell & Plano Clark, 2011). To this effect, Johnson, Onwuegbuzie, and Turner (2007) quote Schwandt (2000, p. 210) when they argue for the decoupling of a research method from a researcher’s worldview:

So the traditional means of coming to grips with one’s identity as a researcher by aligning oneself with a particular set of methods (or being defined in one’s department as a student of “qualitative” or “quantitative” methods) is no longer very useful. If we are to go forward, we need to get rid of that distinction. (Johnson, Onwuegbuzie, & Turner, 2007, p. 117)

I am a researcher with a *pragmatic* worldview, because I am primarily guided by my research question when selecting research methods and considering research methodologies. By employing mixed methods, I choose to mix qualitative and quantitative methods in my study to balance the understanding of multiple perspectives with the ability to generalize my research findings to multiple contexts. I use this

approach to provide a more thorough, nuanced, and critical answer to the problem of mental illness stigma in schools.

Pragmatism is often taken up by researchers who seek to solve ‘real-world’ problems, and who will mix methods when doing so provides the best answer to their research question (Johnson & Onwuegbuzie, 2004). In the same way, I use quantitative and qualitative methods to investigate whether a contact-based anti-stigma intervention contributes to decreased mental illness stigma among teacher candidates. Pragmatists contend that the philosophical differences between qualitative and quantitative research are overemphasized – instead, researchers should be looking for the ways in which they converge (Grafton, Lillis, & Mahama, 2011; McEvoy & Richards, 2006; Morgan, 2007). This emphasis on problem-solving over philosophy results in criticisms that pragmatists (a) overlook important philosophical, reflexive, or theoretical research that is not intended to ‘solve’ a problem, and (b) are unwilling to “dwell” on incommensurable ontological and epistemological assumptions (Grafton, Lillis, & Mahama, 2011, p. 11; Creswell & Plano Clark, 2011). However, I use a pragmatic research approach that “endorses eclecticism and pluralism” in order to avoid the impulse to minimize or dismiss conflicting data (Johnson & Onwuegbuzie, 2004, p. 18). Instead, a pragmatic researcher must find ways to make sense of contradictory results. A pragmatic approach embraces these contradictions because they contribute to a more complete “understanding of people and the world” (Johnson & Onwuegbuzie, 2004, p. 18).

Methods and Participants

I use a pragmatic approach to investigate the effect of personal contact on stigmatizing attitudes, combining quantitative and qualitative methods to provide a more thorough answer to my overall research question: *What is the impact on the stigma of mental illness when youth share their stories with teacher candidates?* Answering this question requires two populations of participants: (1) youth who identify as having a mental illness, and (2) teacher candidates at a Faculty of Education.

Population 1: Youth with the Lived Experience of Mental Illness

The first population in this study is a group of seven youth aged 18-25 who self-identify as having lived experience with mental illness. In the sections that follow, I use pseudonyms to refer to all research participants. I chose to study youth slightly older than the high school age so that they could be close enough in age to high school students – the age that most mental illnesses develop – but over the age of majority to be able to consent to the research themselves. These youth participants were able to reflect on the positive and painful experiences of high school, rather than live in the midst of it. All participants were connected with a national youth mental health advocacy initiative (referred to as Organization X), which recruited the participants to this study. My research question for this part of the study was:

Research Question 2:

What is the process and result when youth co-create curriculum for teacher candidates based on their experiences with mental illness?

Using materials from the Centre for Dignity, Recovery & Stigma Elimination (CDRSE) and Corrigan, Buchholz, & Lundin's (2014) *Coming Out Proud* (COP) program, I facilitated a two-week, 20-hour design studio with the support of staff members from Organization X. I used audio-recordings, field notes, and photography of participants' contributions during the design studio to document this process. The original plan was to facilitate a 10- to 12-week program, where youth would meet with me for two hours each week to discuss the Corrigan (2014) workbook "Coming Out Proud to Eliminate the Stigma of Mental Illness" and develop their stories. However, when we approached Organization X to partner in this research, I obtained ethics approval (Appendix A) to follow the compressed 20-hour format Organization X suggested:

During the first week, after youth read the Letter of Information and completed the consent form (Appendix B) we met for three consecutive days to work through the *Coming Out Proud* workbook, analyzing its merits and shortcomings along the way. Each session was four hours in duration. At the end of the first week, youth participated in a focus group as an additional opportunity to describe and reflect on the process of participating in the design studio. During the second week, we met for two consecutive

days, also lasting four hours each day. During the second week, youth developed the stories that they had chosen to share with teacher candidates. At the end of the second week, youth participated in a second focus group.

Design studio. The design studio is a method adopted by Organization X to honour the mission of the organization: to raise awareness and share youth-relevant information about mental health and mental illness, and “to equip people to design for personal, systemic and social change” (Garinger, n.d.) Garinger (n.d.) explains that “[Organization X] has had a long history of understanding the necessity of involving young people in co-creating the services and systems that impact them.” In response to this understanding, Organization X uses design studios as their primary inquiry method to give youth partners the “opportunity to share their experience, amplify their strengths and design for change.” (Organization X, 2015)

Design studios involve design *charrettes*, or “intensive design periods of development” (Organization X, 2015) where participants work together to address “specific community problems” (Sutton & Kemp, 2006, p. 125). Sutton and Kemp (2006) explain that by combining disciplinary inquiry methods from the social sciences with knowledge from local community members, design charrettes can facilitate “interdisciplinary collaborations” that “facilitate meaningful community outcomes.” (p. 125) Organization X’s design charrettes always involve youth and emerging adults who identify as having a mental illness “work[ing] directly with facilitators, developers, content experts and designers to brainstorm, plan, design, develop and troubleshoot” mental health and anti-stigma materials. These materials, including “support tools, system transformation tools and rich media content pieces” (Organization X, 2015), are designed to help youth “better manage their mental health” (Organization X, 2015). They call this process *co-creation*.

Organization X views the co-creation process as central to their philosophy because their goal is to create materials that are “relevant, meaningful, [and] useful.” (Organization X, 2015) The method of co-creation differs from other traditional research methods because it “collapses the research, design, development and communications planning phases of production into a single, fluid, continuous, agile and ultimately human

process. It is more outcome-focused than older approaches and yields strong results.” (Organization X, 2015) Organization X promotes design studios as a model for collaboration between “youth and adults seeking solutions to complex problems, together.” (Organization X, 2015)

In the design studio structure, youth generate ideas and prototypes of materials, then share them with the larger group. This process of: (a) learning through generating ideas and building materials, (b) recording and reflecting on the process, (c) recognizing how the context and culture of each individual influences what they bring to the group, and (d) sharing ownership of products is based on what Organization X calls “design thinking”, influenced by previous research from the Rotman School of Management, the Future of Learning Institute, and the Harvard School of Education (Organization X, 2015).

All members of the design studio are then encouraged to give feedback and build on the ideas presented in order “to encourage [a] common agenda and ownership.” (Organization X, 2015) As the feedback process continues, the process of idea generation and product generation is documented using creative methods. Once youth develop their final products in the design studio, they evaluate and reflect on their experience in the design studio and “[c]reate a dissemination plan where youth commit to introducing resources to people within their peer networks.” (Organization X, 2015) In this study, I audio-recorded all design studio sessions and took photographs of youth story projects as they developed. Youth who agreed to share their story with teacher candidates each started a project involving their story during the design studio, but not all completed stories were captured, as youth had the option to continue working on their stories on their own time.

Focus groups. The second method I used with youth participants during this study was the focus group. During the five-day design studio with youth, I used two focus groups to ask youth open-ended questions about their experiences: (1) in the design studio, and (2) with stigma that did not naturally arise during the design studio process. According to Liamputtong (2011), focus groups “involve a group of 6-8 people who come from similar social and cultural backgrounds or who have similar experiences or

concerns.” (Liamputtong, 2011, p. 3) The focus group conducted in the afternoon of Day 3 and Day 5 of this study consisted of six youth participants ages 18 to 24 who identified as living with a mental illness. After Day 2, one of the original seven participants did not return to the design studio; therefore she did not participate in the focus groups. These youth participants were purposefully recruited by staff members from Organization X for their ability “to provide valuable contributions to the research questions.” (Liamputtong, 2011, p. 4)

According to Liamputtong (2011), focus groups are an appropriate method to use when the researcher’s goal “is to describe and understand meanings and interpretations of a select group of people to gain an understanding of a specific issues from the perspective of the participants of the group” (Liamputtong, 2011, p. 3). In this stage of the study, the research goal was to describe and understand how youth living with mental illness interpreted the main messages and activities about mental illness stigma in Corrigan’s *Coming Out Proud* workbook.

Liamputtong (2011) explains that there are two main approaches to focus groups: The first approach is highly structured and commonly used in the field of market research. Here, the focus of the interaction is primarily between the focus group moderator and the focus group participants. In contrast, a second “less rigid and structured approach” (Liamputtong, 2011, p. 2) has emerged from social science research, where “participants are encouraged to talk to each other instead of answering the moderators’ questions. Hence the moderator’s primarily aim to facilitate discussion, rather than to direct it.” (p. 3) This second approach aligns with affirming attitudes of self-determination for youth participants; therefore, this was the method I employed. Liamputtong (2011) says that focusing on the discussion *between* participants rather than the direct answers *to* the researcher’s questions allows the analysis of focus group data to put “more emphasis on the points of view of the participants than those of the researchers”(p. 4). In fact, Kitzinger (1995) argues that “people’s knowledge and attitudes are not entirely encapsulated in reasoned responses to direct questions.” (p. 299). Therefore, focus groups are needed for researchers “to hear issues which may not emerge from their interaction with the researchers alone” (Liamputtong, 2011, p. 4).

Analyzing focus group data allows researchers to derive meaning from both *what* participants say and *how* they say it to each other. Therefore, both the knowledge that group participants co-create *and* the interaction between participants are important elements that must be analyzed in research focus group methods.

Focus groups capture what participants say. First, focus groups allow the researcher to capture the knowledge that is produced as participants interact with each other and respond to each other's ideas as they are voiced. Barbour (2014) notes that these "longer exchanges between participants [...] showcase the capacity of focus groups to elicit rich interactional data, as participants go about co-producing explanations" (p. 314). Here, capturing and analyzing the interaction between the participants is part of the research method (Kitzinger, 1995). For example, "instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' (sic) experiences and points of view." (Kitzinger, 1995, p. 299) Kitzinger (1995) explains that "group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview." (p. 299)

Barbour (2014) adds that the discussion captured in focus groups can reveal how "views are debated, defended and sometimes modified, in what is a much more fluid presentation of ideas" (p. 314) than, for example, a written, individual survey. During the design studio, I asked youth to also write down any comments they had as we went through the manual. While some youth filled the manual with additional comments, one particularly vocal participant cautioned me that she would not write very much in her manual because she felt unconfident about her writing skills and preferred to express herself verbally.

Focus groups capture how participants say it. Second, in addition to analyzing *what* participants communicate *to* each other, focus groups also allow researchers to analyze *how* participants communicate *with* each other. Researchers can use focus groups to "tap into the many different forms of communication that people use in day to day interaction, including jokes, anecdotes, teasing, and arguing." (Kitzinger, 1995, p. 299) These day-to-day forms of communication emerge during focus groups because the discussions that occur there "are more akin to natural social interaction among

participants.” (Liamputtong, 2011, p. 3) When these interpersonal communication methods are analyzed, researchers can uncover the “(sub)cultural values or group norms” expressed in the ways in which focus group participants use humour with each other, seek consensus, and maintain dissent within the group (Kitzinger, 1995, p. 300).

Choosing focus groups also reflected my desire to use research methods that supported the empowerment of my study participants. Recall that in Chapter 2, I described empowerment as “an individual or group participatory process that increases personal control by way of critical thinking, action and power sharing, that ensures dignity and equity through social change” (Clark & Krupa, 2002, p. 342). Liamputtong (2011) argues that focus groups “may reduce the imbalance in power relationships between the researcher and participants” when the researcher positions the focus group as a group process, where the group works together to “create data from multiple voices”(p. 4)

On the other hand, the dynamics of focus groups can work against participants if they feel silenced or shunned for not sharing group norms (Kitzinger, 1995). Liamputtong (2011) agrees that focus group participants must “feel comfortable to discuss their opinions and experiences without fear that they will be judged or ridiculed by others in the group” (p. 3). Focus group facilitators must take an active role in developing this comfortable environment: Barbour (2014) cautions focus group facilitators that “participants may react differently to moderators who are or are not perceived to share their own characteristics (and assumed values).” (p. 318) Therefore, one of my primary roles as researcher/facilitator was to actively cultivate an environment that allowed a diversity of opinions, dissent, and original thoughts. Youth participants, Organization X staff, and I worked together to establish this environment during ‘work’ (design studio and focus group periods) and ‘play’ (breaks and lunchtime).

For example, at the beginning of each day, as recommended by Corrigan’s (2014) *Coming Out Proud* manual, youth worked together to establish ‘ground rules’ including confidentiality and mutual respect. Youth participants and I also agreed that conversations that extended into breaks would not be included in the transcripts, but these ‘in-between’ moments were essential in establishing a relaxed, congenial environment for all participants.

In the breaks following difficult conversations with or between youth participants, I engaged with youth individually to re-establish connections and to deepen our relationships by discovering other interests or experiences we had in common. Eating lunch every day with youth participants also provided another ‘off-the-record’ time to build relationships, share jokes, and discuss issues brought up by youth participants that were unrelated to the research project. Youth also took up the responsibility to grow relationships with each other: Youth with more senior roles at Organization X would occasionally check in with youth who were newer to the organization, at times for encouragement in the form of affirmation, but at other times to encourage them to participate in the discussions in more constructive ways.

Finally, it is important to recognize that the facilitator/researcher’s process of analyzing focus group data is not objective: Instead, Barbour (2014) notes that the researcher’s “own cultural repertoire and language” influence the way they “phrase questions and interpret responses.”(Barbour, 2014, p. 318) Therefore, the process of analyzing focus group data must involve “pay[ing] attention to our own reactions to comments that jar with our own understandings and expectations.” (Barbour, 2014, p. 318)

Co-production. The framework of the process of facilitating a youth led exploratory project into their perspectives about the stigma of mental illness can be encapsulated by Slay and Stephens’ (2013) understanding of co-production. The exploratory nature of this study allowed research participants and I to look for opportunities for co-production. Slay and Stephens (2013) define co-production as a “relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.”(p. 3) Despite the diversity in their backgrounds and stories, all of my research participants and I shared the goal of improving the quality of life for people with mental illness by challenging stigma in schools. Slay and Stephens (2013) then describe the “six principles which are the foundation stories of co-production” (p. 3):

1. **Taking an assets-based approach:** transforming the perception of people, so that they are seen not as passive recipients of services and burdens on the system, but as equal partners in designing and delivering services.
2. **Building on people's existing capabilities:** altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use at an individual and community level.
3. **Reciprocity and mutuality:** offering people a range of incentives to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.
4. **Peer support networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge.
5. **Blurring distinctions:** removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.
6. **Facilitating rather than delivering:** enabling public service agencies to become catalysts and facilitators rather than being the main providers themselves. (Slay and Stephens, 2013, p. 3).

Slay and Stephens (2013) argue that the “[m]ost of the strongest examples of co-production have all of these principles embedded in their day to day activities, but some principles may feature more strongly than others.”(p. 3) In Chapter 6, I discuss how both youth with lived experience and teacher candidates with and without personal connections to mental illness engaged in co-production throughout this study.

During the second week of the design studio, youth participants worked with me to develop the stories to be shared with teacher candidates during Mental Health Literacy Day. Following Corrigan's (2014) recommendation that personal stories “should be crafted for the targeted audience” and reflect “local agendas” (p. S6), youth participants who had experienced the school system in this Faculty of Education's city were

encouraged to speak about their experiences. Some of the youth had previously shared their story, but during the design studio sessions, the youth and I dedicated time to reformulating their stories specifically for teacher candidates since none had previous experience sharing their story in a formal setting with teacher candidates.

Youth participants were asked to first write their story using a template, and then after design a story project using whatever creative methods they desired. I offered two templates to choose from: the story template included in the *Coming Out Proud* workbook, and a story template from the Centre for Dignity, Recovery & Stigma Elimination (CDRSE). I offered the CDRSE template as second option because it provided an opportunity for a balance between: (a) an honest retelling of the difficulty of living with an untreated mental illness and (b) an examination of the strengths uncovered during the recovery and management of their mental illness. For example, the CDRSE templates asks storytellers to write about *On The Way Down* – the events that precipitated them seeking or receiving help for mental illness, as well as *On The Way Up* – how they experienced a turning point after getting support for their mental illness. In contrast, the *Coming Out Proud* template and the accompanying sample story end with the presumption that struggle with mental illness represented a single difficult episode in their life, rather than a day-to-day management of an illness that does not have a cure, yet does not rob the person of joy, hope, or opportunity. Therefore, the stories that youth chose to share with teacher candidates affirmed that they continued to experience times when they struggled with their mental health. They did not pronounce themselves cured of their disorder, nor did they claim that their time experience with poor mental health had begun and ended during only one period in the past.

After the design studio, five youth participants decided to share their stories with teacher candidates during the first of two Mental Health Literacy Days. Youth participants Sandra and Quinn shared their story in person. Raina planned to share her story in person, but due to a later conflict with the date of Mental Health Literacy Day, she shared her story via a pre-recorded youtube video. Joan and John chose to share their story anonymously through videos: Joan's video featured her narration and her artwork, while John's video featured his poetry and words presented by a third party. Recall from Chapter 1 that a contact experience that decreases stigma involves the target audience

interacting with a person who is “successfully managing a mental illness”, where there are “opportunities for active discussion and learning” (Arboleda-Florez and Stuart, 2012, p. 461). Therefore, I used a *waiting control* design to ensure that all teacher candidates had the opportunity to engage in active discussion and learning from the stories of youth with mental illness across the two Mental Health Literacy Days.

Mental Health Literacy Day

Two days were designated as Mental Health Literacy Days by the Faculty of Education. Mental Health Literacy Day I occurred in the Fall term on October 3, 2014, the last school day before teacher candidates’ first practicum block. Mental Health Literacy Day II occurred in the Winter term on February 27, 2015, during which teacher candidates who were in the control group at Time 1 had the opportunity to also hear from youth. Mental Health Literacy Day II also occurred on the last school day before the second practicum block.

These days were part of a series of mandatory professional learning days that occurred each Friday during the periods teacher candidates attended classes at the Faculty of Education. Attendance was taken only once at the beginning of the day, where teacher education office staff recorded teacher candidates attendance at the beginning of the day by asking teacher candidates to ‘swipe’ their cards into an electronic system. Since attendance was only taken at the beginning of the day, we could not monitor which breakout sessions students attended, and instead depended on teacher candidates to self-report their attendance in an online survey.

Before the Mental Health Literacy Day I, I obtained ethics approval (Appendix C) and thus arranged for an email (Appendix D) to be sent to all teacher candidates that informed them about the study and provided a weblink to the online survey. When teacher candidates arrived at the webpage, they first viewed the Letter of Information (Appendix E) and a question asking whether they consented to participating in the research study. If teacher candidates selected “YES, I consent to participate in this research”, they would proceed to a webpage that displayed the quantitative measure. If teacher candidates selected “NO, I do not consent to participate in this research”, the online survey tool was programmed to skip to the end of the survey with a simple “thank

you” screen, without displaying any of the survey items. Of the approximately 700 teacher candidates enrolled at the Faculty of Education, 299 teacher candidates consented to participate in the research and completed the online survey (Time 1). All teacher candidates who consented to participate in the study were entered into a draw to win one of five \$25 gift certificates to the university’s bookstore.

The schedule for Mental Health Literacy Day I is provided in Appendix F. All teacher candidates received the same presentations throughout the day, except for the intervention with youth stories. Half of the teacher candidates ($n = 350$) were randomly assigned to one of five intervention groups, including two live speakers and three video speakers, while the other half were randomly assigned to the control group where they listened to a Faculty of Education professor deliver an anti-stigma lecture. The random assignment was done by having teacher candidates select a piece of candy. After they selected the piece of candy, they were informed that the type of candy they had chosen corresponded to the session they would attend, and that the wrapper of the candy was their ‘ticket’ to the corresponding session.

There were two live speakers: Sandra and Quinn. I consulted with Sandra and Quinn to determine the support that they needed during the session and the size of the teacher candidate group with which they wanted to share their story. Due to room capacity limitations, group sizes ranged from 50 to 100 teacher candidates per session. One hundred teacher candidates were randomly assigned to Sandra’s session. She had previous experience telling her story with a non-teacher audience, and asked to be paired with the facilitator who was a Faculty of Education professor with a PhD in clinical psychology. Fifty teacher candidates were randomly assigned to Quinn’s group, who selected a staff member from Organization X as her session’s facilitator. Both facilitators of the live sessions introduced the youth speaker and after the talk, facilitated the discussion between the youth speaker and teacher candidates. One hundred teacher candidates were randomly assigned to watch Raina’s video, fifty teacher candidates were randomly assigned to watch Joan’s video, and fifty teacher candidates were randomly assigned to watch John’s video. The facilitators for each of the video sessions were mental health educators who after viewing the video with teacher candidates, chose from

a list of discussion questions (Appendix G) to facilitate a discussion among teacher candidates.

At the end of the day (Time 2), teacher candidates were sent another recruitment email (Appendix D) containing the weblink to another online survey. This survey was similar to the first survey but also included questions about the intervention or control group they attended, two questions about teacher candidates' perceptions of Mental Health Literacy Day, and one question about whether they wanted to be contacted to participate in a follow-up interview. Participants who indicated that they wanted to be contacted about the follow-up interview were emailed a separate Letter of Information and Letter of Consent (Appendix H).

The procedures for Mental Health Literacy Day II were similar to Mental Health Literacy Day I, except for two details: (a) teacher candidates did not complete another survey before Mental Health Literacy Day II, and (b) teacher candidates were able to choose the intervention they attended because of mass attrition after the first keynote speaker. The agenda for Mental Health Literacy Day II (Appendix I) was based on feedback from teacher candidates who completed the quantitative measure at Time 2 and/or participated in semi-structured interviews. At the end of the day (Time 3), teacher candidates were emailed an invitation to participate in the final quantitative measure (Appendix D).

Population 2: Teacher Candidates

I used an *explanatory sequential design* to investigate the stigma of mental illness among teacher candidates. As shown in Figure 8, “[t]he purpose of this design is to use a qualitative strand to explain initial quantitative results” (Creswell & Plano Clark, 2011, p. 82).

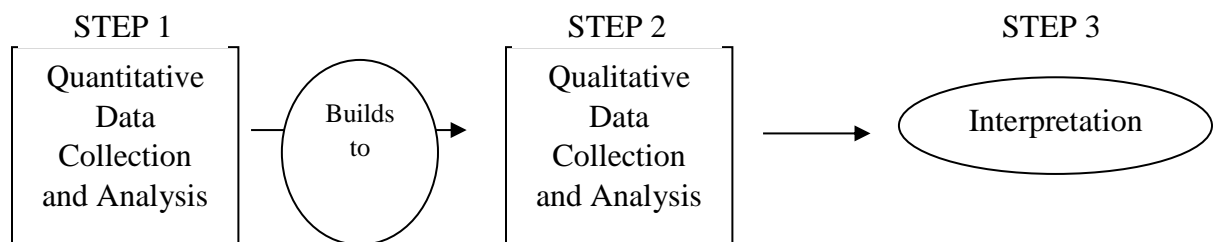


Figure 8. Explanatory sequential design (Creswell & Plano Clark, 2011, p. 69)

Step 1a: Quantitative Data Collection

My quantitative research question was:

Research Question 3:

Is a contact-based intervention involving teacher candidates hearing from youth living with mental illness significantly associated with a decrease in public or private stigma?

At Time 1, 299 teacher candidates consented to participate in the research study. They completed a quantitative measure online that included demographic questions, the *AQ-9*, and the *Opening Minds Scale*. Using a quantitative measure allowed me to quantify the ways in which the intervention was (or was not) associated with a decrease in particular aspects of mental illness stigma in a sample of teacher candidates. Polling a larger sample of participants (and analyzing the resulting data using statistical techniques) (a) increased the likelihood that the results accurately represented the larger population of teacher candidates at the Faculty of Education in the study; (b) and allows me to contribute the findings in this study to the wider body of empirical research about stigma reduction methods. I also considered using a survey in particular to ask participants about a sensitive topic such as mental illness stigma to be advantageous because its anonymity could encourage participants to be more honest with their opinions about stereotypes, prejudice, and discrimination towards people with lived experience. To this end, the online survey included questions about teacher candidates' experiences with stigma, where they could select and expand on their experiences being the victim, bystander, or perpetrator of stigma towards a person with mental illness.

Attribution Questionnaire-9 (AQ-9). I used a modified version of the AQ-9 as the primary measure assessing teacher candidates' public stigma because it operationalizes Weiner and Corrigan's theories about the cause of public stigma. The AQ-9 is a shortened version of the Attribution Questionnaire (Corrigan et al., 2003), a 27-item quantitative measure that "has been used widely in stigma research" (Corrigan, Powell, & Michaels, 2014, p. 467). In the Attribution Questionnaire, participants use a

nine-point Likert-type scale (1 = not at all; 9 = very much) to answer questions about their reactions to Harry, a 30-year-old man with schizophrenia. The 27-item measure has three questions representing “each of the nine factors that emerged from path analyses of responsibility and dangerousness.” (Corrigan, Powell, & Michaels, 2014, p. 467)

Recalling Figure 2 in Chapter 2, the *responsibility* path originates from the Weiner’s (2000) Attribution Theory of Interpersonal Motivation, while the *dangerousness* path represents Corrigan (2002)’s modification of the theory. The two paths are traced in Figure 9. Corrigan Powell, and Michaels (2014) categorize the questions representing *blame*, *pity*, and *help* under the *responsibility* category, while questions representing *fear*, *avoidance*, *coercion*, and *institutionalization* are under the *dangerousness* category. The questions about the potential *danger* posed by a person with mental illness is categorized under both paths (Corrigan, Powell, & Michaels, 2014).

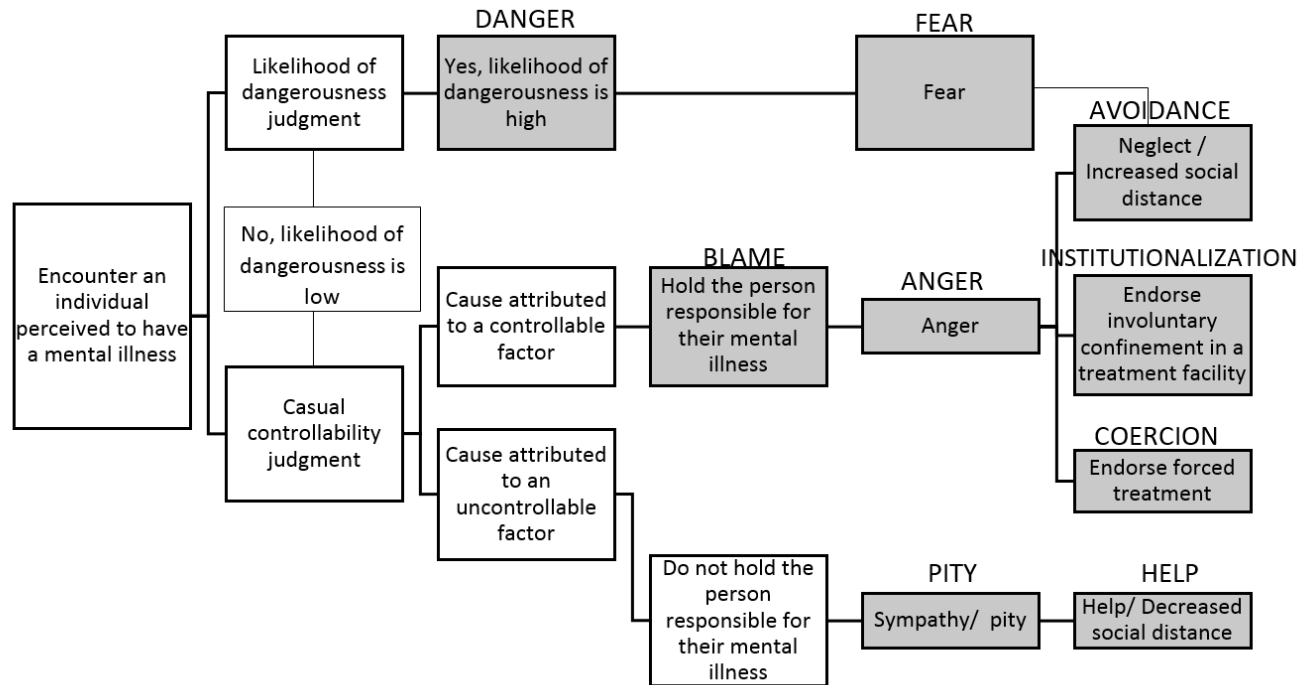


Figure 9. Theoretical mechanism of interpersonal public stigma reconfigured to correspond to the AQ-9. The shaded boxes represent the variables corresponding to the AQ-9. Each of the nine factors measured by the AQ-9 are indicated in capital letters.

In contrast to the Attribution Questionnaire’s three questions per factor, the AQ-9 has one question per factor, for a total of nine questions. Each question chosen for the

AQ-9 was the “single item that loaded most into each factor.” (Corrigan, 2014, p. 467) I modified this measure by exchanging the ‘Harry’ vignette for three different vignettes from Jorm, Wright, and Morgan (2007) about a 15-year old student named John who is experiencing depression, social phobia (anxiety disorder), or psychosis (schizophrenia). While Corrigan’s (2003) vignette names the mental illness (“Harry is a 30 year-old single man with schizophrenia”) and then provides a brief description of Harry’s experience with mental illness, Jorm et al.’s (2007) vignettes do not name the mental illness but do provide a description of John’s experience. Jorm and Wright (2008) say that these ‘John’ “vignettes were written to satisfy DSM-IV criteria and were validated by surveys of mental health professionals asking what was wrong with the person described.”(p. 144)

I exchanged Corrigan’s ‘Harry’ vignettes for Jorm, Wright, and Morgan (2007)’s ‘John’ vignettes for three reasons: (1) to measure teacher candidates’ public stigma towards a student rather than towards an adult; (2) to present a more likely scenario that teacher candidates would encounter during practicum, where they do not always get advance notice of a student’s diagnosis, but instead must rely on the signs demonstrated by the student; and (3) to expand the range of vignettes beyond schizophrenia in order to study public stigma towards students with internalizing disorders in addition to externalizing disorders.

Corrigan et al. (2002) explain that having participants respond to a specific person with mental illness – “rather than to people with mental illness in general” (Corrigan & Watson, 2004, p. 301) – makes the person described the vignette “more real to them.” (Corrigan et al., 2002, p. 173) Corrigan and Watson (2004) add that a vignette describing a specific person “leads to a more sensitive measure of attitudes that better corresponds with concurrent validators” (p. 301). Loades and Mastroyannopoulou (2010) also used vignettes in their investigation of teachers’ perceptions of students with mental health problems. They explain that the advantage of using a vignette in a quantitative measure about attitudes is its uniformity, “as all participants take the same vignettes under secure conditions, a uniform case description is provided to all [...] and participants are not given interpretive information. Hence, the natural conditions of the classroom are mimicked.” (p. 154).

On the other hand, a vignette is *only* a mimick – and therefore never a perfect representation – of natural classroom conditions: Loades and Mastroyannopoulou (2010) concede that unlike the situation presented in vignettes, teachers do not often receive all of the information about a student at one point in time, and then never again. In natural classrooms, teachers' perceptions and actions evolve as teachers learn more about their students. Therefore, Loades and Mastroyannopoulou (2010) acknowledge that people who complete a quantitative measure do not always behave in the way they predict they will in a survey. At the same time, Corrigan, Powell, and Michaels (2014) argue that behavioural intentions are an accepted proxy of behaviour in the psychological literature, “and these kinds of [behavioural] intentions exist in the AQ-9.” (p. 469)

Opening Minds Scale. The second measure used in this study is a modified version of the 12-item Opening Minds Scale for Health Care Providers (OMS-HC). According to Kassam, Papish, Modgill, and Patten (2012), the OMS-HC has a two-factor structure with a cronbach's alpha of 0.78. The first factor has seven items that measure attitudes towards people with mental illness (Cronbach's alpha = 0.75). The second factor has five items that measure attitudes towards the disclosure of a mental illness (Cronbach's alpha = 0.72). The OMS-HC is a stigma measure developed in conjunction with the Mental Health Commission of Canada's anti-stigma initiative. This initiative, called *Opening Minds*, “is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness.” (Kassam, Papish, Modgill, & Patten, 2012, p. 3)

I chose the OMS-HC measure because it was developed by Canadians and for Canadians, to “scientifically evaluate” the effectiveness of “contact-based educational sessions, where target audiences hear personal stories from and interact with individuals who have experience with mental illness and have recovered or are managing their illness.” (Kassam, Papish, Modgill, & Patten, 2012, p. 3) I modified this scale in three ways: (1) I exchanged the words “healthcare provider” for the word “teacher”; (2) In the first question, I exchanged the word “helping” for the word “teaching”; (3) In the fourth question, I changed “I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace” to “I would be more inclined to seek help for a mental illness if my insurance provider or employee assistance

program (EAP) was not associated with my workplace” to better reflect the experience of teachers.

Demographics at Time 1. Prior to Mental Health Literacy Day I, 299 teacher candidates completed the quantitative measure, where 230 (77%) were female, 67 (22%) were male, one answered “other”, and one declined to answer the question. The median age of participants was 23, $M = 25.78$, $SD = 6.03$. Teacher candidates in the Intermediate-Senior division represented the majority of the participants (42%, $n = 125$), followed by Primary-Junior (29%, $n = 88$), Intermediate (26%, $n = 77$), and Technological Education (3%, $n = 9$). The majority of participants completed a bachelor’s degree as their highest level of education (88%, $n = 262$), followed by a master’s degree (7%, $n = 22$). Two participants had a diploma as their highest level of education, and one participant had a PhD. Twelve participants selected “Other” that their highest level of education, including a graduate certificate, an interprovincial license, a post-graduate diploma, a chef school diploma, a TESOL diploma, and a college certificate.

Demographics at Time 2. Just after completing Mental Health Literacy Day I, 131 teacher candidates completed the quantitative measure, where 112 (85.5%) participants had also completed the survey at Time 1 (before Mental Health Literacy Day I), while 19 (14.5%) had only completed the survey at Time 2 (immediately after Mental Health Literacy Day I). The gender distribution of the participants was similar to Time 1: 78% were female ($n = 102$), while 21% were male ($n = 28$). The median age of participants was 24, $M = 26.58$, $SD = 6.71$. Teacher candidates in the Intermediate-Senior division represented the majority of the participants (42%, $n = 55$), followed by Primary-Junior (44%, $n = 29$), Intermediate (22%, $n = 29$), and Technological Education (1.5%, $n = 2$). The majority of participants completed a bachelor’s degree as their highest level of education (88%, $n = 115$), followed by a master’s degree (8%, $n = 11$). One participants had a diploma as their highest level of education, one participant had a graduate certificate, and one participant had a PhD.

Demographics at Time 3. Just after completing Mental Health Literacy Day II, 46 teacher candidates completed the quantitative measure, where 36 (78%) were female, 9 (20%) were male, and one declined to answer this question. The median age of participants was 23, $M = 26.07$, $SD = 5.91$. Teacher candidates in the Intermediate-Senior

division represented the majority of the participants (44%, n = 20), followed by Junior-Intermediate (26%, n = 12), Primary-Junior (24%, n = 11) and, and Technological Education (4%, n = 2). The majority of participants completed a bachelor's degree as their highest level of education (80%, n = 37), followed by a master's degree (9%, n = 4). Three participants had diplomas as their highest level of education, and one participant had a PhD.

Step 1b: Quantitative Data Analysis

Immediately after the intervention, teacher candidates embarked upon their first practicum of six weeks. During this time, I analyzed the quantitative data from Time 1 using the computer software program SPSS. I conducted a t-test to determine whether teacher candidates' stigma changed significantly after Mental Health Literacy Day, and whether teacher candidates in the intervention groups' stigma differed significantly from teacher candidates in the control group after Mental Health Literacy Day.

Step 2a: Qualitative Data Collection: Semi-Structured Interviews

I used the results from the quantitative data to inform the eleven individual semi-structured interviews I conducted with teacher candidates when they returned from their practicum in December. Interviewees were not compensated for their time. I chose to collect qualitative data from teacher candidates "to explain the mechanism or reasons behind the resultant [quantitative data] trends" (Creswell & Plano Clark, 2011, p. 82). The quantitative items in the online survey measured the primary theoretical constructs of public stigma, but the qualitative data from the semi-structured interviews helped explain the quantitative results and answer new questions that developed from analyzing the quantitative results. Therefore, I used the results from my quantitative data analysis "to guide the development of the qualitative strand." (Creswell & Plano Clark, 2011, p. 83) This allowed me to illustrate quantitative findings, including contradictions and outliers, with teacher candidates' own words. My qualitative research question was:

Research Question 4:

How did teacher candidates' new knowledge from Mental Health Literacy Day inform their teaching practices?

DiCicco-Bloom and Crabtree (2006) explain that semi-structured interviews “are generally organized around a set of predetermined open-ended questions, with other questions emerging from the dialogue between interviewer and interviewee/s” (p. 315) The interviews in this study were *semi-structured* because according to the ethics protocol (see Appendix J for the Interview Guide), I chose open-ended questions for teacher candidates to answer that corresponded to my research questions. However, the *semi* of the structure allowed me to pursue the ideas and concepts that teacher candidates raised themselves. Each interview lasted between 30 minutes and one hour, and always started with the protocol suggested by Whiting (2008):

- Purpose of the interview
- Clarification of topic under discussion
- Format of the interview
- Approximate length of interview
- Assurance of confidentiality
- Purpose of digital recorder – ask permission to use it. Explain who will listen to the recording.
- Assure participant that he or she may seek clarification of questions.
- Assure participant that he or she can decline to answer a question.

(Whiting, 2008, p. 37)

Whiting (2008) also recommends assuring participants “that there will be opportunity during the interview to ask questions” (p. 37), but instead I asked participants: “Do you have any questions for me before we begin?” I also explained that in addition to recording the interview, I would be taking notes with pen and paper in order to remember poignant issues that teacher candidates raised so that I could ask follow-up questions at an appropriate time without interrupting interviewees’ train of thought.

DiCicco-Bloom and Crabtree (2006) argue that “because of the public nature of the process, [a group interview] prevents delving as deeply into the individual.”(p. 315) Similarly, I chose to conduct individual interviews in order for teacher candidates to have

a more private space to speak freely about their perceptions of the stigma of mental illness in schools, with the understanding that while their voices would be featured in this study, distinguishing demographic details of each interviewee would be kept confidential. During Mental Health Literacy Days, teacher candidates had the opportunity to converse with their peers and mental health professionals about similar issues; in contrast, teacher candidates used our individual interviews to give feedback, ask questions they considered to be controversial, and tell personal stories about the impact of stigma in schools. Many teacher candidates thanked me for the opportunity to participate in the interview after it was completed, explaining that it was the first or one of few opportunities to speak honestly about the influence of mental health in their lives. This outcome required building rapport with each teacher candidate during the interview, which according to Whiting (2008) is a continual process that “occurs in stages throughout the interview.” (p. 37)

Building rapport during semi-structured interviews. DiCicco-Bloom and Crabtree (2006) explain “rapport involves trust and a respect for the interviewee and the information he or she shares. It is also the means of establishing a safe and comfortable environment for sharing the interviewee’s personal experiences and attitudes as they actually occurred.” (p. 316) In contrast to my work in the design studio with youth where we spent up to 20 hours together, I had to establish a trusting environment at a more rapid pace within the 0.5 to 1-hour time period of each interview. DiCicco-Bloom & Crabtree (2006) and Whiting (2008) describe four stages of rapport that the interviewer and interviewee can move through during the semi-structured interview: “apprehension, exploration, co-operation and participation” (DiCicco-Bloom & Crabtree, 2006, p. 316).

The *apprehension* phase of the interview “is characterized by uncertainty stemming from the strangeness of a context in which the interviewer and interviewee are new. During this phase the goal is to get the interviewee talking.” (DiCicco-Bloom & Crabtree, 2006, p. 316) Therefore, I conversed with each teacher candidate in a cordial manner, then I thanked the teacher candidate for agreeing to do the interview. Next, I asked: “What drew you to participate in this interview?” Some teacher candidates used this question to immediately give me background about their personal experiences with mental health, while others gave shorter answers about helping me with the research or,

in one teacher candidate's case, to give me feedback about the problems she perceived with Mental Health Literacy Day. This gave me the opportunity to express interest by asking follow-up questions about the topic that was at the forefront of each teacher candidate's mind, while adjusting the order of the questions to suit the flow of the conversation and eliminating questions that the teacher candidate had already answered.

For participants who provided more reticent responses to the first question, I proceeded with the pre-determined order of questions, asking about their reaction to a definition of mental health literacy. For more participants, having a non-personal topic to analyze and discuss allowed them to enter into the *exploration* phase, "when the interviewee becomes engaged in an in-depth description." (p. 317) During this phase, it was important for me to demonstrate that I listening to my interviewees in order to learn from their perspectives.

DiCicco-Bloom and Crabtree (2006) add that during the exploration phase, interviewees also test interviewers for their reactions to the interviewee's answers. The interviewer's reactions allow the interviewee to determine how much they will continue to share. In the interviews for this study, it was important for me to adopt a non-judgmental, curious point of view during interviews, where I listened carefully, asked clarification questions, and provided brief summaries of what I was hearing in order to ensure that I understood their positions and was learning from their experience.

As we continued the conversation, we entered the *co-operative* phase, which DiCicco-Bloom and Crabtree (2006) say "is characterized by a comfort level in which the participants are not afraid of offending one another and find satisfaction in the interview process." (p. 317) In some interviews, we entered this phase as I explained why an idea or story made by the teacher candidate was particularly poignant to the study, and I asked follow up questions to learn more about their perspective. In other interviews, we entered the co-operative phase when we worked together to craft their ideal curriculum for Mental Health Literacy Day II. DiCicco-Bloom and Crabtree (2006) say that "at this point the interviewee takes on the role of guiding and teaching the interviewer." (p. 317)

Achieving this stage with interview participants allowed me to engage in co-production, blurring distinctions between mental health literacy curriculum designers (myself and other ‘experts’) and consumers (teacher candidates). Teacher candidates built on the experiences and knowledge they shared with me to become partners in designing the curriculum for Mental Health Literacy Day II. This required enough honesty with me to share where they felt unsatisfied by the first Day, and honesty with themselves to identify the mental health literacy skills and knowledge that they felt were underdeveloped.

Step 2b: Qualitative Data Transcription

I transcribed the audio recordings of the design studio, focus groups, and semi-structured interviews verbatim, also using *verbal exchange coding* (Saldana, 2013) to represent the non-verbal cues, laughter, verbal stressing of certain words, behaviours, and pauses that occurred as participants spoke. According to Saldana (2013), “Verbal Exchange Coding is the verbatim transcript analysis and interpretation of the types of conversation and personal meanings of key moments in the exchanges.” (p. 136) I completed this transcription soon after the data collection date in order to more accurately recall the non-verbal aspects of each exchange.

Step 2c: Qualitative Data Analysis

To analyze the qualitative data in my study, I used first cycle and second cycle coding methods (Saldana, 2013). During the first cycle of coding, I used *elemental* and *affective* types of coding. Under the elemental category of first cycle methods, I used *descriptive* coding, *structural* coding, and *in vivo* coding.

Descriptive coding and structural coding. The first time I read through the transcripts, I used *descriptive* and *structural* coding to categorize the topics covered by both youth and teacher candidates. According to Saldana (2013), *descriptive coding* uses a “word or short phrase” (p. 88) to summarize “the basic topic of a passage of qualitative data.” (p. 88) Here, the code is the topic of the passage in the transcript, not the “substance of the message” (Tesch, 1990, p. 119) or an analysis of the deeper meaning or message behind the participants’ words. When the topic of the passage directly answered a research question, I used *structural coding*, where I applied “a content-based or

conceptual phrase representing a topic of inquiry to a segment of data that relates to a specific research question used to frame the interview” (Saldana, 2013, p. 84).

Coding using descriptive and structural coding allowed me to collect “a categorized inventory, tabular account, summary, or index of the data’s contents” (Saldana, 2013, p. 89). In the youth participant transcripts, I used these coding methods to quickly categorize the topics discussed during each four hour session. I gathered the quotes that fell under the same code in a Microsoft Excel file to record the frequency that each topic was discussed, and returned to these to see the similarities and differences in the experiences of each participant within the same code. This topical listing of codes was useful when, in a later stage of analysis, I used versus coding to highlight the tensions and contradictions as youth differed in their perspectives on the same topic.

For the teacher candidate transcripts, I also used these coding methods to itemize the topics that teacher candidates spoke about during their individual interviews. This allowed me to quantify how many times a certain topic was addressed (for example, most teacher candidates mentioned the influence of stigma on perceptions about mental illness) and to then subdivide each topic (for example, some teacher candidates had personal experiences being – or having a close family member be – the object of stigma, while other teacher candidates described how their own stigmatizing views influenced their perception of others struggling with mental illness). I also used descriptive coding to gather all of the ideas that teacher candidates suggested for the Mental Health Literacy Day II. This gave me a ‘checklist’ when planning the second Mental Health Literacy Day II to verify that I had responded to all of the teacher candidates’ suggestions.

In vivo coding. According to Saldana (2013), *in vivo coding* involves using codes that are “a word or short phrase from the actual language found in the qualitative data record” (p. 91). After reading over all of the transcripts, I looked for “words and phrases that seem[ed] to call for bolding, underlining, italicizing, highlighting, or vocal emphasis if spoken aloud.” (Saldana, 2013, p. 92); I determined which words or phrases were salient enough to be considered as *in vivo codes* when they had particularly salient features such as “impacting nouns, action-oriented verbs, evocative word choices, clever or ironic phrases, similes and metaphors, etc.”(p. 92).

In vivo coding was my primary choice of coding when analyzing the transcripts from the youth during the design studio and focus groups because coding using words or phrases that the participants used themselves allowed me to respond to the dearth of research involving the voices of youth with lived experience. Saldana (2013) agrees that in vivo coding is appropriate for “studies that prioritize and honor the participant’s voice” (p. 91) because it allows the researcher to verify that he or she has grasped what was particularly important to the participants, rather than the researcher, during the study. In fact, Saldana (2013) observes that in vivo coding is “particularly useful” (p. 91) for studies involving youth participants because their “voices are often marginalized, and coding with their actual words enhances and deepens an adult’s understanding of their cultures and worldviews.”(p. 91).

Affective coding. After applying elemental first cycle codes to the data, I used *affective coding* in the form of *versus* and *values* coding to continue analyzing the qualitative data from youth and teacher candidate participants.

Versus coding. According to Saldana (2013), researchers use versus coding to “identify in dichotomous or binary terms the individuals, groups, social systems, organizations, phenomena, processes, concepts, etc., in direct conflict with each other”, especially where “there is generally an asymmetrical power balance” between the individuals, groups, and other concepts (p. 115). This form of coding “is an important diagnostic for initiating and facilitating positive social change” (p. 116) because it allows researchers to discern “the conflicting power issues among constituents and stakeholders” (Saldana, 2013, p. 116). Each time I applied a versus code to a passage, I identified “the primary stakeholders, how each side perceives and acts toward the conflict, and the central issue at stake” (Saldana, 2013, p. 117). This allowed me to develop the implications of each conflict.

Values coding. The second form of affective coding I used to analyze the qualitative data in this study was values coding, where I applied codes “that reflect a participant’s values, attitudes, and beliefs, representing his or her perspectives or world-view.”(Saldana, 2013, p. 110). I gave each values-coded passage a name that described the participant’s value, belief, or attitude and labeled each with a V for value, B for belief, or A for attitude. According to Saldana (2013), “a *value* is the importance we

attribute to oneself, another person, thing, or idea.”(p. 111, emphasis theirs); I assigned a value code to a passage in which participants described an issue that was important to them. Saldana (2013) describes an attitude as “the way we think and feel about ourselves, another person, thing, or idea.”(p. 111). I used this code when participants made evaluative judgments. Analyzing the transcripts, I observed that these attitudes were often informed by their beliefs. “A *belief* is part of a system that includes our values and attitudes, plus our personal knowledge, experiences, opinions, prejudices, morals, and other interpretive perceptions of the social world.” (Saldana, 2013, p. 111). Here, we can see parallels between Saldana’s definition and Corrigan’s conceptualization of prejudice as a negative attitude that a person believes. Corrigan argues that these prejudicial beliefs lead to discriminatory actions, including increasing social distance towards people with mental illness. Therefore, I used the belief code to contrast beliefs that led to *decreasing* social distance with beliefs that led to *increasing* social distance towards people living with mental illness.

Next, I grouped the codes under each category, which Saldana (2013) argues can provide “richer opportunities for gathering and assessing, in language-based meanings, what the participant values, believes, thinks, and feels about social life” (p. 114) than what quantitative measures of values, attitudes, and beliefs can provide. Saldana explains that analyzing qualitative data can provide a richer understanding of participants’ perspectives because “quantitative scales assume direction and intensity of a value, attitude, and belief, necessitating a fixed, linear *continuum* of response [...] rather than a three-dimensional *ocean* allowing for diverse responses and varying levels of depth” (p. 114). On the other hand, Saldana (2013) cautions that the decisions researchers make about whether passages in the transcripts represent values, attitudes, and beliefs depend on the researcher’s “paradigm, perspective, and positionality.”(p. 114) Therefore, the researcher must decide whether “the goal is to capture the participant’s worldview or personal ideology,” (p. 114) or whether it is to label critically or against a theory. My primary goal was to capture the worldview of participants by putting their words in the forefront of this study, so combining this method with in vivo coding was a check to ensure faithfulness to the voices of the participants.

Second cycle coding: pattern coding. Next, I used *second cycle coding* to consolidate all of the original codes into a condensed number of codes organized by category, theme, or theoretical underpinning (Saldana, 2013). In particular, I used *pattern coding* to bring meaning to the categorization of my codes into meta-codes. According to Saldana (2013), each meta-code is a “category label that identifies similarly coded data.”(p. 209) Miles and Huberman (1994) say that pattern codes “identify an emergent theme, configuration, or explanation. They pull together a lot of material into a more meaningful and parsimonious unit of analysis.” (p. 210). Saldana adds that pattern coding furthers the process of qualitative analysis because it allows researchers to find “rules, causes, and explanations in the data” and form “theoretical constructs and processes” (p. 210). In this mixed-methods study, I looked to the short-answer questions and the semi-structured interviews completed by teacher candidates to help explain the impact of youth’s stories when quantitative measures revealed that they were no more effective than education at decreasing mental illness stigma. Miles and Huberman (1994) note that many pattern codes “are captured in the form of metaphors (‘dwindling efforts,’ ‘interactive glue’), where they can synthesize large blocks of data in a single trope” (Miles & Huberman, 1994, p. 212).

Saldana argues that code mapping can be “part of the auditing process for a research study. It documents how a list of codes gets categorized, recategorized, and conceptualized throughout the analytic journey.” (p. 198) For example, my analysis of all of the teacher candidate data had three rounds of code mapping. I began with 40 codes from the first cycle of coding. I then categorized these 40 codes into eight categories. The names of these eight categories were each “a statement that describes a major theme, a pattern of action, a network of interrelationships, or a theoretical construct from the data.” (p. 212). Next, I consolidated these eight categories into three categories with new names, or “super codes” (Saldana, 2013, p. 212), whose names accurately represented the relationship between the codes. The last round of code mapping involved renaming each category “into higher-level concepts” (p. 198) that answered or corresponded to my research questions.

Step 3: Quantitative and Qualitative Data Interpretation

Finally, I combined the analysis of data from Population 1 and 2 to give an overall picture of the mutual effects, benefits, and drawbacks of sharing and hearing lived experiences about mental illness to both the story creator and the listener. An in-depth examination of these mutual effects has not yet been done in the mental illness stigma literature. Drawing conclusions from both sets of data allow me to gain a more complete understanding of the effect of personal interaction on the stigma of mental illness from multiple perspectives. I aim for my research findings to contribute to evidence-based research for education stakeholders who want to decrease the stigma of mental illness in their working and learning environments.

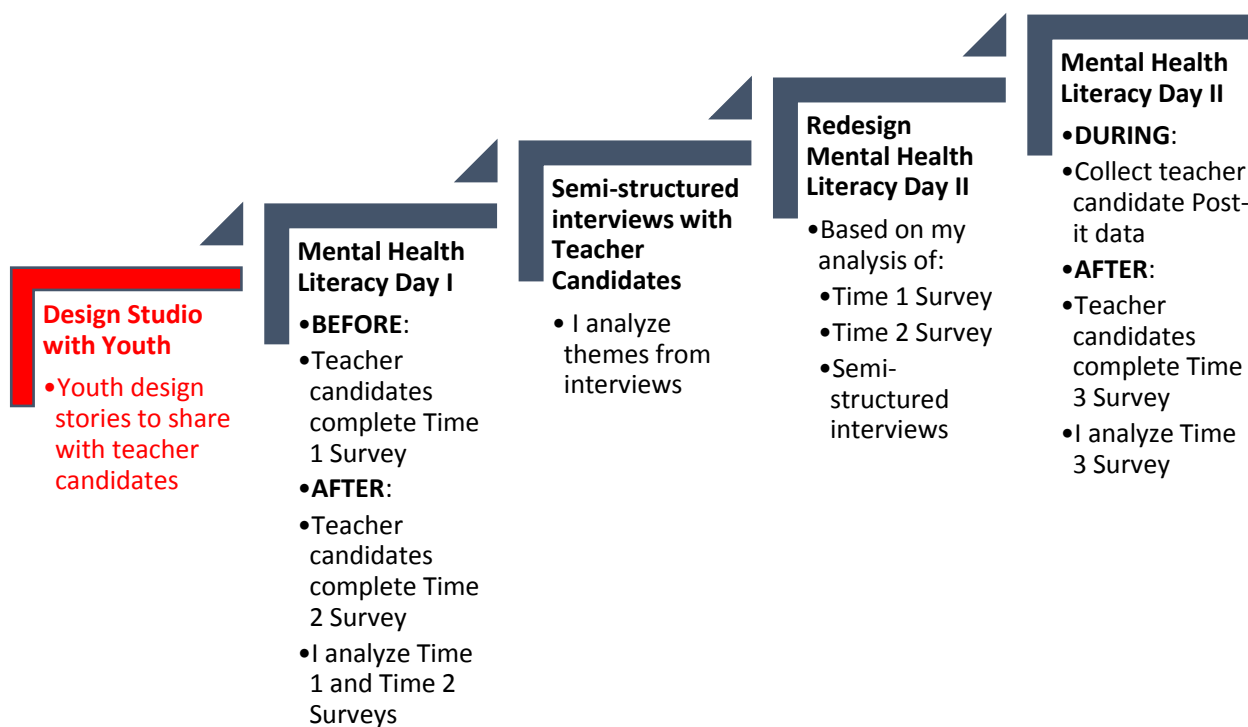
Chapter 4: Results from Youth Stories

In this chapter, I present the youth and teacher candidate data used to answer the research question:

Research Question 2:

What is the process and result when youth co-create curriculum to share their story with teacher candidates?

I start by presenting the qualitative data from the five-day design studio (including two focus groups) that youth participated in. Next, I present quantitative and qualitative data from teacher candidates to illustrate the impact that youth stories had on teacher candidates.



The Process

As outlined in Chapter 3, the youth participants and I used the first three days of the design studio to work through Lesson 1, Lesson 2, and the first part of Lesson 3 in Corrigan's *Coming Out Proud* workbook. Appendix K contains a list of the main issues that youth raised during each Lesson. Youth raised the longest and strongest objections to

Lesson 1, particularly in the way that the material in Parts 2 and 3 were presented. Therefore, in addition to summarizing their objections in Appendix K, I briefly present their comments here.

Workbook Lesson 1 Part 2: Secrets are a part of life. Youth participants objected strongly to the use of the word ‘secret’ to describe choosing not to disclose a diagnosis of mental illness. Youth felt that it was grounded in the assumption that choosing not to disclose a mental illness diagnosis was motivated by feelings of guilt or shame about the diagnosis. Youth participant Alana explained that when we use the word ‘secret’, we are either shaming a person for keeping a secret (“The way that we often talk about secrets is that we shame others into sharing someone else’s secrets”) or shaming a person for revealing a secret (“or we feel like we have to be defensive [because] we’re being deviant by sharing a secret.”). She argued that

it’s not deviant behaviour to keep things to yourself – it’s respecting boundaries and respecting your own privacy. Having privacy and boundaries isn’t deviant – that’s how you stay healthy. It’s disrespectful to others to talk about their life without their consent, so [...] I think using the language of “secrets” doesn’t give people the proper tools to fully understand the ways to either disclose in a healthy way or speak to other people that are disclosing.

Alana did not return to the study after finding the discussion about this topic upsetting, but she did follow up later with me to ask to be included in future projects. Youth participant Sandra proposed that instead of using the word “secret”, the workbook should use a discourse that respects and affirms individuals’ “right to have some things that they don’t have to disclose.” When I consulted with Organization X’s staff members to ask why youth objected so strongly to this section, they explained that many youth participants had previously experienced violations of their privacy, where their diagnosis was revealed – and their story was told – without their consent or their input. Often, decisions were made about the welfare of these youth based on stigmatizing attitudes about the capacity of students with mental illness, leaving them marginalized in their classroom, in their families, or in their community. Part of the reason for participating in

this research, then, was for youth to reclaim the choice to tell their story, and to decide the parameters under which their story was shared with others.

For example, after previous negative experiences feeling exploited by others asking her to share her story, Sandra explained that she now chooses to tell her story when “I get to choose how much to disclose.” For Sandra, agreeing to share her story is not equivalent to the asker or the listener owning all of her story. Instead, Sandra constructs her story according to the elements of her choosing: She chooses the elements that become public knowledge, and the elements that remain private.

I want control of my story, so by being active, being conscious of what parts of my story I want to share and with who, and being very forward about what I’m not ok with people sharing, [...] it helps me have control over my own story.

Sandra came to this understanding about the importance of purposefully constructing and controlling her story after experiencing multiple events when her story was also shared without her consent. As a student who experienced foster care, homelessness, and major trauma with episodes of dissociation during elementary school and high school, it was common for others in charge of her care and rehabilitation to speak about and for her. As a result of these experiences, Sandra values being able to choose the parameters under which she shares her story. She chooses to share her story when she is recognized as having valuable, intimate, and unique knowledge about mental health. To her, these affirming attitudes towards the value of her story are demonstrated when people who request her story offer her compensation for telling her story: “When you share something with someone [e.g., an audience, and they say] “oh can we videotape this”, it’s like “no because you can use that, and I want to get paid for my story!” [laughs] Therefore, a record of the story she shared with teacher candidates during Mental Health Literacy Day is not included in the results I present here, but her voice and experience is represented in the data.

Workbook Lesson 1 Part 3: Considering the pros and cons of disclosing.

While using this section of the workbook to discuss why youth wanted to share their stories, youth objected to order in which the material was presented. Youth argued that while the workbook presents the costs and benefits of disclosure first, individuals

considering disclosure should first consider the *concrete goal* of their disclosure before considering the more *abstract costs* against the benefits of disclosure. The reason for considering the goal before the costs and benefits was because based on their experience, the weighing of costs and benefits changes based on the goal. What's more, youth participants challenged the notion that a decision about disclosure could be made by a strict tally of the costs and benefits to disclosure. In fact, as shown in Appendix K, youth named more costs to disclosure than benefits of disclosure. Still, they argued that when disclosure was the key to receiving support, the cost of remaining silent was always too high.

After generating a robust list of the goals, benefits, and costs of disclosing a diagnosis of mental illness (summarized in Appendix K), youth participants shifted their discussion from a broad discussion about disclosure in general to a specific focus on friends and families' reactions to sharing their story about their experiences with mental illness. While youth generally described their friends as being supportive of their decision to share their stories, some youth acknowledged that their parents feared the cost of sharing. Raina and Quinn described the difference between friends' reactions and parents' reactions as a product of a younger, more accepting generation. In the same way, youth viewed the workbook as being unsuitable for their generation because they perceived it to be authored by people from an older generation who endured more stigmatizing attitudes towards people with mental illness. For example, Raina dismissed Corrigan's workbook as "definitely written for not young people" because the attitudes presented in the workbook were "old school":

[The workbook is] written for the older generation of mental health advocates because they are dealing with a lot more guilt than thankfully a lot of young people will have to deal with. Because we're changing this conversation – we're talking about it.

Quinn also reasoned that her parents struggled her decision to be open about her mental illness "because they grew up in a different time"

where it wasn't a thing for them. And then all of a sudden it's like everyone's accepting them but they don't understand that it's acceptable. So it's weird.

Maybe it's even weird for them to be like: "Oh, it's ok that my kid has depression? Like, you're not angry at them?"

Raina decided not to tell her parents about her struggles with depression. She managed to do this by only speaking to her teachers about her difficulties, and by the time that she was hospitalized for depression, she was living at a friend's house, "and they covered for me." Raina 'came out' about her diagnosis of depression by giving a public talk that became popular when it was posted online: "Yeah, my parents found out that I lived with depression at the same time that 3000 other people did. So they didn't know."

Like Quinn, Raina's parents had trouble believing that others would not denigrate her for sharing her experiences with mental illness. Raina says that her mother went from being "really scared" for Raina's welfare to being supportive after seeing the positive impact of Raina sharing her story with others. However, her dad remains unsupportive: "My dad called me and told that I was just as bad as a porn star." She explains that

my dad gets very angry. Because not only does he have PTSD, but he when he was in the war one of his friends took his own life. And so he doesn't understand still, like why somebody would be sharing this, and it's scary for him.

When reflecting on the way that she chose to have her parents to find out about her experiences with mental illness, Raina called herself "lucky in that sense and unlucky because I was telling from a place of health. And honestly if I was sick and they acted the way they did, it would have made it much worse." John added that there continued to be some things about his journey through mental illness that he had not told his parents

and probably wouldn't. If I did tell them, they would probably be more [...] putting more pressure on me and that's the one thing I don't really need right now. But telling your parents is one of the hardest things you can do.

John explained that it is difficult to talk to his mother and father about his struggles with mental illness for two different reasons. He says that his mother "feels more distraught about it" because "mental illness runs in [his mother's] family", which

has resulted in his mother caring for his grandmother “for like 20 years or so, just trying to get her healthy and stuff.” He does not want to add to the burden of his mother feeling responsible for the emotional health of another loved one. On the other hand, John also finds it difficult to tell his dad about his mental illness “because if I talk to my dad about it, he shows no emotion. It’s hard for him to show emotion. And that’s really why I don’t talk to him.” Quinn also talked about hiding her struggles with mental illness from her parents at times in order to shield them from the reality that Quinn was struggling with emotional pain that they could not help abate.

It would probably weigh really heavily on them if I was like: “Just so you know, I’m really bad right now.” And they would want to know, but it would be hard for them, and it can be hard as a kid to feel bad especially if you’re close with your parents and they tell you everything, right?

In contrast, Sandra’s biological father, who also lives with mental illness, reacted to her disclosure by apologizing for their genetic predisposition to mental illness: “With my bio dad, he wasn’t upset or whatever, but he was just like: “I’m sorry” because mental illness runs in the family – ‘I’m so sorry that I gave this to you.’” Similarly, Madison maintains “a very open dialogue” with her mother about mental illness because of the hereditary nature of mental illness in their family. However, this open dialogue only exists in her mother’s generation and younger. She says that “in the upper generations [of her family], it’s not talked about.” For Sandra’s family, she describes a divide between two sides of her family. For the side of her family that includes her biological father, “it’s all out there, like ‘Oh, I just heard from your uncle and he’s in a tree and the clouds are chasing him’”, but

the other half is like: “You never talk about anything. You don’t even talk about poverty, and you don’t talk about anything. Everything is perfectly fine, make it work, make it look like it’s working” – that’s the rule.

Writing the story: Choosing the template. After three days of working through the Lessons from the *Coming Out Proud* workbook, youth began writing their story on Day 4. For the reasons I discussed in Chapter 3, I offered two templates for youth to choose from: (1) the story template included in the *Coming Out Proud* workbook, and (2)

a story template from the Centre for Dignity, Recovery & Stigma Elimination (CDRSE). Youth preferred the CDRSE story template. Sandra found the *Coming Out Proud* template to be too “cookie-cutter” and “too confining and from a very specific point of view, so it wasn’t really accessible to a lot of people.” In contrast, Sandra found the CDRSE story template

more open and just had general suggestions, not so much “this is how you do step 1 step 2 step 3 step 4” but it had just “on the way up” which could mean anything, and multiple questions clarifying what it was meaning by that.

In particular, Sandra appreciated the clarifying questions that accompanied the titles. Quinn also commented that the clarifying questions helped youth to “jog your memory, being like: ‘Oh, this would be a good part of my story to put here!’”

Youth participants also rejected the *Coming Out Proud* story template because it required all speakers to come to the conclusion that: “I, like all people with mental illness, live, work, and play just like you. So, please treat me the same. Do not view me based on any unfair stereotypes.” Quinn said that coming to terms with the daily experience of mental illness can mean that sometimes you cannot do things like others: “I’m pretty sure that if you have depression, you’re actually not capable of...not that you’re not *capable* of doing things, but sometimes you do them differently.” Youth also criticized the essentializing discourse of an individual being “like all people with mental illness”. Although this was not the workbook author’s intent to diminish the diversity of people living with mental illness, it was important for youth to establish that they would not be speaking for all students with mental illness – all they could do was to present their own story.

Sandra: I, like every single person with a mental illness – no!

Quinn: “We’re actually just one person! You’re all big clump of mental illness” is what it makes it sound like.

John: Yes there is a chance that you’re going to find someone who has the same mental illness as you, but it’s a less likely chance that you’re going to find a person who has the same symptoms and

Sandra: Present the same way

Joan: Yeah

Sandra: Deal with it the same way

John: (signals assent)

Sandra: And have similar personality and context...No!

John: It's very hard to find somebody who copes the same way as you, has been through the same more or less, with the same history as you, with the same illness.

Youth participants who were considering sharing their story for the first time struggled with describing how they were empowered as a result of – or in spite of – their mental illness. Madison said that because she was still coming to terms with accepting the fact that she has a mental illness, she could not yet “reflect on it.” Quinn also “wrote that I don't have a conclusion 'cause I [don't] think I'm at that point too.” In contrast, Raina says that she considers depression to be “one of the best things” that has happened to her because of the purpose it gave her life.

The weirdest looks I've gotten from people is when I tell people that depression is probably one of the best things that's happened to me, because it gave me purpose. And they look at me [strangely], especially if they're a family member supporting somebody [with a mental illness]. It's like “Yeah it sucked and I've felt bad sometimes, but it's provided me an opportunity to have an amazing amount of self-awareness to be able to do all this stuff.” Because when you think about it, if people never get sick, then they live their lives not optimally. Because they don't have to fix it. [laughs]

Writing the story: Benefits. Youth described the benefits of writing their story as “therapeutic” because it allowed them to express their emotions and affirm the legitimacy of their stories. Madison “found that as someone who's never shared their story”, that she had “never had it all in one place” before – she had never worked through all of the elements of her story, as suggested by the template. She described the

experience as “pretty therapeutic actually, and I’ve made connections that I’ve never made before.” John found the writing exercise “hard for me because I haven’t been good at writing anything down – I’ve been good at talking – I can talk for hours if I had the chance.” Therefore, he had “never – in full – spilled my guts per se on paper” as opposed to “short things on Facebook [like] ‘yes, I am suffering from this...’” John described the benefits as “I had a way of emoting it somehow...instead of just keeping it all to myself and [only] telling someone when they ask.” In contrast, although this was also Quinn’s first time writing her story down on paper, she said that “the questions didn’t help me– I didn’t even really pay attention to them” but because she described herself as “a really visual person”, she used the boxes “to just categorize things.” To Quinn, the benefit of writing her story down was that it “made [her story] feel real because it’s actually on paper.”

Writing the story for a teacher candidate audience. Sandra and Joan also described the unexpected outcomes that came from crafting their stories for a teacher candidate audience. Sandra explained that when writing her “story with the context of speaking to future educators, a lot of different things came out that I don’t usually talk about as much.”

I know this is kind of egotistical-sounding, but I wasn’t actually expecting to learn anything about telling my story because I’ve told it a lot and put a lot of thought into it. But having a different target audience gave me a good new angle on my story.

Sandra found that she focused more than usual on her experiences in high school so that she could explain to teacher candidates why she found certain actions helpful and harmful. Sandra said that in the past, she generally described all of her teachers as unhelpful or harmful. However, upon reflection, she realized that there were certain actions from certain teachers that did help. By thinking about specific teachers who did offer help, she recognized the importance of describing to teacher candidates how she advocated for herself and negotiated how school staff would execute the “safety plans” she had drawn up to help teachers respond more constructively when, for example, she experienced dissociation in class. She appreciated when teachers were honest about what

they felt they could and could not do, as long as they were willing to help connect her with further support.

And I was like: “Hey, sorry, there’s some things on this list that you can’t do, but what would be really helpful is if you went and got someone else who could do them. And that’s super helpful if you’re willing to do that.”

Joan found that when planning her story for teacher candidates, “I realized that I had to re-evaluate the attitude I had when talking about it.” She realized that she had moved on from a lot of the anger that she felt while she was still a high school student dealing with bullying from students, ostracization from teachers, and a sense of abandonment from her medical community when she turned 18. During her high school years, Joan found that she was telling her story to alert people to the cracks in the system.

Because usually when I talked about it with my friends or [other] people about my high school experience, I had very negative outlook about it, and don’t really talk about solutions. I just talked about “Oh they were terrible, terrible they were just... you know, I had a terrible time” I’m trying not to swear, but usually I would swear [laughs] A shitstorm – there!

When planning for teacher candidates, Joan forced herself to think about solutions to the problems she had faced. This in turn caused Joan to be able to re-evaluate her experience for herself personally.

So I had to re-evaluate how I was going to actually approach talking about my story because I thought this is going to go out to new teachers and I need to have some type of suggestion to solution. So not only was I doing that but I was also re-evaluating it for myself as well.

Dear Teachers: Messages for future teachers. In addition to writing their stories individually, youth participated in a group activity where they reflected on the messages they wanted to send to future teachers, based on youth’s past experiences at school while struggling with a mental illness. Youth completed a mural titled “Dear Teachers” (Figure 10), containing the messages they wanted to convey to teacher candidates.

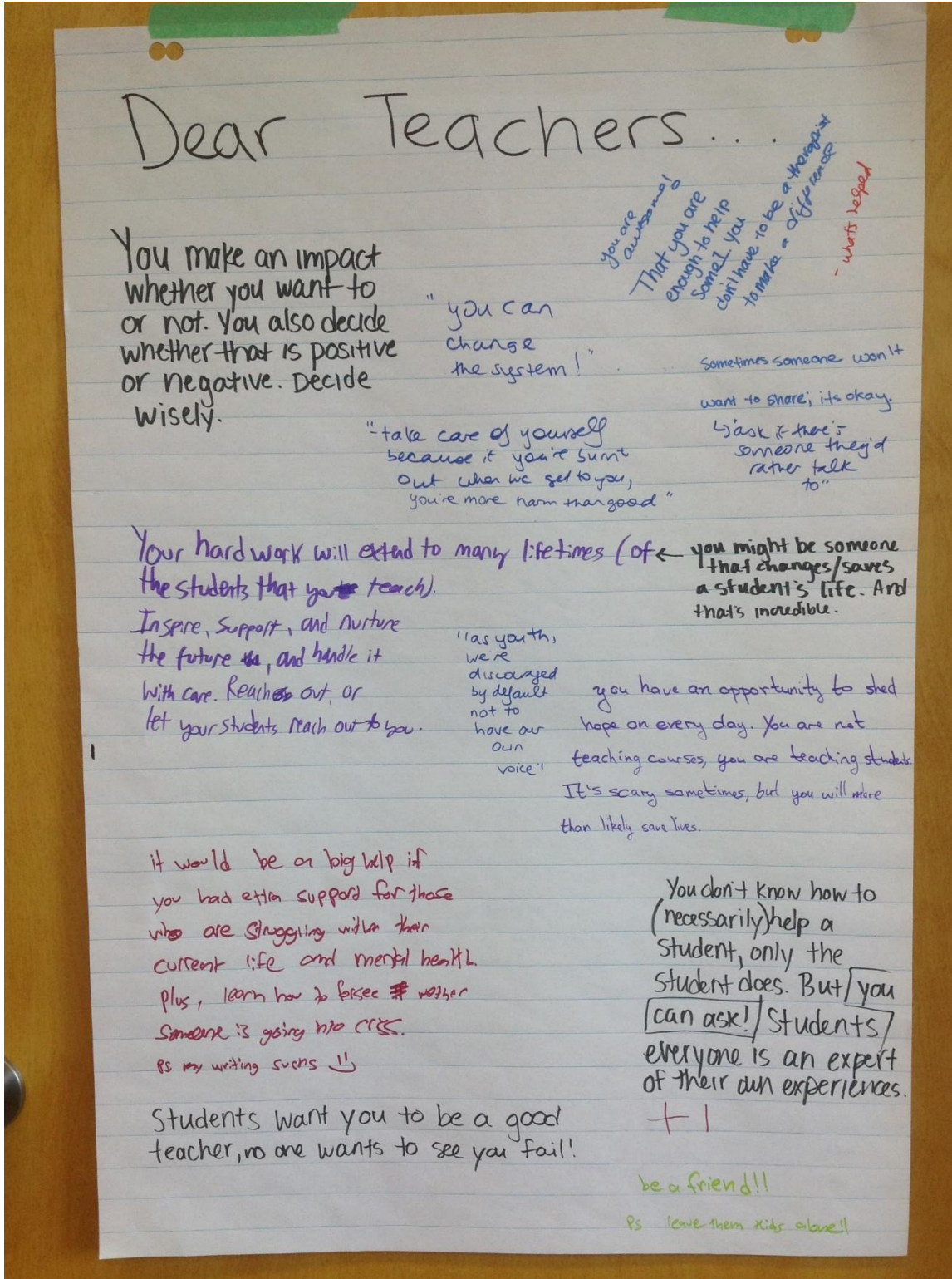


Figure 10. Youth participants' mural illustrating the messages they wanted to send to future teachers.

In this next section, I summarize how youth explained these messages to teachers.

My story is more than a crisis, but don't look for linear story of recovery either. I don't know how my story will end...and neither do you.

Quinn described recovery as “start[ing] when you decide to get help,” but pointed out that seeking help “doesn't necessarily mean that you get better.” Instead, life after getting help for a mental illness “means that you just acknowledge it, and that there's still a lot of bad – it's just you know how to handle it better.” Madison described recovery as “reconciling being realistic with yourself but also having big dreams. And being kind to yourself but also pushing yourself to be the best you can be and how to do that in a healthy manner.”

I know you talk about me with other teachers – and I wish you wouldn't.

Quinn commented “teachers have a really bad habit of talking about their students they always joke about how they never do that and I'm like: ‘You know you do!’ It's so frustrating.” She described the embarrassment she felt when after departing class on a Friday with a panic attack, her teacher “told all the other music teachers: ‘Well watch out on Monday when she comes in ...she had a bad day on Friday.’”

Your classroom might be the most mentally healthy environment in my life.

Speaking about her experience, Sandra commented “if the student has a really shitty home life, you're the closest thing to a healthy relationship they probably have.”

I understand that your job is hard, so self-care is important. In fact, I can tell when you're burnt out.

Reflecting on her experiences during high school, Joan commented that “judging from past teachers who weren't able to help me, you can sense the burnt-outness. You can sense it. So being burnt out, it affects everybody around you.” Quinn wanted teachers to know that students also support the importance of self-care for teachers: “Being burnt out isn't funny, like [if] you actually can't teach your class in a good way at the end of the semester, you need to take a look at yourself and you need to get support!” Joan explained that when teachers are burnt out or when teachers do not feel supported, they have trouble viewing each student as an individual, and instead take shortcuts or fail to act when faced with a student with internalizing symptoms of mental illness.

For example, when Joan returned from school after being hospitalized for depression and anxiety, teachers “treated me like this weird at-risk youth who might hurt people and bring in a gun to school.” Her teachers explained to her that “We just don’t want you to hurt people around you” because “a lot of school shootings were in the news” at that time. She thinks that because of the events in the news, teachers “just took me as that type of person who would fit in that box.” She was disappointed that while teachers were concerned about her hurting other people, no one told her that they were concerned about “hurting myself as well!” She wished that her

teachers could see me separately, and talk about what I want to see in my class, and what I can handle. And you know, how I feel about my peers, and how they can help out. I want[ed] them to talk to me one on one, not make assumptions.

I know that you have power over my life, so use it wisely.

Madison explained “for youth, teachers have such power in their students’ lives. If I think about it, I might not be here today if I didn’t have teachers who were understanding so I could get into university and things like that.” As shown in Figure 11, when reflecting on living with an undiagnosed mental illness during high school, Madison illustrated how she tried to protect her sense of self-worth by making good grades and hiding her symptoms from her teachers whenever possible.

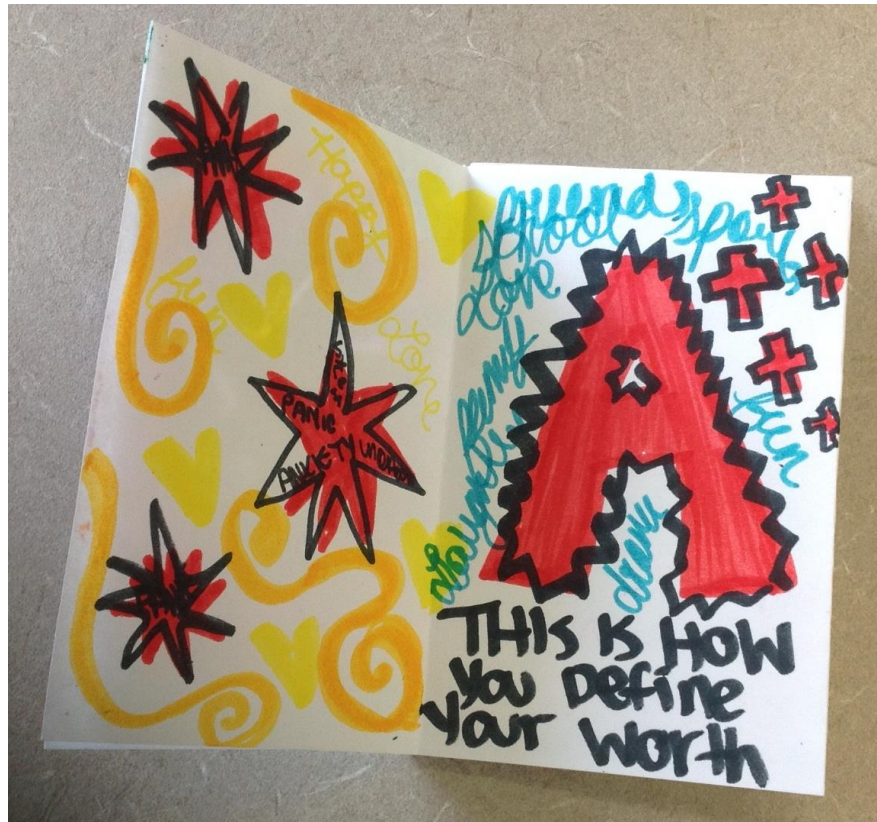


Figure 11. Madison's illustration of how her grades were tied to her self-worth.

Sandra had a more difficult time than Madison during her high school years – Sandra described how she “got kicked out of both public high schools” and therefore agreed that teachers “can affect your grades, which affects your future.” Joan elaborated on the reasons why students feel that teachers are a powerful influence in their lives.

From 5 to 18, school’s your whole life. So the fact that a teacher and you have a rift means a lot. And a lot of teachers are like: “You’ll get over it someday,” but that is *some* day. Right now matters. And when your whole world consists of your classroom, there are no other ways to look. [...] You have to face this teacher every day for four years! Yeah, it might be miniscule to you [because] you’re a grownup and you’re a teacher and you have more life experience and compared to that...[It] might be miniscule, but it’s really big to a student.

Sandra also resented how some teachers used their power to control their classrooms, but understood why teachers felt the need to do so: “As a teacher, you’re

always outnumbered. And in some ways it can be terrifying that if you do lose power, you've lost control of the class and then you're screwed basically. And that can be terrifying." She acknowledged "there needs to be a dynamic of respect and understanding and that can often be mistaken for power or authority. And so in order to maintain that, it can be a struggle." From her point of view, many teachers used the wrong approach to gain the respect of their students. "It may be counterintuitive, but by being kinder and more understanding, you actually gain more respect" She compared this kind of respect to a grandparent:

It's sort of like when you have a respected grandparent, and you're actually more terrified of them saying that they're disappointed in you than anything else possible in the world. [...]They could scream at you, and you'd prefer that over them saying that they're disappointed. [...] And I've had teachers where I will do the work just because I don't want them to be disappointed in me. Or [because] I had the respect for them that they put the energy into doing this, so I'm going to do the work, even if it's a really stupid assignment, I don't care because I respect that teacher. And they actually want me to do well. So it can be counterintuitive but it works much better than the tyrant. [laughs]

I may resist stereotypes because early on in my journey, I want to feel normal...but I may still need your help.

John resented having teachers mention his diagnosis with ADHD in elementary school because he felt that it led to him being "babied." Instead, he wanted his teachers to treat him like everyone else. "When you're going to elementary school, you want to be treated just like everyone else, not separated from the group or put out there as someone different." Quinn experienced anxiety in high school and university, but also feared how her diagnosis would threaten her sense of being normal: "Especially in high school and I guess in university, as soon as you're not normal, it's like the worst thing in the entire world." Therefore in her story, Quinn made a point of discussing "how normality prevents you from getting help" because as Madison put it, "it's at odds with the vision that you have of yourself."

I want you to ask me how you can support me. But if you want me to speak up for myself, I might be waiting for you to tell me that I'm allowed to do that.

Quinn could not “understand why teachers have a problem with asking kids how they want them to help.” Therefore, Joan wanted teachers to “encourage students to tell you what they want. Because usually students are not asked.”

It should be that teachers should ask you what you want, or [that] students should tell [teachers]: “This is how you can help me,” but it’s really hard for students to say that to teachers. Because as youth, we’re by default discouraged to have our own voice.

But I understand that you need to set boundaries for what you're willing to do to help me.

Sandra described how a teacher setting boundaries about what the teacher was willing to do helped Sandra discover more options for help than Sandra imagined her teacher would be willing to give. Sandra recounted the time that she “kind of set up a teacher” by asking her

“How’s life?” and she was like: “Pretty good – how’s yours?” and I was like: “It’s sideways and scary.” [Sandra’s teacher was] like: “Oh, if there’s anything I can do...” I’m like: “You know, that’s one of those things people say but they don’t really mean, because the fact that I need 50 dollars and a ride to Montreal or something ... You technically could do that, but you probably wouldn’t want to. So [I] appreciate the thought, but it would probably just make *you* feel better *not* to make *me* feel better.” She was like: “Well, maybe there are some things that I can do, but how about you write a list of things that you need, and I’ll write a list of things that I *can* do and we’ll see what matches up.” And I was like: “Well I didn’t expect that!” [laughter]

I want you to approach me from a strengths-based perspective,

Sandra described developing three strengths “that [have] only happened because I’ve had to deal with” mental illness: advocacy, self-awareness, and literacy. Sandra explained that she is “able to advocate for myself and others”, and identify “gaps in systems” because “I’ve fallen through them. So I know they’re there! Personal experience! I can give specific details.” Sandra also considers herself to be “more self-

aware due to the level of self-observation and reflection I need to understand my PTSD. Because I [needed] to know my red flags, like: “Ok I’m starting to tense up – why?” Finally, Sandra explained that because she experiences “high levels of dissociation” because of her “type” of ADHD, “I would space out with books and would read for hours”

because I just zoned in and I couldn’t zone out again. And so I have high levels of literacy, and I’m fairly competent when it comes to language. I’m a fairly competent, fairly articulate person. So that’s a strength that came from ADHD and living in books when I was little.

instead of trying to “just excuse it or pretend that’s not happening” (Quinn)

I want high expectations.

Quinn explained that because of her diagnosis of anxiety, her teachers allowed her to do ‘whatever she wanted.’ However, looking back on her experiences in high school, she realized that “I didn’t want my guidance counsellor [to] just let me do whatever I wanted to. He just gave me sympathy.”

All I wanted was for someone to tell me I was intelligent enough to not almost fail high school, [but] because everyone just let me do whatever I wanted to, I almost did [fail high school].” “I didn’t want my teacher to be my friend, I wanted them to push me and to tell me that it’s ok to struggle but it’s not an excuse not to succeed.

Sometimes I have low self-awareness and need help.

Madison said that she struggled with “paying attention to how I’m feeling” so when teachers notice that she is out of sorts, she admits that

for teachers it can be difficult to address it because their students might not know what’s going on or how they feel. It seems simple, but verbalizing exactly how you’re feeling sometimes is difficult. And understanding that especially if you’re younger.

Approaching me about my mental illness may go well, or it may not go well,

Madison describes a time in which the approach did not go well.

I was at [a university health clinic] and I'm like: "I'm anemic" and [the nurse] was like: "I think you're depressed" and I was like: "No! You don't know me – don't tell me what to do!" And so I was anemic, but also depressed. [chuckles] So her being like: "I'm only going to give you a blood test if you make a counselling appointment"...Like, I can see where she's coming from, but at the time I was like: "Well you don't know me – don't tell me what to do." So it was interesting, because that could have been a perfect person to possibly intervene, but just the way that she obviously went about it...

Madison admitted that she reacted defensively because she did not want to be associated with her family history of suffering from depression. "I probably was more on guard because I've seen so many female family members suffer so severely with depression that I didn't want to be associated with that." Therefore, when Madison noticed that she was experiencing symptoms of depression, she "put on a really good front" for her teachers. At the same time, Madison realized that this "front" also prevented others from reaching out to her because as a popular, outgoing, high-achieving student, she did not appear to be someone "who's suffering or going through something."

Before Quinn decided to seek help, she also had a similar experience not wanting "to take that risk" of asking for help because

I had a ton of friends, and I went to parties all the time, and I was always invited to everything. And it's really hard because everyone in your group is expected to be normal. And there's this big expectation of everyone in your school that you're part of the normal crowd. And losing that is the scariest thing ever because you lose everything that you ever thought was important.

Madison began to feel that because of the image she had worked diligently to uphold, "if I were to talk to people, they wouldn't believe me because I'm not like a stereotypical person suffering..." Similarly, Taylor described wanting to feel normal as "a preventative measure of you getting help."

but I may come to appreciate it later. Just show me you care.

Reflecting further on her experiences, Madison reasoned that she may have appreciated a teacher approaching her about her symptoms of mental illness if she judged the teacher to genuinely care about her welfare. Madison commented that “you can pick up pretty quickly on [which] teachers” care, because there are

generally teachers you feel like if their building was on fire, they would help you get out first. That’s usually the kind of people who become teachers but I distinctly remember teachers that I was like: “You would definitely elbow us out of the way.” [laughter] You can pick on people who are like that.

Sometimes I won’t want to talk to you, but don’t take it personally.

Raina explained that

it doesn’t mean there’s anything wrong with you if somebody doesn’t want to share their story with you. It’s not you. Sometimes it is your fault; most times it’s not. [laughs] It’s ok just ask them if there’s somebody they would rather talk to, and help [the student] get that person.

Most of all, my story represents no one else but me, and I want my voice to be heard.

Sandra explained that

when I’m speaking, I don’t want to say I’m representing every single person with mental illness, because I’m not. I can’t speak for everyone – that wouldn’t be fair. I’d be taking on their voices. I just want mine to be heard.

The Result

While all youth participants permitted their work during the design studio to be shared in this dissertation, only John, Joan, Raina, Quinn, and Sandra decided to share their story with teacher candidates at Mental Health Literacy Day. John used “spoken word, songs, and poetry” to compose his story because they “generally bring a lot of emotion” and “because I’m really good at music and poetry. That’s something I know how to do, and how to do it well.” He chose songs from the artist Evanescence because “generally Evanescence brings a lot of emotion to her songs.”

Joan initially used drawings to put her story together, describing her work as “like a zine-ish.” “It starts off with how to listen, because then you find out that I’m complex, just like everybody else. And then I did my short, two-sentence story [laughs]” She was inspired by “comics that don’t really illustrate as much but they’re like ‘how to do this; how to do that.’” Her main messages were that “I am complex, not a cop out, and I am more than just these emotions.” At first, Joan felt that she should ‘remove herself’ from her story “because I just want this to be applicable to everybody. Everybody has different things.” Joan “was very hesitant at first to share her personal story” because she struggled with feeling selfish for talking about her personal experience. She explained that in the past, friends had told her ““Oh, it’s always about your experiences’ even if there’s a balance of hearing what they have to go through too.”

I felt like I didn’t want to make it about me, because usually [when] I do somewhat of a personal story I have this weird feeling where it’s like “oh am I only talking about me? Am I being selfish?” I think a lot of people get that too especially when you do talk about that personal experience

After further discussion about the purpose of sharing youth’s stories with teacher candidates, and with some encouragement from Quinn, Joan decided to add narration of her story using the text of an email she had sent to Quinn about Joan’s story. Joan explained that she “was glad to actually finally know what was the purpose of the project – that actually yes! They want my story! Just as much as everybody else’s. So I felt very encouraged to just send it in.”

Raina, Quinn, and Sandra planned to do live presentations about their stories. Raina could not attend the sessions where youth had time to reflect on their stories, and Quinn and Sandra used most of the designated time to create artwork as visual aids to guide them through retelling their story for a live audience.

As shown in Figure 12, Quinn used a canvas to illustrate meaningful words contained in her story because

I just really like painting. It’s a really good coping mechanism too if you had a really bad week and you can’t slow your mind down. I’m convinced that’s why

art is therapeutic: because it's the art of complete focus. Like, you can be thinking of it, but it's hidden in the nooks and crannies of your brain, and you just have to focus on what you're doing. And your wrist movement – it's really calming.

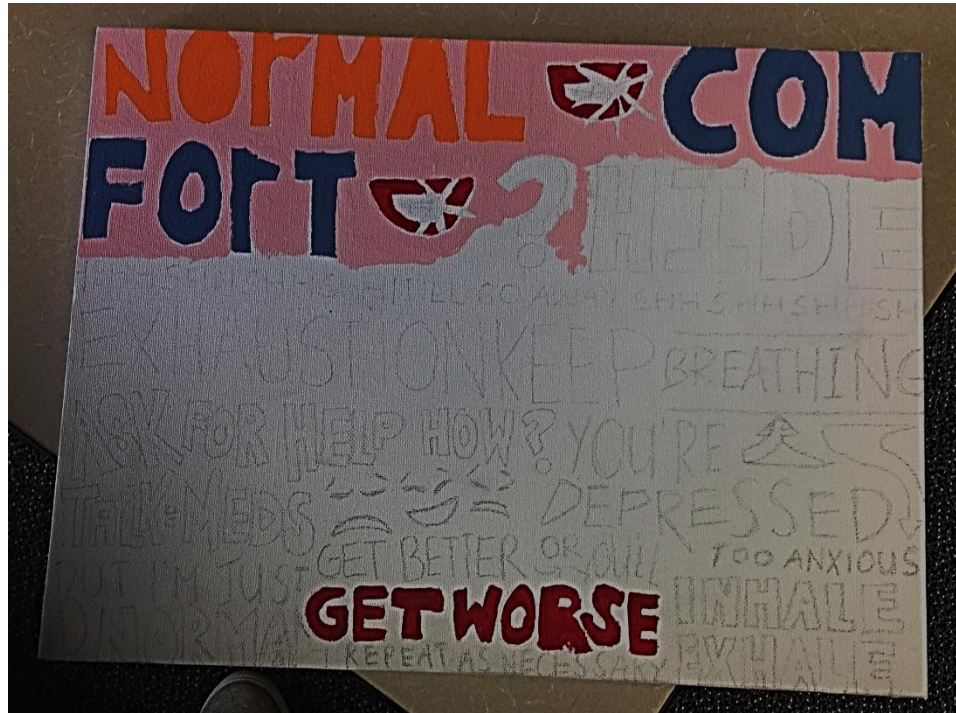


Figure 12. The beginning of Quinn's canvas painting, with the words "normal", "comfort", and "get worse" already painted in.

As shown in Figure 13, Sandra also

started doodling trying to think of ways that could help me stay on track. So I've decided that the main points based on some of the '[on the way] up', '[on the way] down' or whatever structure is strength, hope, and experience. So just having visuals of those words – strength, hope, and experience – I try to keep those themes present.



Figure 13. One of Sandra's "doodles" of the three main points of her story: strength, hope, and experience.

What was the impact on youth of telling their story? During the first two days of the design studio, youth participants became increasingly frustrated by the *Coming Out Proud* workbook because they perceived the material in it to be unsuitable for a youth audience (see Appendix K). They began to raise regular objections to continuing with the workbook to help them decide whether or not to share their story with teacher candidates because based on the material in the workbook, youth were skeptical about whether continuing with this project would be useful. Quinn said: “At the beginning, I wasn’t really sure what we were doing. So now that I know what we’re doing, I’m pretty excited about it and really happy that I have the opportunity to do that.” Once participants understood that working through the *Coming Out Proud* workbook was to give them the opportunity to reflect on their decision to tell their story, their attitudes changed drastically. Quinn said that sharing her story with teacher candidates “feels useful. It feels like it’s actually going to change something. Which is nice. Because I never have to go back to high school, but a lot of kids do. And that sucks. And I hope that if I have kids I don’t have to feel bad about sending them to school. I want them to feel comfortable.”

Specifically, youth described being motivated by the opportunity to help the next generation of teachers be more supportive of their students. Sandra described telling her story as a “sacrifice, but, yeah, knowing it’s going towards good and then you can see and be confident in the impact it’s going to have, helps. It makes [me] feel like I’m more ready.” She was

super appreciative when there’s opportunities for up and coming professionals and service providers to hear from people actually experiencing the service being provided. And that’s a really important thing that should happen, I would say, more often. But the fact that it’s happening it makes me excited. The fact that I get to be a part of that is also very cool.

Quinn said that while she is passionate about mental health literacy, she finds that trying to change stigmatizing attitudes about people with mental illness can feel like an attack. “I think when you try to attack schools with mental health, it’s like trying to change the entire world and it can get really overwhelming.” Therefore, Quinn said that “it’s nice knowing” that she can also help change stigmatizing attitudes by simply telling her story.

You can’t really change the whole [system], but if you go and tell your story and you change the way that teachers think then that’s something. So there’s no way you’re going to walk out of there losing. Everyone’s going to win, which is a really cool thing.

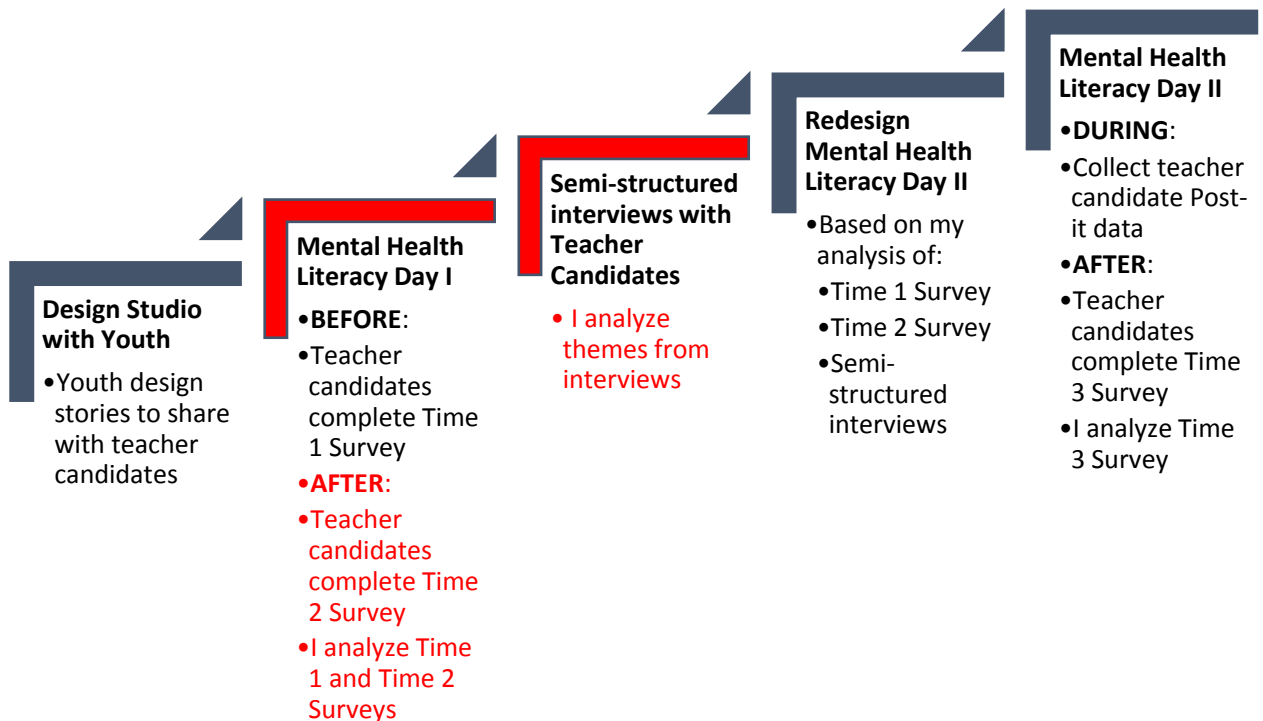
Joan described the process of sharing her story as “healing” for one public reason and one private reason. First, sharing her story allowed her to “do something to make it better for the next generation and onwards the next after that.”

What’s really positive about this is just knowing there are people who are about to be teachers [who are] going to take this information, and [as a result] that students [in] this upcoming generation [are] hopefully going to have a better transition process when it comes to talking about mental health. And that’s really inspiring and that makes me really happy. It was kind of frustrating dealing with this document, but knowing the fact that we are editing it means that it’s something

positive. [It] means that people acknowledge – especially administration – acknowledge that things need to change. And I’m very happy with that.

Second, crafting her story for teacher candidates made Joan ‘re-evaluate her attitude’ on the way that she viewed her high school experiences. By feeling that she had permission to be honest about her experiences, she realized that she had made a large amount of progress in her own life after difficult experiences in high school. She also had the opportunity to tell her story without being made to feel ashamed that she was only talking about herself. “I mean I’m not going to say my story is so powerful, but each of our opinions here will do something. Will help one teacher at the least change something.”

What was the impact of the stories on teacher candidates?



In general, teacher candidates responded positively to youth’s stories of lived experience: Analyzing the short answer questions from the Time 2 survey revealed that

74% of the teacher candidates who were placed in one of intervention groups specifically cited the youth's story as having the "biggest impact" on them that day, because of the opportunity for discussion through reflecting on youth's personal experiences with the stigma of mental illness. Please note that all of the teacher candidates' short answer written responses are transcribed here verbatim, including original punctuation, capitalization, and spelling.

Youth stories promoted discussion. Teacher candidates used the survey and semi-structured interviews to describe the impact of the discussions in the intervention groups with youth stories. This teacher candidate used the survey to describe why the discussions had the greatest impact on him or her during Mental Health Literacy Day:

The conversation between the group and the person who presented her story was what had the biggest impact. We talked a lot about mental health issues, and the stigma related to mental health issues. The work shop setting had a lot more impact than the auditorium lecture setting.

In her semi-structured interview, Emma explained that the small groups provided a safe space for teacher candidates across teaching divisions to learn from each other through meaningful discussions:

The discussions that we had were really amazing because it was like I/S and J/I and whatever – all the streams mixed together. And we had in our room some great talks because we were all mixed with other people. It felt like a safe space where people were able to share some personal stories and it felt like we just got really into some specifics to the core. And so the individual kind of breaking down into smaller groups was probably the most memorable, yeah.

In fact, Emma observed that the discussion in her small group went in a different direction than her facilitator anticipated, but the freedom to move in the direction that teacher candidates identified allowed her group to answer questions about situations they anticipated facing in their classrooms.

I think [the discussion] branched in a different direction than the facilitator was expecting. It just kind of went down one specific road. [...] Somebody raised an

issue about something to do with students who exhibit signs of suicidal thoughts, and how we're supposed to deal with that when we have classrooms of 30 other kids and how we could possibly recognize that, [compared to] an elementary school, [where] we have the whole day with the same set of students.

Teacher candidates discussed differences between strategies to support students in elementary school versus in high school because of the differences in the amount of time they perceived teachers had to establish relationships with individual students. For example, Emma remarked that when teaching at an

elementary school, you can really be in tune with a specific group of students. But in high school it's just...they come in and then leave, and then you have, like, four periods or however many, and how you can possibly be in tune with all of the students. So we had some really good discussions about the differences between elementary and high school.

Youth stories allowed teacher candidates to learn from youth's experience.

Teacher candidates who completed the survey wrote that they enjoyed learning about how real students navigated the local school system,

Hearing the personal story from a youth dealing with mental illness made a huge impact on me. It was great hearing from the perspective of someone who went through the school system while dealing with significant mental health problems.

Case Study in my small group, listening to experiences of someone who had successfully coped and advocated in dealing with mental illness. Very inspiring!

...the break-away groups. The story of [Raina] was both heart-breaking and very informative. To be able to see the effect of mental illness makes it more real than hearing about theory and practices.

and hearing youth speak for themselves about how teachers can support them in the classroom.

Hearing my speaker's talk really opened my eyes, it was helpful to hear a student's perspective from the classroom environment.

Hearing [Quinn]'s story and discussing ways we can help students with mental health issues

Watching the video made by a student who suffered from mental illness and hearing what they thought teachers should do and what worked for them.

The audio journal presentation of the lived-in experience. It is helpful to hear from a person who has experienced [it] first hand.

Teacher candidates who completed semi-structured interviews were able to expand on the impact of youth stories. For Pauline, youth stories gave teacher candidates the opportunity to put themselves in the shoes of a teacher who acted or failed to act when they encountered a student struggling with mental illness. Teacher candidates also had the opportunity to hear about – rather than imagine – the consequences of those decisions.

Those community people you brought in that told their own stories – that, I find, is always the most impactful. Because it's a face. [...] You see a face, you hear a story, you hear the shitty stuff that happens, the really awful things you would never want anyone to have to go through, and how they came out the other end. And how what someone did or didn't do can impact them, you know, what side of the coin do you want to be on as a person going into the teaching profession?

Stories with particular impact. Teacher candidates who completed the survey were most likely to mention Joan's video or Sandra's live presentation. Teacher candidates who viewed Joan's video were particularly affected by her experience of being told to drop out of school.

That some students with mental illness have actually been told to drop out of school. I was shocked.

that some teachers don't believe mental illness is a disease. I couldn't believe the video where a student was told to drop out of school because they couldn't do math.

Could not believe that a teacher actually told a student who had a mental health issue to drop out because they did not understand the student's situation. Cannot believe the amount of people who do not know about mental illness or how to deal with children with a mental illness.

This appealed to teacher candidates' sense of empathy, motivating them to make better choices when supporting a student with mental illness.

How Joan's story felt relevant to me and how I want to prevent any of students from ever experiencing such a horrible stigma.

Teacher candidates who listened to Sandra's story often described being affected emotionally by "how the system both worked for her and failed her",

[Sandra]'s presentation reached me on an emotional level and her story is one that will make me be more aware

or admiring her tenacity.

[Sandra]'s story .. It was heartbreaking and she is so brave.

Teacher candidates in semi-structured interviews also explained that they admired the choices that Sandra made during her presentation. Simon admired Sandra's agency in deciding what to tell, and what not to tell.

She was able to stand up there and tell her story and do it in a way that [...] was real. She did it from her heart. She didn't go to places where she didn't want to – she controlled that but she shared her perspective and took questions and she was very professional about it. It was impressive the way she did that.

The stories that Sandra chose were particularly memorable to Patricia because they appealed to her sense of empathy as a mother.

The one that really really struck me – I think [Sandra] said she was in Grade 8 when this happened – [was] when she was digging her lunch out of the garbage – when she was digging through garbage to eat! [...] Because to me, ok I'm a parent myself, so I would go hungry before I would let my kids go to school without food. So I cannot...if I saw a 13-year-old starving, my first thought [would be] “That child is really hungry” and why?

Sandra's story compelled Patricia to consider what she would do if she encountered Sandra at school. At first, Patricia opined that she would simply ask Sandra why she did not bring a lunch.

My first thought is: “Oh my God. Gosh, does this child not have enough to eat? Why not?” And then I would probably ask the question: “[Sandra], did you not bring some lunch today?” And then if she said no, I'd say: “Why not?” And then hopefully get a response.

Upon further reflection, Patricia remembered how Sandra explained why seeking help was not straightforward: Sandra did not want to be separated from her caregivers, even though they were neglecting to care for her.

Now of course [Sandra] probably didn't want to share that, because she touched on that too – she didn't want people to pry.

Because Sandra presented live, Patricia also took the opportunity to ask Sandra follow-up questions to provide her with more context.

I asked her afterward – I said: “Did nobody ask you why you were digging in the garbage instead of just telling you to stop it? Did nobody wonder why you were digging through the garbage?”

She said they just told her to stop it but they didn't delve into why she might find it necessary to use the garbage for food. Like, that just struck me. How could a whole school just turn a blind eye like that?

Sandra's story also helped personalize the experience of stigma for teacher candidates with no previous experience with mental illness. For example, stigmatizing

language and behaviours took on a new personal meaning to Patricia when she heard how Sandra dealt with discrimination.

[Sandra] talked about how she was treated by people. And again because I haven't encountered anybody like that, I haven't encountered that stigma. And so that was really eye opening for me. And the fact that we call that person a loony or they're crazy –we don't use those kind of words when people have physical health issues, we only use those derogatory terms when they have mental health issues.

On the other hand, John's story was least well-received. One teacher candidate used the survey to explain that John's video disturbed him or her because it "was too close to home", and that the explanation of the video beforehand was not sufficient to describe the contents of the video, which mentioned suicide and self-harm.

i was very disturbed by the video present. i was not expecting to see that video and i didn't attend the rest of the day. the video was too close to home for me (i'd rather not go into any more details - it is too raw for me) i think perhaps while we all talk about mental health it is forgotten that the people attending the literacy day may actually be suffering from some mental illness as well and that by showing a video like that unannounced may be too disturbing to watch. we give students (and their parents) to participate or not participate on some matters that may be disturbing i did not have any advance notice on what i was watching and subsequently didn't feel comfortable after.

Teacher candidates participating in semi-structured interviews also expressed dissatisfaction with John's video. Similar to what Couture and Penn (2003) found in their review of the impact of interpersonal contact on the stigma of mental illness, Lindsay felt that John's story was ineffective because it confirmed too many stereotypes about people living with mental illness. Lindsay remarked that John's video failed to promote the view that there was more than one way for students to present with depression:

so that people can see that it's not just like the little boy who sits in the corner who is gloom and doom all the time. And not to say that there's anything wrong with

that, but just so people can realize that you can appear normal, and be going to be struggles because again that is normal!

According to Reinke, Corrigan, Leonhard, Lundin, and Kubiak (2004)'s findings, John's honest description of his experience struggling with dysfunctional relationships, self-harm, and destructive thoughts may have drawn the focus away from John's experience of recovery. For example, only one slide in John's video (see Figure 14) described the "hopeful consequences" of seeking help and "personal accomplishments" (Corrigan, 2014, p. S6) in the midst of living with mental illness. Corrigan (2014) names these two characteristics as contributing to the "most effective" (p. S6) stories to decrease the stigma of mental illness.

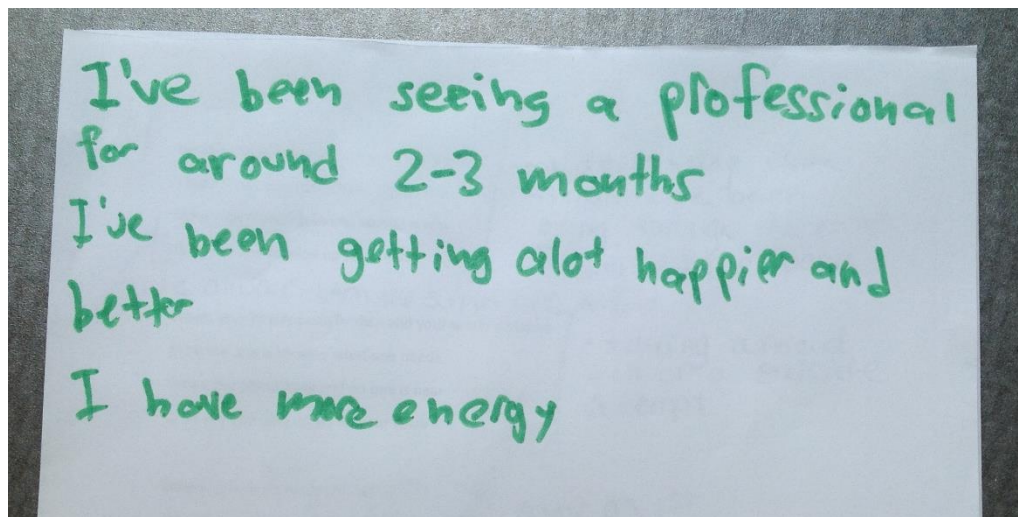


Figure 14. John's story of recovery

Similarly, Alan felt that there was not enough focus on a resolution to the problems John described in his video. This raised an alarm to Alan because of his experience with having several loved ones die by suicide.

They showed the couple of videos and I think I had the same feeling then, is that I think it's great that these kids are getting it out there, but I had the same thought, sort of: "It's great, but...because there's so much that kids are looking at it and saying: "Yeah, that's me." And some of them are saying: "Yeah, that's me" in a good way, but some of them are saying: "That's me" in a bad way.

Even though John's video was never shown to youth, and only shown to teacher candidates at Mental Health Literacy Day I to discuss how they could support a student like John in their classroom (see Appendix G for the discussion questions facilitators could choose from), Alan remained concerned about the effect that videos like John's could have on other youth. He explained that identifying with a story like the one portrayed in John's video could cause another young person to die by suicide because John's video would put "the thoughts in their minds."

I hear a lot more about kids killing themselves these days because of stuff. And again, I'm not saying there's more depression or there isn't now – I think one of the problems is the media's perception of it and the stuff that they see. You know, they see people doing it on YouTube or this and that so... And I'm not belittling their feelings or whatever, but I think it's become more prevalent. People read about it, and people hear about it, and it puts the thoughts in their minds, unfortunately.

In fact, as shown in Figure 15, John also worried that his suicidal ideation would negatively impact his friends.

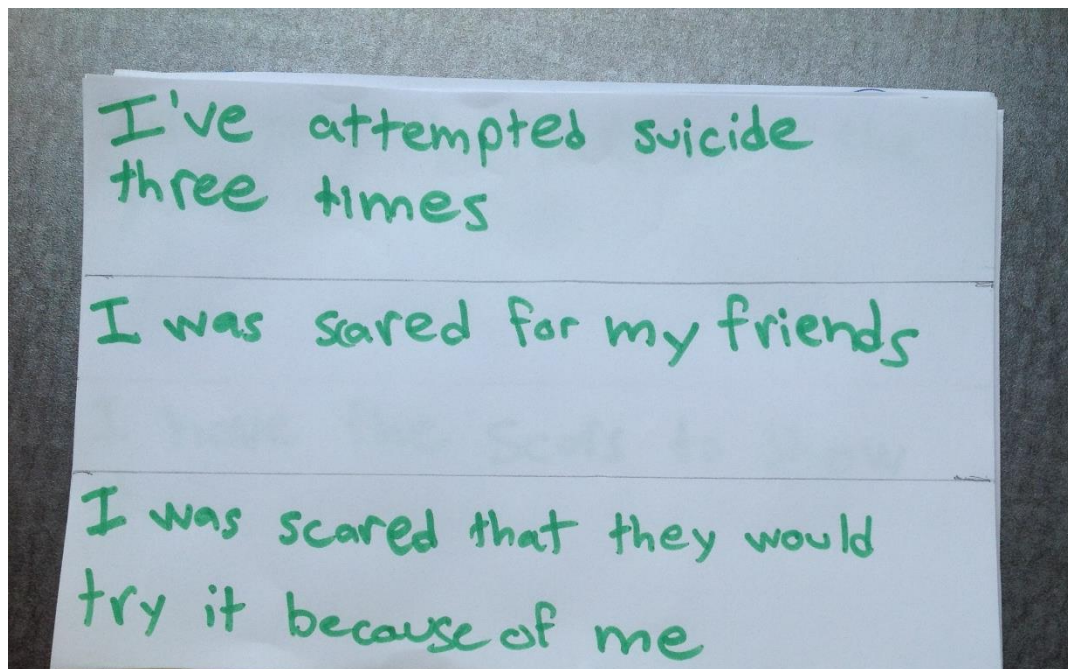


Figure 15. John's worries about how his actions affected others.

Instead, Alan wanted the video to feature more details about how John received support.

It's easy enough [to say] “Well I got help,” but how did you get help? What did you do? And I can't remember if [the video] did say that. Did you do something – did you talk to family? Did you go to your religion? Was it school – did school help you through it? Because I don't know.

Because characteristics involving the type, effectiveness, and length of treatment – among other factors – can vary widely among people living with mental illness, speakers with lived experience are normally discouraged from giving specific details about their course of treatment. Raina explained that in her extensive experience sharing her story of mental illness, she learned not “to sell certain types of recovery – meds, my best friend's mom walked on hot coals and that made her feel not depressed anymore...” because “if something worked for them, they assume that that thing is going to work for everybody else.” Instead, Raina tells

people that your recovery journey is going to be your own. However long it takes to reach whatever it is, it's yours. And it's not going to be the same as anybody else's. And you're going to learn a lot of unique lessons because of that, and it's also going to feel lonely at times. But it's your own journey.

On the other hand, Wei, Kutcher, Hines, and MacKay (2014) consider “learning about strategies to obtain and help maintain positive mental health” and “knowledge about mental disorders and their treatment” (p. 1158) to be key components of mental health literacy. Therefore, more research needs to be done on how to speakers with lived experience can present help-seeking information in a way that decreases stigma but does not promote any one kind of treatment.

Because I made the decision to facilitate the design studio portion of this study using principles of self-determination, all youth participants – including John – had the freedom to design their story to their own specifications, as long as they included the basic elements of the CDRSE anti-stigma template they chose. As shown in Figure 16, John illustrated his process of recovery as a formerly broken heart that had been stitched

back together, because as shown in Figure 17, he connected many of his experiences struggling with his mental health to his relationships with friends and partners.

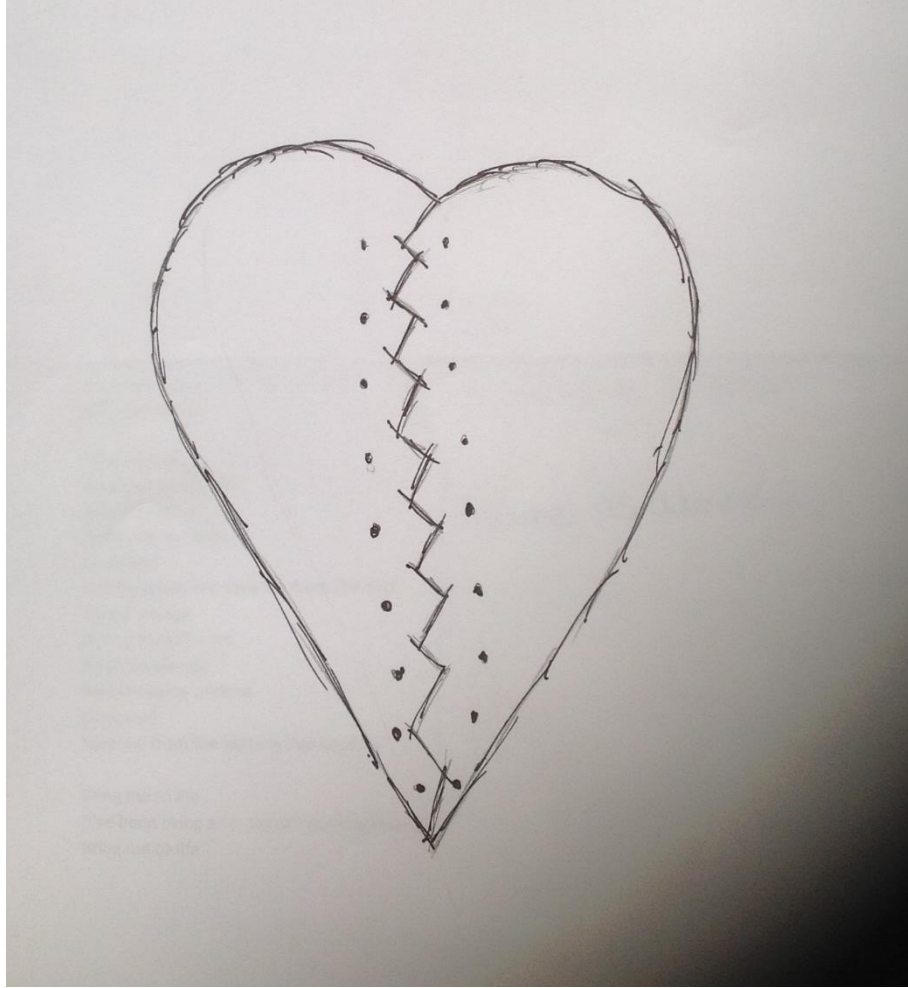


Figure 16. John's artwork of his journey recovering from mental illness.

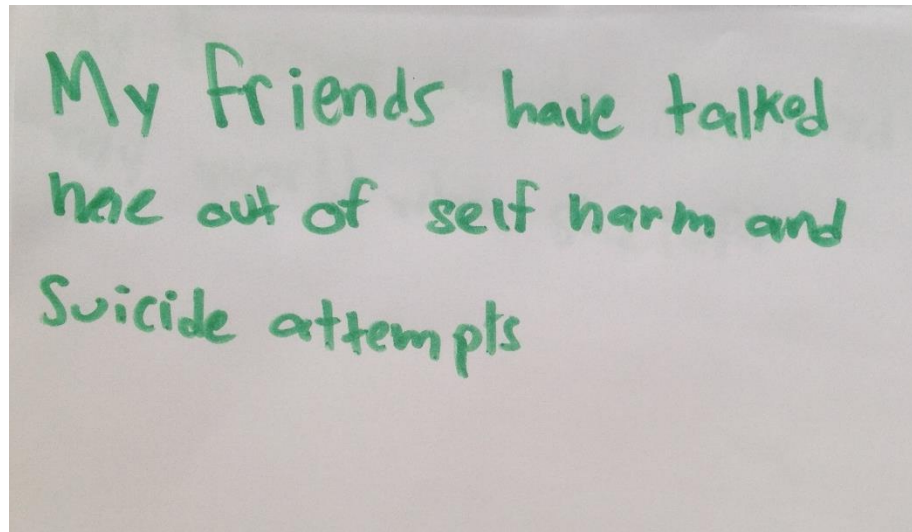


Figure 17. John's description of how his friends supported him through suicide attempts.

Although he identified as being in recovery, John did not pretend – nor did this study make it a requirement – that his past experiences did not continue to affect his daily living. This was John's first time sharing his story publicly, and while Organization X invited him to join the study because he was “psychologically ready to share” (Stuart et al., 2014, p. S15) his experience with teacher candidates, youth participants in the Design Studio also identified ‘self-education’ (learning more about your mental illness) and ‘catharsis’ as reasons to share their story (see Appendix K), and described the story writing process as ‘therapeutic’. In contrast, Stuart et al. (2014) caution that the most effective stories are not “to achieve a personal therapeutic goal”. This reveals the tension between making the process of developing their story an empowering, affirming experience for youth, while delivering an authentic story from youth that provides an effective learning experience for teacher candidates.

Summary

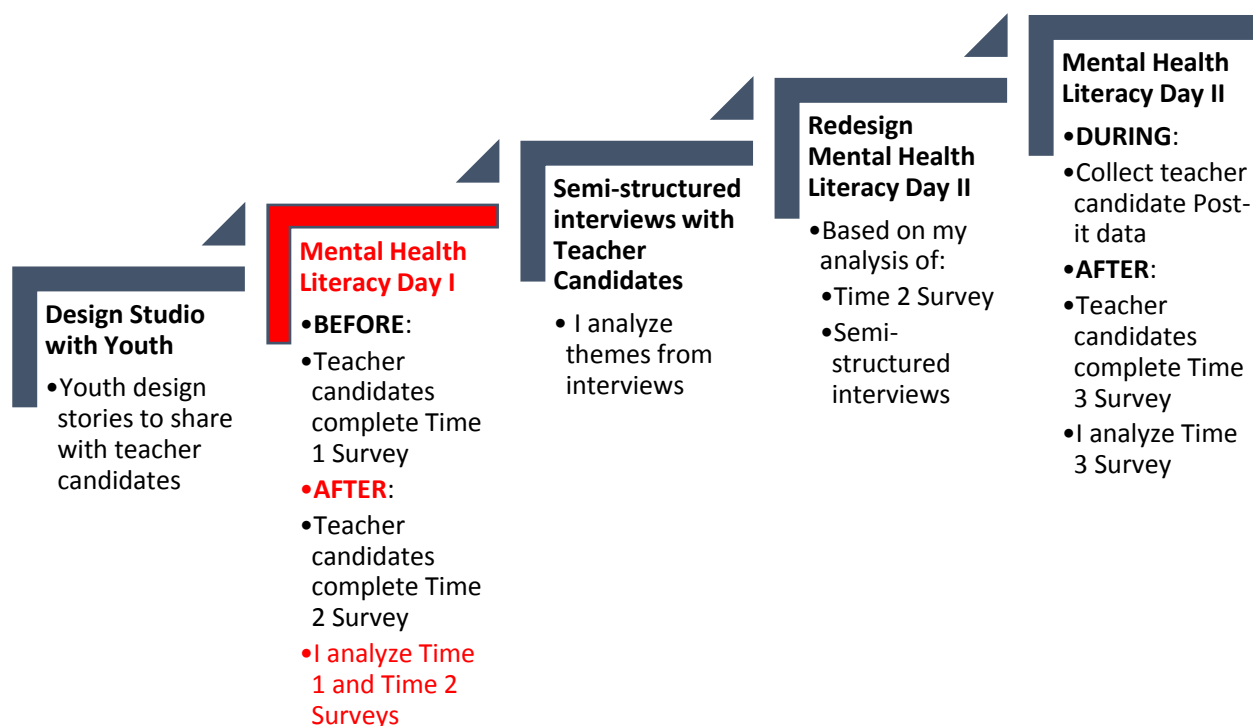
In summary, the *process* involved youth considering why they wanted to share their story, and how they wanted to do so. The *result* was that reflecting on the specific messages youth wanted to send to teacher candidates allowed youth to discover new insights about what they had learned and how they had grown from their experiences living with mental illness at school. Teacher candidates responded positively to most youth stories during Mental Health Literacy Day because they provided a unique opportunity to hear directly from a young person about what it was like to live with

mental illness as a student in elementary and high school. Teacher candidates responded more positively to youth stories that disconfirmed stereotypes and promoted recovery, but across all groups, teacher candidates participated in vigorous discussions about the role that they could play in the lives of students living with mental illness.

Chapter 5: Teacher Candidate Results from Mental Health Literacy Day

In this chapter, I follow the explanatory sequential design introduced in Figure 8 to present the results from the quantitative and qualitative data collected from teacher candidates. I start by presenting the results from the quantitative measures, including the AQ-9, the Opening Minds Scale, and the written short-answer questions in the Time 2 survey. Next, I present the qualitative results from the semi-structured interviews. Finally, I combine the quantitative and qualitative data to demonstrate how I redesigned Mental Health Literacy Day II.

Quantitative Data Analysis



Research Question 3:

Is a contact-based intervention involving teacher candidates hearing from youth living with mental illness significantly associated with a decrease in public or private stigma?

The contact-based intervention was not significantly associated with a decrease in public or private stigma. However, scores on certain measures of public stigma were significantly improved after Mental Health Literacy Day.

Attribution Questionnaire-9 (AQ-9) Results. In the modified version of the AQ-9 (with vignettes more suited to education contexts) used to measure public stigma in this study, participants used a nine-point Likert-type scale (1 = not at all; 9 = very much) to answer nine questions about their reactions to John, a student who is experiencing depression (Cronbach's alpha = .63), an anxiety disorder (Cronbach's alpha = .77), or schizophrenia (Cronbach's alpha = .72).

Table 2

Descriptive Statistics for Total AQ-9 Scores by Time and Type of Vignette

	<i>n</i>	<u>Time 1</u>		<u>Time 2</u>		
		<u><i>M</i></u>	<u><i>SD</i></u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
<u>Mental illness</u>						
Depression	42	24.05	8.75	23	19.61	5.36
Anxiety	49	21.80	8.62	21	20.38	10.38
Schizophrenia	44	30.00	10.60	23	27.09	8.50
Total	135	25.16	9.91	67	22.42	8.83

I created a total stigma score at for each participant at both Time 1 and Time 2, reverse coding where indicated by the author of the scale. The computer program that administered the survey randomly assigned participants to either depression, anxiety, or schizophrenia each time participants took the survey, so participants who took the survey at Time 1 responded to a different mental illness than they did at Time 2, precluding any repeated-measures analyses.

Previous research has demonstrated that we can expect differences in the the appraisal of mental illness and stigma, based on the type of mental illness presented in a

vignette or a case study (in the present study, these were depression, anxiety and schizophrenia). For the participants in the control group at Time 2, results did not align with these previous findings: conducting an analysis of variance revealed no differences in AQ-9 scores between groups, $F(2, 31) = 2.40, p = .108$. However, among teacher candidates at Time 2 who participated in one of the intervention groups, the pattern was similar to previous research: conducting an analysis of variance revealed that stigma scores between groups were significantly different, $F(2, 30) = 3.60, p = .040$. Specifically, stigma scores towards John when he had schizophrenia ($n = 9, M = 29.11, SD = 8.61$) were significantly higher than stigma scores towards John when he had depression ($n = 12, M = 19.42, SD = 5.99$).

Visual inspection of the mean scores for both the control and intervention conditions, for each type of vignette, showed the expected pattern: mean scores decreased from Time 1 ($M = 25.16, SD = 9.91$) to Time 2 ($M = 22.42, SD = 8.83$). However, to answer my research question, I conducted an independent samples *t*-test to determine whether there was a significant difference between total stigma scores for participants in the control group ($n = 34; M = 22.09, SD = 8.61$) and intervention group ($n = 33; M = 22.76, SD = 9.18$). I found that scores did not significantly differ from each other, $t(65) = -.31, p = .759$.

Principal Components Analysis. Next, I conducted a principal components analysis using all of the AQ-9 data from Time 1 and Time 2 ($n = 202$) to determine whether the factors represented in the AQ-9 followed the *responsibility* and *dangerousness* paths I discussed in Chapter 3, where the responsibility path originates from the Weiner's (2000) Attribution Theory of Interpersonal Motivation, while the dangerousness path represents Corrigan (2002)'s modification of the theory. According to Corrigan, Powell, and Michaels (2014), the *responsibility* path includes the questions representing *anger, blame, pity, and help*; the *dangerousness* path includes questions representing *fear, avoidance, coercion, and institutionalization*; and the question about danger is categorized under both paths.

Table 3

Structure Matrix of AQ-9. Rotation Method: Oblimin with Kaiser Normalization

Item name and question	Component 1	Component 2	Component 3
Anger: <i>How angry would you feel at John?</i>	.865		
Blame: <i>I would think that it was John's own fault that he is in the present condition.</i>	.790		
Institutionalization: <i>I think it would be best for John's community if he were put away in a psychiatric hospital.</i>	.784		
Danger: <i>How dangerous would you feel John is?</i>		.845	
Fear: <i>How scared of John would you feel?</i>		.794	
Coercion: <i>How much do you agree that John should be forced into treatment with his doctor even if he does not want to?</i>		.679	
Pity: <i>I would feel pity for John.</i>		.631	
Help (reverse coded): <i>How likely is it that you would help John?</i>			.912
Avoidance: <i>I would try to stay away from John.</i>			.563

The results of this factor analysis must be interpreted with caution, however, because participants who completed the survey at both Time 1 and Time 2 are counted twice in this sample. As shown in Table 3, and in contrast to Corrigan, Powell, and Michaels' (2014) reporting of a two-factor structure, I found a three-factor structure, confirmed by the structure matrix and examination of the scree plot. The first factor included anger, blame, and institutionalization (Cronbach's alpha = .724), but unlike Corrigan et al., it did not include pity. The second factor included danger, fear, coercion, and pity (Cronbach's alpha = .671); unlike Corrigan et al., it did not include avoidance. The third factor included help and avoidance, but showed internal consistency levels that were too low to allow for reliable interpretation (Cronbach's alpha = .390). The two items on the third factor may not have been able to be answered reliably because lack of knowledge (for help) may have been connected to avoidance for some, but not others. The avoidance item may have also been influenced by social desirability. Therefore, rather than forcing these items onto one factor, I treated them as separate items.

Did stigma significantly decrease after Mental Health Literacy Day I? Using the factor structure described above, I conducted one final analysis with the AQ-9 to determine whether stigma scores significantly changed after Mental Health Literacy Day I. I conducted a multivariate analysis of variance with time (before Mental Health Literacy Day I vs. after Mental Health Literacy Day I) and type of John's mental illness (schizophrenia, depression, and anxiety) as independent variables, and the four factors (weighted factor 1, weighted factor 2, the *help* item, and the *avoidance* item) as dependent variables. I found a main effect of time ($F(4, 193) = 4.39, p = .002$) and type ($F(8, 388) = 6.44, p < .001$), but no interaction between time and type ($F(8, 388) = .54, p = .830$). However, Levene's test of equality of error variances revealed that the error variance for the weighted Factor 2 ($F(5, 196) = 2.28, p = .049$) and the *avoidance* item ($F(5, 196) = 5.338, p < .001$) were significantly different across the groups.

Teacher candidates' *help* scores significantly decreased from Time 1 ($n = 135, M = 3.47, SD = 2.01$) to Time 2 ($n = 67, M = 2.48, SD = 1.76$), $F(1) = 11.60, p = .001$. In other words, after Mental Health Literacy Day I, teacher candidates were more likely to report that they would help a student with mental illness, compared to before Mental Health Literacy Day I. The type of mental illness also significantly affected teacher candidates' scores on the weighted Factor 2 ($F(2) = 19.18, p < .001$) and the *avoidance* item ($F(2) = 5.88, p = .003$), but these results must be interpreted with caution because Levene's test was significant for the weighted Factor 2 and the *avoidance* item. Therefore I used the Games-Howell test to conduct post-hoc analyses.

As shown in Figure 18, using the Games-Howell test I found that teacher candidates' scores on the weighted Factor 2 for anxiety, depression, and schizophrenia were each significantly different from each other: Stigma towards John when he had schizophrenia was significantly higher than when John had anxiety ($p < .001$) or depression ($p < .001$); and stigma towards John when he had depression was significantly higher than when John had anxiety ($p = .029$). Also using the Games-Howell test, I found that teacher candidates' *avoidance* scores were significantly higher when John had schizophrenia compared to when John had anxiety ($p = .013$) or depression ($p < .001$). However, avoidance scores for depression and anxiety were not significantly different

from each other ($p = .596$). In other words, teacher candidates reported that they were more likely to avoid John when he had schizophrenia, as compared to when he had anxiety or depression.

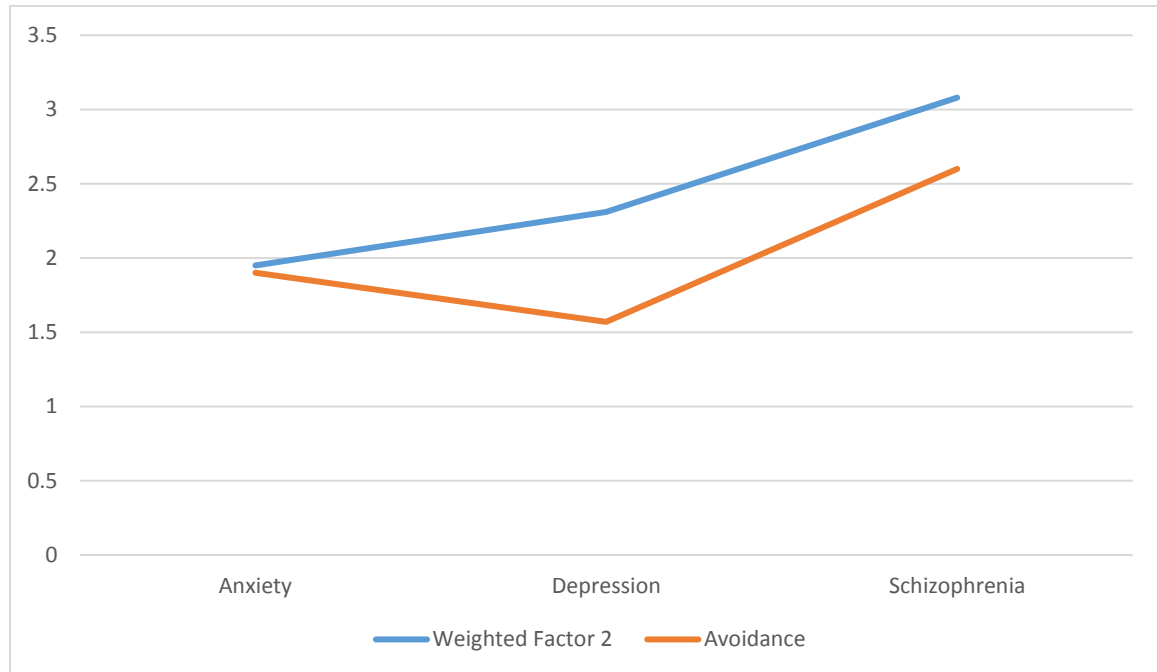


Figure 18. AQ-9 scores for teacher candidates on Factor 2 and the *avoidance* item.

Opening Minds Scale Results. In the modified version of the Opening Minds Scale used for this study, participants used a five-point Likert-type scale (1 = strongly disagree; 5 = strongly agree) to answer 12 questions measuring public and private stigma. An aggregate score was created, and the scale showed acceptable internal consistency reliability (Cronbach's alpha = .804). Table 4 contains a list of the number of participants, mean, and standard deviation for each question in the Opening Minds Scale at Time 1 and Time 2.

Table 4

Descriptive Statistics for Opening Minds Scale Teacher Candidate Data

Question		<i>n</i>	<i>M</i>	<i>SD</i>
<i>Despite my professional beliefs, I have negative reactions towards people who have mental illness.</i>	Time 1	97	1.78	.86
	Time 2	97	1.73	.91
	Total	194	1.76	.88
<i>There is little I can do to help people with mental illness.</i>	Time 1	97	1.75	.78
	Time 2	98	1.64	.82
	Total	195	1.70	.80
<i>More than half of people with mental illness don't try hard enough to get better.</i>	Time 1	97	1.64	.904
	Time 2	98	1.68	.89
	Total	195	1.66	.90
<i>Teachers do not need to be advocates for people with mental illness.</i>	Time 1	97	1.46	.79
	Time 2	98	1.53	.91
	Total	195	1.50	.85
<i>I struggle to feel compassion for a person with a mental illness.</i>	Time 1	96	1.55	.92
	Time 2	97	1.51	.86
	Total	193	1.53	.88
<i>I am more comfortable teaching a student who has a physical illness than I am teaching a student who has a mental illness.</i>	Time 1	97	2.95	.78
	Time 2	98	2.85	.92
	Total	195	2.90	.86
<i>If a person with a mental illness complains of physical symptoms (e.g. nausea, back pain or headache), I would likely attribute this to their mental illness.</i>	Time 1	97	2.52	.86
	Time 2	98	2.63	1.02
	Total	195	2.57	.94

<i>If I were under treatment for a mental illness I would not disclose this to any of my colleagues.</i>	Time 1	97	3.32	1.07
	Time 2	98	3.03	1.00
	Total	195	3.17	1.04
<i>I would be more inclined to seek help for a mental illness if my insurance provider or employee assistance program (EAP) was not associated with my workplace.</i>	Time 1	97	3.02	1.03
	Time 2	98	3.10	1.13
	Total	195	3.06	1.08
<i>I would see myself as weak if I had a mental illness and could not fix it myself.</i>	Time 1	97	2.27	1.11
	Time 2	98	2.19	.97
	Total	195	2.23	1.04
<i>I would be reluctant to seek help if I had a mental illness.</i>	Time 1	96	2.39	1.16
	Time 2	98	2.29	1.00
	Total	194	2.34	1.08
<i>If I had a mental illness, I would tell my friends (NOTE: scores have been reverse coded)</i>	Time 1	97	2.66	1.02
	Time 2	98	2.50	1.00
	Total	195	2.58	1.01

Using the aggregate score, I conducted an analysis of variance on the Time 2 data to determine whether teacher candidates who heard youth stories had significantly different stigma scores on the Opening Minds Scale than teacher candidates who were in the control group. I found that teacher candidates' total scores on the Opening Minds Scale did not significantly differ between teacher candidates who heard youth stories ($n = 53$, $M = 26.74$, $SD = 5.98$) and teacher candidates who were in the control group ($n = 43$, $M = 26.81$, $SD = 7.50$), $F(1, 94) = .003$, $p = .955$.

Next, I conducted a principal components analysis to determine whether the data in this study aligned with the two-factor structure found by Kassam, Papish, Modgill, and Patten (2012), where seven items loaded onto one factor that measured attitudes towards people with mental illness (public stigma; Cronbach's alpha = .78) and five items

measured attitudes towards the disclosure of mental illness (private or self-stigma; Cronbach's alpha = .72). Unlike what Kassam, Papish, Modgill, and Patten (2012) found, my principal components analysis ($n = 193$) revealed a three-factor structure, confirmed by the structure matrix (Table 5) and examination of the scree plot.

Table 5

Structure Matrix of the Opening Minds Scale. Rotation Method: Oblimin with Kaiser Normalization

Item Number and Question	Component 1	Component 2	Component 3
Item 12: <i>I struggle to feel compassion for a person with a mental illness.</i>	.867		
Item 10: <i>More than half of people with mental illness don't try hard enough to get better.</i>	.844		
Item 11: <i>Teachers do not need to be advocates for people with mental illness.</i>	.831		
Item 8: <i>Despite my professional beliefs, I have negative reactions towards people who have mental illness.</i>	.767		
Item 9: <i>There is little I can do to help people with mental illness.</i>	.749		
Item 7 (reverse coded): <i>If I had a mental illness, I would tell my friends.</i>		.631	
Item 3: <i>If I were under treatment for a mental illness I would not disclose this to any of my colleagues.</i>		.663	
Item 5: <i>I would see myself as weak if I had a mental illness and could not fix it myself.</i>		.624	
Item 4: <i>I would be more inclined to seek help for a mental illness if my insurance provider or employee assistance program (EAP) was not associated with my workplace.</i>		.616	
Item 6: <i>I would be reluctant to seek help if I had a mental illness.</i>		.503	
Item 2: <i>If a person with a mental illness complains of physical symptoms (e.g. nausea, back pain or headache), I would likely attribute this to their mental illness.</i>			.832
Item 1: <i>I am more comfortable teaching a student who has a physical illness than I am teaching a student who has a mental illness.</i>			.702

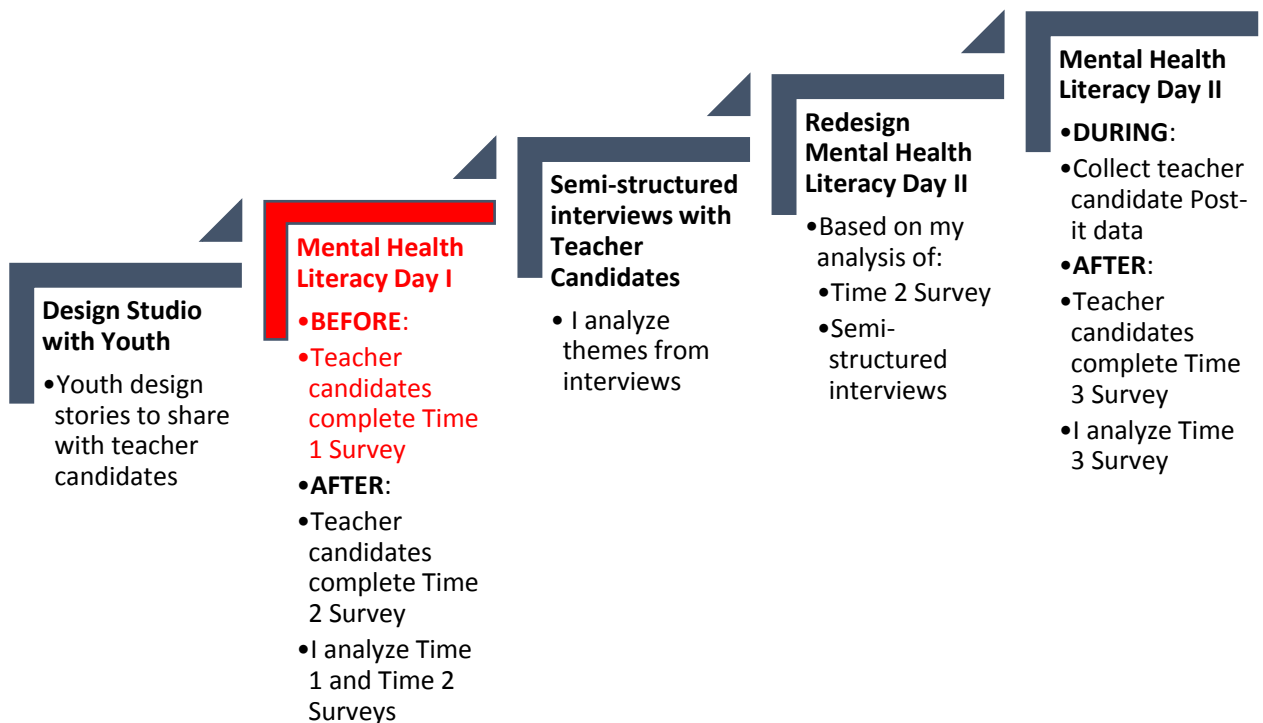
The results of this factor analysis must be interpreted with caution, however, because participants who completed the survey at both Time 1 and Time 2 are counted twice in this sample. The first factor (Cronbach's alpha = .876) included items 8, 9, 10,

11, and 12. Together, these items represent public stigma – in particular, teacher candidates' attitudes towards students with mental illness. Higher scores indicate higher public stigma. The second factor (Cronbach's alpha = .650) included items 3, 4, 5, 6, and 7 (reverse coded). Together, these items represent self-stigma – in particular, teacher candidates' perceptions of themselves when asked to imagine that they had a mental illness. Higher scores indicate higher self-stigma. The third factor (Cronbach's alpha = .509) included items 1 and 2, representing teacher candidates' perceptions a physical illness versus a mental illness. Higher scores indicate a higher amount of stigma.

Because the Cronbach's alpha for Factors 2 and 3 were too low to allow for reliable interpretation, I summed all of the items together on the Opening Minds Scale to create a total stigma score. Finally, I conducted a paired samples *t*-test to determine whether the total score on the Opening Minds Scale significantly differed between Time 1 and Time 2. I found that teacher candidates' scores did not significantly differ between Time 1 ($n = 93$, $M = 27.46$, $SD = 6.23$) and Time 2 ($n = 93$, $M = 26.75$, $SD = 6.75$), $t(92) = 1.21$, $p = .229$.

In conclusion, the contact-based intervention I designed for this study was not significantly associated with a decrease in public or private stigma. However, teacher candidates' public stigma scores on the AQ-9 significantly decreased after Mental Health Literacy Day.

Teacher Candidates' Experience with Mental Health Prior to Mental Health Literacy Day I



The majority (78%, $n = 233$) of teacher candidate participants who completed the quantitative measure indicated that they had learned about “mental health concepts in the past”, and just over one third of participants (35%, $n = 105$) indicated that they had “experience working in schools with children and youth who have had mental health issues”. Figure 19 illustrates where teacher candidates learned about mental health concepts in the past.

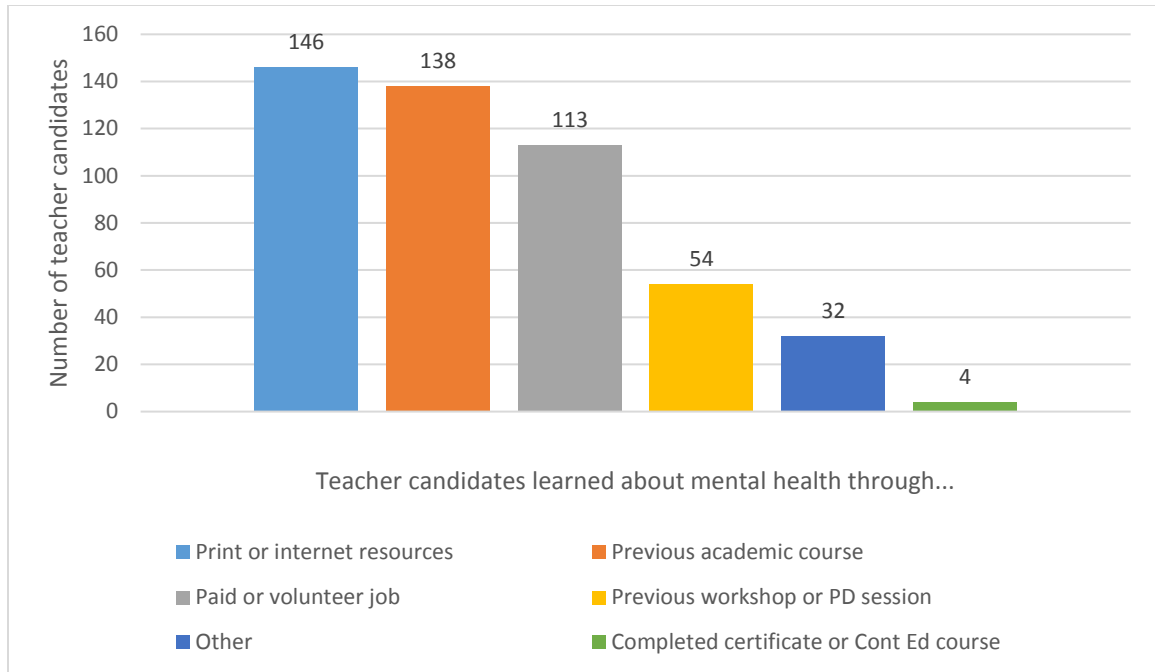


Figure 19. The methods by which teacher candidates learned about mental health concepts in the past. NOTE: Teacher candidates selected as many methods as applied to them personally.

Thirty-one of the 32 teacher candidates who indicated that they had learned about mental health concepts through ‘other’ methods chose to describe these methods. As in Chapter 4, all of the teacher candidates’ short answer written responses are transcribed here verbatim, including original punctuation, capitalization, and spelling.

The majority (71%, $n = 22$) described learning about mental health through personal contact: 15 participants described learning through personal experiences such as “counselling” and “therapy”, while seven participants described learning through personal contact with friends, family, or acquaintances who had experienced mental illness. One participant described how personal contact decreased her stigmatizing attitudes toward people with mental illnesses: “Many people have a negative stigma attached to mental health illnesses without fully understanding what that entails and the certain individual's situation. I was one of those people until I came to know someone with schizophrenia.” Other answers included learning about mental health through other courses and workshops ($n = 2$), through friends in psychology and social work programs ($n = 2$), and through work experiences ($n = 1$). Only one participant described learning about mental health through “religious doctrine”: “Learning not to worry, having

boundaries, putting off wrong thoughts and putting on truths, journalling, prayer, building faith, and speaking to a Christian counsellor.”

Experience working with children and youth. Just over one-third of teacher candidates (35%, $n = 105$) indicated that they had “experience working in schools with children and youth who have had mental health issues.” Of the 105 teacher candidates who had experience, 76 teacher candidates chose to describe their experience. The great majority teacher candidates described how they decreased their social distance to support these children and youth. Most teacher candidates described how they personally supported their students,

I volunteered through [a national mental health organization] where I worked one on one with children and youth who were having difficulties in their homes. My role was to help them with their self esteem and be a role model, support system and someone to talk to.

or how they worked with other staff members to support students.

One student revealed to me that she had suicidal thoughts. I was just doing an observational placement at the time so I told her that the staff at the school was here for her and that she wasn't alone. I also told the teacher what she said immediately after and the teacher informed the guidance department.

I supply taught at an elementary school where many kids in my classes had mental health issues. I was able to work with education assistants who helped me modify activities and lessons according to student needs.

Lived experience informed teaching practices. Some teacher candidates chose to disclose that they had a mental illness. They described how self-knowledge about informed the way they supported students with mental illness.

I have worked with many students in the past who have had issues with either anxiety or that showed signs of depression and self harming. I have also struggled with depression myself in the past so I know that each student and each case or scenario is different and needs to be handled in a way in which the student does not feel undervalued or centred out

Encountering mental illness is common. Fourteen teacher candidates explained that they felt comfortable working with children and youth with mental illness because it was a common occurrence in places of work where teachers are likely to be employed, including schools, summer camps, and tutoring centres.

Stress and anxiety are both mental health concerns. I recall tutoring students prior to high school exams and needless to say there was a bit of stress and anxiety. I did my best to calm and reassure to the student that everything would be okay amidst the parameters.

Experience with anxiety, depression, and ADHD is most common. When describing how they helped children and youth, most teacher candidates named anxiety ($n = 14$), depression ($n = 10$), and/or ADHD ($n = 8$) as the specific mental illnesses they encountered. No teacher candidates described working with children or youth with schizophrenia. Teacher candidates' descriptions of how they "handled it" also differed according to the type of mental illness. Teacher candidates who described interactions with students with ADHD were more likely to describe how they dealt with disruptive behaviour.

Many of the students with ADHD were on medication so I did not have to deal with misbehaviour, but rather with a lack of skills of how to behave and successfully learn. I tried to build their note and test taking skills by giving them fill in the blank style notes and interactive group work. The assessments varied in nature and were held frequently to teach them how to succeed at different types of evaluation.

In contrast, teacher candidates were more likely to describe comforting students experiencing anxiety.

I worked as a Unit Head at a day camp and one of my staff had anxiety disorder and had run out of her medication. I offered her the support she needed by providing extra assistance on the job and frequently checking in with her to make sure she felt comfortable. I would encourage her to take breaks whenever she felt overwhelmed.

Teacher candidates' descriptions of interactions with students living with depression were the most varied. Some described positive interactions with students,

A boy in a classroom I was working in has severe depression. My associate teacher informed me about his mental illness beforehand, and we both made sure to maintain a positive attitude around the student. I made sure that he knew he mattered within the classroom, and I assisted him with quiet desk work when he was having trouble.

while others perceived being in conflict with students with depression .

Severe depression. This student was acting out in class and refusing to take part in the assignment. I was a volunteer at the time and attempted to have a one-on-one with the student to resolve the issue. In the end the teacher had to step in and the student was taken to the Principle. The next day I was told that this poor student had missed a day of medications and also had some rough times at home the day he had acted out. The student came to me and apologized.

Experience with stigma. A slim majority (55%, $n = 166$) of teacher candidates indicated that they “had an experience with the stigma associated with mental illness”: 84% ($n = 138$) “witnessed it”, 33% ($n = 54$) indicated that they were “the victim of it”, while 10% ($n = 16$) “participated in it.” Of the 126 teacher candidates who chose to describe the experience, most described experiences with interpersonal stigma and self-stigma. Teacher candidates who experienced interpersonal stigma described how others used oppressive language and practices (Holley, Stromwall, & Bashor, 2012) to stigmatize individuals with mental illness. Teacher candidates who experienced or witnessed self-stigma described how it led to secrecy (Alvidrez, Snowden, & Kaiser, 2008; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002) or became a barrier to help-seeking. Some teacher candidates also described how they responded to interpersonal stigma with education or preventive telling (Alvidrez, Snowden, & Kaiser, 2008; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002).

Oppressive language: “crazy”. Some teacher candidates described how friends living with mental illness were labelled as “crazy”:

My best friend is suffering with mental illness and the biggest issue is people thinking that she's "crazy". I think both her mom and my mom don't have as much education about mental illness as we do and they are intimidated by it. They tend to brush it off.

while others described how “crazy” was used to trivialize the experience of mental illness.

I have witnessed many people misuse the diagnosis of mental health, either in an offensive way "she is crazy, I think she must be manic depressive or schizo", or a way that trivializes the seriousness of it " I feel so manic today." I also lived in countries that do not provide much support for mental health patients and so many of these people are left homeless and avoided by society.

This teacher candidate explained that using the word “crazy” was dehumanizing:

My grandma was diagnosed bipolar and manic-depressive and she has spent many extended stays in a mental hospital. It really bothers me when people refer to "insane asylums" and crazy people because it's really insensitive and discounts that people staying in these institutions are still human and have feelings and families that care about them too.

Oppressive practices: blame, increasing social distance, mocking. Teacher candidates described stigmatizing behaviours such as blame, increasing social distance, and mocking.

Blame. Teacher candidates described how individuals with mental illness were blamed for their mental illness by minimizing their experience, where people denied the existence of mental illness,

My mother has mental health issues and I have seen and heard people making light of her condition. I have heard specifically people saying "It's all in her head" as if to mean she does not have an illness. I politely corrected them and walked away.

by classifying mental illness as a personal weakness, where individuals with mental illness could cure their illness if they chose to try harder,

I've been depressed and people just think that you need to snap out of it, and also that you need to try and be happy. Or, the more depressed you get, the less time people want to spend time with you because no one wants to spend time with a depressing person... Many people don't understand.

or by associating it with a moral transgression, where individuals with mental illness used their diagnosis to take advantage of someone or to escape responsibilities.

A family member has depression and many other family members look down at her and think she is just being selfish and lazy instead of fulfilling her obligations and responsibilities. She clearly needs help and is in need of support, not criticism.

One teacher candidate described how he or she responded to being called “lazy” by using education or preventive telling (Alvidrez, Snowden, & Kaiser, 2008; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002).

When I was first diagnosed with severe Generalized Anxiety as well as Depression I had "friends" call me lazy because I was unable to participate in the same activities that I was able to participate in before. I dealt with this by educating them on what Depression and GAD can do to a person through various anecdotes and provided them with outside resources so that they didn't spout hurtful ignorance to anyone else.

Some teacher candidates who did not have a mental illness described how they were still subjected to blame and judgment when a family member died by suicide.

My step father committed suicide. People had a lot to say about it, no body considered he had a mental illness. They only thought to place blame on our family instead. Whoever did ask questions, I would simply comment that he was a victim of mental illness.

Increasing social distance. Teacher candidates also described how people increased their social distance from individuals with mental illness:

A friend of mine suffers from mental illness and I have seen the way people have avoided speaking to her

This teacher candidate was one of the few to describe both participating in stigmatizing behaviours *and* demonstrating affirming attitudes towards friends with mental illness:

I have several friends with depression, anxiety, and one with schizophrenia.

Throughout high school I would listen to them, discuss with them, and try to help in whatever small way I could. Most of them felt ignored or ostracized - complete outsiders from their peers because of the issues they were dealing with and the lack of connection to those around them. Some of us still keep in touch today. Participated in it: I think I would be fooling myself if I believe I haven't been a part of the stigma at some point in my life, as educated in mental health issues I strive to be. I think there's always more to learn, always more to be done. I may know more than the next person, but I also may not know enough to do enough.

Mocking. Teacher candidates described how family members made light of their mental illness,

Still to this day my sister refers to me visiting a 'special doctor' when I was attending therapy. We have talked about it, and while before she said it out of a place of jealousy, as it was special attention I was getting. She understands now why that offended me. and is only used in rare circumstances often in a special circumstance, such as if my psychiatrist/psychologist recommended something new-agey

or how they were affected by others making fun of family members with mental illness.

My dad has mental health issues and was a teacher in my high school. Students would make fun of him and I struggled how to react

Self-stigma. Teacher candidates also described experiences with self-stigma. As Link, Cullen, Struening, Shrout, and Dohrenwend (1989) explain using modified labelling theory, some teacher candidates described concealing a mental illness diagnosis to avoid devaluation or discrimination.

I did not want to discuss with my family, as I was concerned that they would not understand me and that they would overreact.

One teacher candidate did not describe experiencing self-stigma, but was encouraged by a nurse to avoid the label of ‘anxiety’:

I was told by my doctor that I had anxiety. When I witnessed an "anxiety attack" and went to the hospital, I told the nurse that according to my doctor I had anxiety, and she said not to say that because it has a negative connotation attached to it.

Others described how self-stigma became a barrier to help-seeking.

I wasn't exactly a victim of stigma, but the stigma prevented me from talking about and pursuing treatment for my anxiety and depression.

This teacher candidate described how caring for a loved one with mental illness did not prevent him or her from experiencing self-stigma as a barrier to seeking help:

I can attest to my own high school experience in which I was dating a severely depressed girl under the care of mental health professionals. I began to experience some significant signs of depression from the stresses of trying to be her primary pillar of stability and confidant. I have never admitted my state to anyone, even (and especially) my parents who were the ones who could have helped me the most. I didn't feel directly victimized, but retrospectively I can see that the stigma related to mental health prevented me from seeking much needed help without me even noticing it.

This teacher candidate described how his or her experiences with stigma influenced his or her goals as an educator:

I grew up as a very hyperactive child and refused outside assistance because I was ashamed of the stigma attached to ADHD. During university, I finally had the courage to be tested and felt extremely confident in my decision. It is my goal as a future educator to inform students about the negative stigmas attached to mental health and the effects they can have on a student's life. Another factor to my choice to be diagnosed was that I knew that I could sympathize with my own students who may be dealing with a similar situation. I will be able to offer my personal experiences to my students as well as educate parents about the diagnosis process.

Responding to interpersonal stigma by educating others. Many teacher candidates described how they sought to improve negative attitudes about mental illness by correcting false information about individuals with mental illness. This is similar to Link, Struening, Neese-Todd, Asmussen, and Phelan (2002)'s description of education or preventive telling, but these teacher candidates educated others on behalf of friends or loved ones with mental illness. Some teacher candidates focused on how their friends with mental illness disconfirmed stereotypes,

I lived with my good friend who has both ADHD and bipolar disorder. She has been judged by others when they found out about her conditions. They would say to me, "That must be a handful to live with." I would calmly respond that she is the nicest person to live with, and if they didn't already know she had these disorders they wouldn't have even realized.

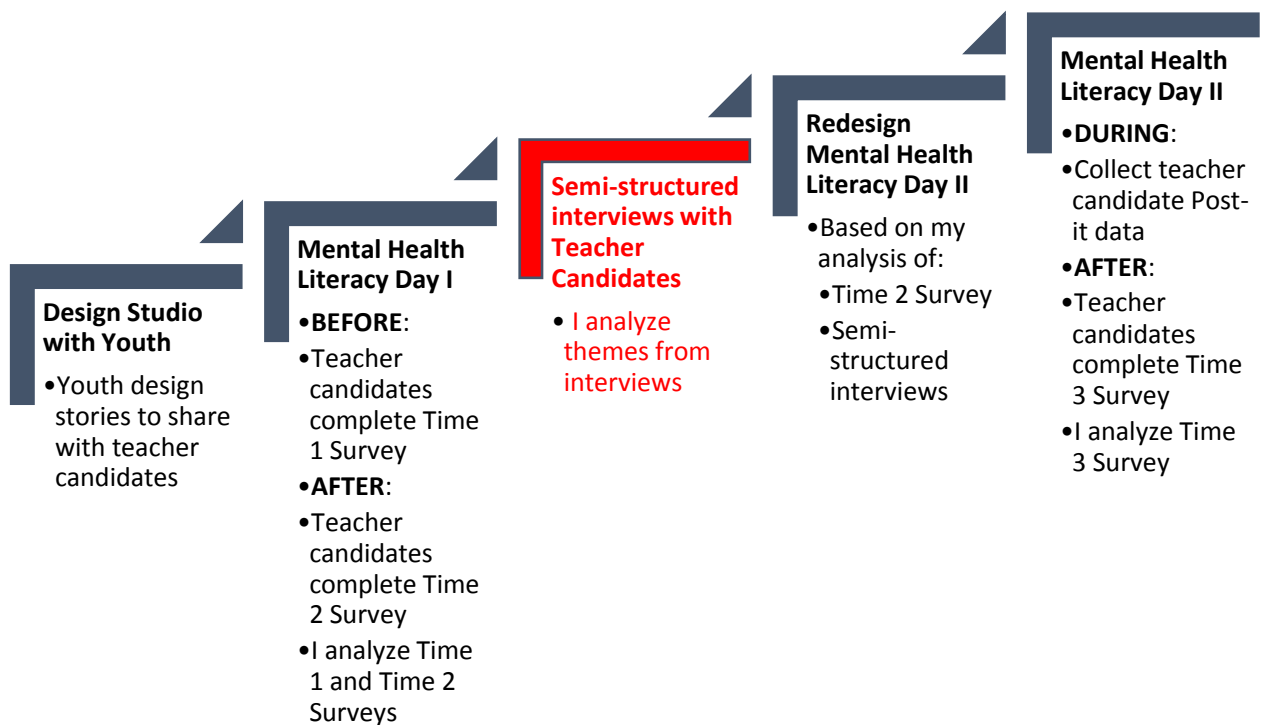
Experienced individual who believed [a student] with ADHD could not focus enough to learn and therefore did not focus on them. I gave the student extra help and patience. I discreetly mentioned that it was not true to this individual and attempted to guide them otherwise and to help the child more.

while others focused on why individuals with mental illness should not be stigmatized.

My husband suffers from anxiety and depression. It was difficult telling our friends and family because some of them do not understand mental illness. We tried to explain that he was battling a disease, like heart disease or cancer, but it was in his mind, and it was bigger than we could handle (so we sought help).

One of my close friends was diagnosed with severe depression many years ago. Whenever she tells someone that she suffers from severe depression, people often avoid or stigmatize her; however, she may have a mental illness, but it does not define her as a human being. I always make a point of mentioning this to someone who stigmatizes mental illness (such as depression).

Qualitative Data Analysis



I conducted eleven individual semi-structured interviews with teacher candidates who attended Mental Health Literacy Day I (see Appendix L for brief biographies of each participant) to answer the research question:

Research Question 4:

How did teacher candidates' new knowledge from Mental Health Literacy Day inform their teaching practices?

Analysis of the semi-structured interview data revealed that overall, Mental Health Literacy Day increased these teacher candidates' awareness of – or boosted their confidence about – the impact they could have in the lives of students with mental health challenges. For teacher candidates without previous experience working with children and youth with mental illness, Mental Health Literacy Day raised their awareness about the importance of mental health literacy. For example, Nicole was surprised to learn about the impact she could have in her students' lives:

One thing that I was really surprised to learn about [at Mental Health Literacy Day] was how big an impact a teacher does has on a child's mental health. And just some of the statistics – I don't really remember all of them now – but the teacher is a big figure in a child's life, like at school six hours a day.

Learning about the prevalence of students living with mental illness compelled Jacqueline to consider supporting these students as part of her role as a teacher:

I mean you've told us [at Mental Health Literacy Day] how prevalent it is. Is it one in five? Yeah, that's huge! That's too huge to ignore. It's just too huge. I mean, I know there's a lot of issues – there are so many things for us to consider, but we can't ignore this. It's one of many things, but that's what we're paid for – this is our job.

Some teacher candidates without previous experience also felt that Mental Health Literacy increased their confidence in their ability to teach students facing mental health challenges. For example, Emma felt that Mental Health Literacy Day gave her “a more enhanced sense that I was able to tackle some of these issues, or at least I'm able to recognize what my role is and then where I can go to get help to further that.” She concluded that Mental Health Literacy Day

gave us a good foundation of facts and statistics that we can become equipped with when we go into the classroom. So that day taught me more specific figures and local context of what students are dealing with. I know I was very surprised by how many students are dealing with self-harm or suicidal thoughts.

For teacher candidates with low mental health literacy, which included teacher candidates with and without the lived experience of mental illness, Mental Health Literacy Day revealed gaps in their knowledge, and sparked their motivation to learn more about mental health and mental illness. Some teacher candidates like Emma felt encouraged to continue learning independently,

I feel prepared to get prepared. So I don't feel like I'm totally ready to just walk in and be amazing, but I feel like I have the tools to get there. So it's something that I'm going to have to work at, but between now and when I become a teacher. And definitely, like, first day of teaching I'm not going to be like "Okay I'm totally ready and prepared and this is going to be great," but I feel like the Fridays especially had given me the knowledge and resources that I need to get to the place where I need to be.

while other teacher candidates like Jacqueline wanted the Faculty of Education to provide more education about strategies to support students living with mental illness.

Didn't [the professor presenting at Mental Health Literacy Day] survey the schools and come up with numbers that said there is a lot of mental health? [Throws her hands up] Yep, there is! Now what? It's just that – now what? Ok great, you've raised awareness, you've got us. That was like a hook – now what? What do we do with all that mental health?

Teacher candidates appreciated hearing about self-care during Mental Health Literacy Day, citing that it was the only time during their studies that a professor mentioned its importance, but many found it difficult to engage in self-care during practicum or during classes at the Faculty of Education. For example, Patricia stated plainly that self-care was a good idea in theory, but she did not have time to take care of herself.

I've got a three hour daily commute and I've got kids at home and trying to fit everything in is incredibly stressful. I'm managing, but there's been some ups and downs on the way and I took away...I mean it's great in theory, but right now I don't have the time to take the time for myself.

Next I present the main themes from the semi-structured interviews. See Appendix L for a brief biography of each teacher candidate interview participant.

Themes from Semi-Structured Interviews

Theme 1: Navigating the conflicting identity of student and teacher. This theme involved teacher candidates describing their experience navigating their identities as 'student' and as 'teacher'. When reflecting on their roles as students at the Faculty of Education, many teacher candidates described struggling to take care of their own mental health during classes or during their practicum.

When describing their roles as teachers at their practicum schools, most teacher candidates described how they observed their associate teachers "creat[ing] a positive, strengths-based learning environment" and "promoting healthy peer relationships" (Koller, Osterlind, Paris, & Weston, 2004, p. 43). Teacher candidates also described the steps they took to inform their associate teachers and other school staff members about "students who may have, or are headed toward, a mental health problem such as depression or anxiety" (Koller, Osterlind, Paris, & Weston, 2004, p. 43). Although teacher candidates appreciated learning about mental health resources for students, no teacher candidates referred students to any of these resources. Instead, most teacher candidates felt that their role was to act as early identifiers of their students' troubling mental health-related behaviours. Most teacher candidates passed this information on to their associate teachers and other members of school staff, and deferred to their judgment to decide how they would follow up with students and parents.

Teacher candidate as student: Problems during practicum and class time at the Faculty of Education. As I hypothesized in Chapter 1, teacher candidates struggled to take care of their emotional health during practicum and during classes at the Faculty of Education. Jessie named being evaluated, loneliness, and competition between teacher

candidates as factors that challenged her emotional coping skills during practicum. Anna, Patricia, and Jacqueline named family responsibilities and keeping up with classwork as factors that made it difficult to practice self-care while being students at the Faculty of Education.

During practicum, Jessie described multiple challenges despite eventually “destroying the evaluation – like, it went really well”. She struggled with loneliness because she felt that there was no one to confide to when she was facing challenges in the classroom.

As a teacher candidate, it was a bit lonely. Because the teachers above you, they already have a job and they're judging your every move. And also with students, they are your *students*, so you're not on the same level as them. But it was like you're in this weird limbo of: “I have no idea who I can vent to” so it was really lonely sometimes. That was stressful. That was stressful!

Jessie did not feel that she could confide in her fellow teacher candidates either, because she sensed competition between her teacher candidates, where teacher candidates were hesitant to help each other unless it could improve their résumé.

And within the teacher candidates themselves, it wasn't like I could even go to them, because a lot of them are super... like, it's just really competitive. It's, like, really competitive. And I was like: “But you're not even the same...like, why are you treating me like this?” Because I'm very much like: “We are all in this together – let's work through this together” and people are just like: “Will that help my résumé?” I'm just like: “Oh my God, really?” It was hard. It was hard.

From Jessie's perspective, this sense of competition resulted in teacher candidates concealing their practicum struggles when speaking to each other at social events.

They did have a social [event for teacher candidates] but even that I found was anxiety-inducing. Because it was just everyone talking about how great their practicum was and blah blah blah, and literally I just wanted to cry and not talk about school [laughs].

Anna, Patricia and Jacqueline, all parents of young children, also described the difficulty involved in balancing schoolwork, family responsibilities, and self-care during their time as students at the Faculty of Education. During the interview, Patricia commented that her fatigue distracted her from answering my questions. This made her advocate for self-care to be included in any mental health education for teachers.

I still think it's important to talk about our mental health because if we are not functioning...you know, I keep on apologizing because I can't think, and I'm tired, because I'm at that point in the term. So if we don't make a point of focusing on our mental health, then we can't be in a position where we can do anything for anybody else. So for me, that has to be a focus.

Anna agreed that self-care was an important topic for the Faculty of Education to teach, because even though she did not “follow a lot of it”,

putting the idea in your head – I feel like that was helpful because...especially me this year with the two kids, I feel like I'm just really overwhelmed and I'm just working nonstop and so it's really hard to find that time too, you know?

Committees at the Faculty of Education organized wellness events for teacher candidate peers to participate in, but Jacqueline could not attend them because of her family responsibilities.

I mean, it's kind of funny, like yes we need balance, and I know there's volleyball Wednesday nights now, but I can't do that – I've got 3 kids at home!

Patricia pointed out that teacher candidates without family obligations also felt overwhelmed by the breadth of the Faculty of Education curriculum. She explained that this also affected teacher candidates' willingness to learn about a topic that seemed as daunting as mental health.

Other people who aren't in the same boat as me [with family obligations] still are feeling overwhelmed at this point in the term. To go to throw more stuff at them – especially something like mental health – because it's like “[Gasp], my gosh, we have to do this too?” Like, there's so much!

Patricia explained that feeling overwhelmed by the workload at the Faculty of Education explained why many teacher candidates did not participate in Mental Health Literacy Day. She felt that only teachers with a personal connection to mental health – or those who were confronted by it during practicum – would feel capable of learning about how to support students' mental health.

Because there's so much, I mean we're just learning how to function at this point, so it's not even a question of “Do I want to [learn more about mental health]?”, but “Am I capable at this point?” Because the learning curve is so high, and the workload is so high when you're just starting out. So it's not a question of not wanting to [learn about mental health], it's just... Where can I fit... [...] So it's not that we are avoiding [learning about mental health], but unless there's something that happened that makes you confront it, I don't know.

Teacher candidate as student: Solutions promoted by teacher candidates.

Teacher candidates named seeing their situation as temporary, normalizing the experience of feeling stressed during evaluation, and maintaining boundaries as coping mechanisms to deal with the stress of practicum and classes. They also suggested solutions that the Faculty of Education could take up to better promote the mental health of their teacher candidates.

Jessie found her practicum to be the most stressful part of her experience as a student at the Faculty of Education, so she persevered by thinking of her practicum as a temporary investment in her future career as a teacher.

The process of [practicum] was horrendous and it was just stressful and really lonely. Really lonely. But I knew it was temporary, and that's what helped me get through. It was just like: “I know I'm crying now but it's not going to be like this again!” Like: “This is an investment and I know it is.” But it's stressful. Yeah it's an investment of six weeks that's going to be *way* worse than teaching actually is, because it's so different.

Jessie also recognized that teaching is more stressful for anyone when they are being evaluated.

Like, even if my associate [teacher] was marked, she would act differently: It's like: "So imagine [that] you're not going to get a job again. Now teach!" [laughs] and it's like "I can't!"

However, Jessie considered the process of being evaluated by her associate teacher once during practicum to be worse than the prospect of being evaluated by her students during the rest of her teaching career. In fact, she looked forward to being evaluated by her students in order to ensure that she was helping them learn. Still, Jessie accepted the necessity of having to be evaluated by her associate teacher in order to obtain a permanent teaching position.

It will never be like that again. It's worth it for now, because if I do get to be a teacher, I won't be marked in that way, I'll *just* be marked [by] my students. Like that's how I'm seeing it. Every class is different but it's like: "I'm *so* willing to be marked by you because I'm trying to get *you* to learn," but when it's all these other factors and the politics and everything like that that, then it's like "I have to kiss your [associate teacher] ass right now!" But I know it's temporary, just to get the job.

However, teachers who are certified by the Ontario College of Teachers and hired into permanent positions must undergo teacher performance appraisals where they "have the chance to engage in professional exchanges and collaborative inquiries that foster continuous growth and development." Therefore, teachers continue to be evaluated by more than just their students. Here, thinking of performance appraisals as opportunities for collaboration and professional development, which Jessie enjoys, may be more useful to her than thinking of the appraisal as a temporary measure necessary only to obtain permanent employment.

In contrast, to Jessie naming practicum as her most stressful time as a teacher candidate, Patricia found classes at the Faculty of Education to be the most stressful part of her experience. Patricia coped with the stress by considering her class time to be temporary: "I know this is just a short term thing, because when I was in practicum I had lots of time to take care of myself." Patricia explained that she did not find her practicum stressful because she had "a fantastic experience" with a "great" associate teacher, where

she was able to experience “a lot of success.” During practicum, she maintained clear boundaries between her and her students in order to guard against burnout.

I think it's important to stress that you need to show that you care, but to also keep that distance. Because if you care too much, then you're going to burn out.

Other teacher candidates described wanting closer relationships with their students. For example, Nicole explained that a close relationship with her students was a central component in order

to make the time at school the best it can possibly be. So just trying to meet students where they're at, not only follow the curriculum, but more on this side, being... I don't want to say a friend...but being somebody that they can come to for support, somebody who will listen to their problems and issues and not dismiss them. Being somebody like that in a child's life I think is so important.

Anna described her husband's struggles with bullying and depression as “one of the big reasons why” she went back to school to become a teacher.

If I see an unhappy or withdrawn child like [her husband was], I would do whatever I could. I'm not a social worker, but I would at least try to get the wheels in motion and get someone involved, just so that I can make a difference and help someone so that they don't go through a whole lifelong battle like my husband has.

This points to the importance of engaging teacher candidates in a clear discussion about how to constructively channel their empathetic nature in order to help students, while maintaining appropriate boundaries, working as a team with other school staff to share responsibility for students' care, and practicing regular self-care to prevent teacher burnout.

Jacqueline and Emma also discussed solutions that the Faculty of Education could implement in order to promote the well-being of teacher candidates. Jacqueline pointed out that the workload during the Bachelor of Education program was too high to expect teacher candidates to practice self-care.

It's funny how... Because on the one hand, it's, you know, "Find time and recognize balance, but don't forget you have a 50-page assignment due tomorrow" So what's with that [laughing] right? It's one thing to say it, but the other hand is handing you all the work.

Jacqueline recommended that the workload be reduced by allowing "a free pass once in a while", where teacher candidates could not attend one class without fearing a penalty in their classroom participation grade.

Is there a free pass once in a while? Like, I'm just imagining, say, last night and I'm hearing my son coughing and I'm like "Oh if you start throwing up tonight I'm screwed - I have a presentation at 8:30 in the morning!" What do you do?

She also felt that scanning student cards was not necessary for an education program designed for adults, and that the practice of only scanning cards at beginning of the day unnecessarily punished teacher candidates who could not arrive on time because of unforeseen circumstances.

Give me some numbers to work with. So that I don't feel I have to speed to get here for 8:30 in the morning. [laughs] I'm an adult - I can get myself where I need to be. If I want to get a degree, I will do what it takes to get one - I don't need you to scan my...you're recording this! [Laughs]

Emma agreed that she did not "like the student card [swiping] thing because it feels like policing," and proposed that some teacher candidates were actually practicing self-care by *not* attending Friday professional development sessions like Mental Health Literacy Day.

[Were teacher candidates] more stressed out with other things and just doing self-care by not being there? I have no idea.

At the same time, she acknowledged that it may have been necessary to encourage teacher candidates to attend.

But I would love – kind of in an evil way – if we had to swipe our cards at the end of the day, just to see people squirm a little bit. But it's kind of mean, because

that's totally like: “We don't see you as responsible adults”, but it's because people don't act like responsible adults!

Instead of punishing teacher candidates for not staying until the end of the day, we rewarded teacher candidates who did stay by drawing names for five prizes immediately after the talk about self-care at the end of Mental Health Literacy Day I.

Teacher candidate as teacher. Jacqueline demonstrated the largest contrast between her understanding of her responsibilities as a teacher candidate and her understanding of her responsibilities as a teacher. As a teacher candidate, Jacqueline felt absolved of her responsibilities to care for students – she understood her role as “to learn” from her associate teacher.

They're the associate teacher's students. [The students] are [the associate teacher's] responsibility - they're not my responsibility. I'm there to learn and it's not my job. Well, I think if I witness abuse, I think as a citizen to report that, but if I have a suspicion of abuse and my teacher doesn't feel that way, I kind of feel my hands are tied.

She felt that this was because of the hierarchy between the associate teacher and the teacher candidate, where Jacqueline did not feel that she was permitted to act without her associate teacher's permission.

Well luckily we have our associate to go to for every question. I kind of had that sense - you don't act without her agreeing, so to speak - because really, we are inferior. I've got that impression [that] we're down here on the totem pole and really, we're just students. [Associate teachers] have the authority, it's their room, they know their rules, it's their job, so we bounce ideas off them and we can ask them anything we want. Then when we're on our own in the classroom all by ourselves, what do we do then?

On one hand, Jacqueline appreciated having her associate teacher's guidance, but on the other hand, Jacqueline felt underprepared for her responsibilities as a teacher in her own classroom. In large contrast to her perception of her role as a teacher candidate,

Jacqueline felt that when she became a teacher, she would take on full responsibility for “almost everything” that happens to students during the school day.

We are responsible for not only their learning, but we are responsible, I think, for almost everything that happens between the time there with us. I feel that we are responsible for them – we're not responsible to necessarily make them lunch, but if we see they don't have a lunch, and there is a program available, I feel we're responsible to find something for them. I mean, although I don't feel like we'd get fired for [not doing] it, but we have sort of a responsibility to help our children and as they seem to be experiencing some mental health issues or distress, or a lack of a good mental health, I feel we [have a] responsibility to provide them with whatever they need to be more healthy.

All of the other teacher candidates I interviewed fell somewhere in between – they felt free to take on some of the responsibility of caring for students' emotional health during practicum, but looked to their associate teacher for guidance. All teacher candidates saw the influence of mental health on students during their practicum. Some teacher candidates responded to these students directly, while other teacher candidates observed how their associate teachers created mentally healthy environments.

Teacher candidate observations: Creating positive classroom environments, promoting healthy peer relationships, and enhancing students' self-concept. Lindsay described how her “pretty exceptional” school staff members modeled affirming attitudes towards one student who struggled with multiple mental health problems, embracing him as part of their school community.

You would sort of hear the EAs and teachers talk about him, but it was always really in a positive, like: “Oh, poor so and so, he's having a really tough day today” and the EAs would be like “We're having a tough day with him!” And they had this little sort of like quieting, calm down room for him that was right beside the staff lounge.

Echoing what youth participant Sandra described in her own life as a student, Alan described how his associate teacher taught him that many of his students without

diagnosed mental health problems still cherished their school community as the most mentally healthy environment in their lives.

Where I was in [Southwestern Ontario], it was a lot of poverty and that sort of stuff, broken families. And the [associate] teacher would actually say that [the students] don't look forward to the weekend because they're going to the other parent and they don't want to go to that house. So the school was like the shelter for them. It was where they had structure. It was where they had security.

Therefore, Alan's associate teacher modeled "respecting the kids' feelings and really listening to them", making them feel 'seen' at school:

It was more about like, *seeing* the kids. She liked to greet the kids at the door and talk to them. And then they walked in and there was a difference in their reply. And she keep an eye on them and she could say: "Oh yeah, are you okay today? How's it going?" So I learned a bit from that.

Patricia observed that getting to know her students built community in the classroom and allowed her to better identify who needed extra mental health support.

If you get to know your kids and their background – and what they bring to the table or bring to the classroom – then [...] you just have a better idea of who your community is. So from the mental health point of view, if you're doing that to build a class community, you can also be using that to see if there are people who need help.

However, she cautioned that teacher candidates should be taught that it was not the teacher's responsibility to "deal with" the student's mental health problem.

Just because we recognize there could be a mental health issue because we're not mental health experts, to know that it's not our responsibility to deal with the mental health issue. It's our responsibility to deal with the whole student, and get them whatever support or help they need.

Teacher candidate observations: Identifying students who may have, or are headed toward, a mental health problem. Nicole's associate teacher was a classroom teacher and a guidance counsellor,

so she let me spend time in the guidance office. And I didn't get to sit in on individuals' interviews but I would hear about things going on. And it was shocking to me how much students feel, and need support, and what they're going through it's just so diverse, and it's amazing.

Nicole described herself as having no background in psychology and no personal experience with mental illness, so she was surprised to find that she could not always identify which students were struggling with mental illness.

There was a student in my [Grade 6] class who had anxiety. [...] My associate teacher said that she had missed a bunch of days of school, [so] her parents were really working with her to get her interested in coming to school – for some reason, she felt really nervous and uncomfortable coming to school.

Her first impression of this student was the opposite of what she expected for a student struggling with anxiety:

And my first impression of her was the total opposite! She seemed to me like a very outgoing, engaged child that enjoyed her peers – she was very social and things like that.

Simon also could not identify the students that his associate teacher was “keeping an eye on.” He also did not see how struggling with emotions could be a sign of a possible mental health problem.

With my associate teacher when I first got there, she was like: “These are a few of the kids that I’m keeping an eye on their mental health” and I guess why I feel that I don’t have enough training is because I didn’t see it. I was there for six weeks and I didn’t see anything more besides just the kid who was [...] struggling with how to deal with their emotions.

Teacher candidate actions: Creating positive classroom environments, promoting healthy peer relationships, and enhancing students' self-concept. Brian described how he used books to help his kindergarten students constructively explore and express their feelings.

So I was in JK/SK split class and [for] weeks before, kids were getting rowdy, pushing each other, not listening to the teacher, not cleaning up after themselves, it was mostly like they were just not being nice to each other. So I went to this workshop [with my associate teacher] about how to explore feelings [using] kids' literature. And I was like "There is all of that out [there]? I never knew about this!" I just thought it was a really well good approach to deal with those behaviours ... problems or issues? I don't know what you call them, but I just thought it was neat because you're addressing how they're feeling, being like: "We all feel like that, but at the same time this is what you should maybe think about doing if you want to improve your situation."

Brian felt inspired by the workshop, and "loves" children's literature, so he borrowed seven of the recommended books from the library "and then I asked my teacher if instead of doing what I was supposed to do, 'Can I, every single week, read one of these books [to the kindergarten class] and then we can talk about it?'" "I was like: 'I really think this might be a great thing to access their feelings and see what they can change on it.' So she was like: 'Yeah, sure! Do it!'" Brian used the books to ask his students questions

Like: "When you're angry, when you push your friend, how do they feel? And how do you feel if you were to be treated this way as well?" And [the books] would say things like: "Sometimes I'm happy, sometimes I'm not happy" and "If you're not happy, this is what you do: You can talk to your friends and you can talk to your teacher" and then I involved [the students]. I was like: "What do you think?" "How do you feel when you're unhappy?" and they would say things like "I don't know, I cry." and I was like: "Okay, so we're going to talk about crying in this book." And then we talked about crying and [discussed how] crying is fine -

it's a way to release emotions and that stuff. So I just normalized all these feelings

He explained that students often felt that they would be automatically punished for having any negative feelings. Instead, he used the book discussions to discuss with his kindergarten students that “It’s natural – it’s normal – we just have to make sure we know how to navigate that.” This was Brian’s first time teaching kindergarten, so he was unsure as to how much his students would understand the lessons from the books. He found that he “underestimated how smart the kids are!” He observed that his students “were able to communicate their feelings and they were able to communicate with each other.” They were more responsive when he asked students to “tell me how you feel, then we can work together on it.”

So when they were angry or mad I was like: “Hey, remember we read this the other day, that there were some other ways that you could talk to me. You don't have to throw things [...] I'm here to talk to you.”

In this case, Brian was able to explore creative solutions to promoting healthy relationships between his students because his associate teacher was supportive of his desire to alter his assigned classroom duties.

Teacher candidate actions: Identifying students who may have, or are headed toward, a mental health problem. Pauline had the most experience working in the mental health field, so she felt confident sharing her observation that a student in her class could be struggling with a mental health problem.

There was an issue with one of the Grade 5s [and] no one had ever thought of [the issue] from a mental health perspective. So when I was talking about it, I asked [if] that had been explored, [asking] “Is there a social worker onsite? Is there another approach that maybe you could try with this student to see if this is an issue?”

Pauline felt that her mental health literacy allowed her to

support people who have mental health issues, whether they're defined as that or not, whether they're diagnosed with that or not. I can also recognize it and say "well there's maybe potential."

In contrast, Jacqueline also struggled with the identification process of a Grade 5 student in her class who she described as having

issues. He feels victimized - he feels he's always bullied. So we know about that and his parents know about that. But on top of that, he also has this shaking head thing that he does all the time.

Jacqueline was conflicted about "what do I do about my little suspicion. Do I just go home and google it? Or do I just [say to myself]: "No, I'm sure he's fine." But what do I do about that? Is it my concern?" She decided to tell her associate teacher about her observations in the case that it was a sign of a developing mental health problem.

And I keep thinking about that and trying to think of: "Does he have another issue, like some kind of a mental illness or some kind of another issue that causes him to shake his head as a coping mechanism?"

When she shared her observation, her associate teacher said "We can't diagnose" and did not pursue it further.

She felt there's not much you could do. She didn't see it as a problem. It didn't 'red-flag' her. His head shaking - it was only something I thought of. So was it just, you know, his little nuance? That it's not a big deal? How do I know? Do you just let that go for years and years? Or is it just his quirky little thing? Or is it something?

When I asked Jacqueline what she would have done as the classroom teacher, she described how she would have consulted "the learning support teacher who has more expertise in Special Ed" and "if I had a good relationship with the mother or the parent," during a parent teacher interview, if the opportunity sort of was moving in that direction where I could say "Yeah, and I've also noticed he has this...head shaking. Is that a coping mechanism?" I could just put a little slight spin on it

where it doesn't sound like “Well, do you think he's got some serious mental disease?” But [instead I would say]: “Have you noticed that? Does he use that?” and just see what I get from that. Just to feel it out a bit more.

Therefore, Jacqueline would have further pursued her instincts if she felt permitted to by her teacher. This is why we teach teacher candidates to trust their instincts, despite some teachers feeling that this is ‘common sense’. For example, Simon felt that only teacher candidates without previous experience would need to hear that advice.

When you said: “Trust your instincts”, I mean...I feel like that’s good to hear, but I feel like I kind of know. And [...] I’m not insulted that you said that, but that’s how I felt [during Mental Health Literacy Day], that [...] it was like: “Remind yourself that they don’t all have the same experience that you do, and from their eyes this could be important [to hear].”

Still, Jacqueline worried about the consequences of trusting her instincts to pursue a potential problem, because “once you raise that questions, you can’t ignore it.” She felt that once she raised a question about a student’s mental health, “it must be investigated and therefore it's documented.” On the other hand, Jacqueline didn’t “want to find out that I was right and I didn’t do anything about it!”

Anna did receive the message during Mental Health Literacy Day to trust her instincts. This compelled her to follow up with her associate teacher when a student in her Grade 2/3 class

wrote a lot about death [in his journal] and it was very disturbing actually. And guns...it was a little bit of death...but mostly guns and violence. And it was just one or two sentences here and there, so before [Mental Health Literacy Day], I wouldn't have said something.

Anna did not expect her associate teacher to say:

“Oh, maybe he's depressed.” And I was impressed that the [associate] teacher actually made that connection [before Anna did]. I was just more: “Whoa, we need to look at this!” And then he actually said: “Maybe he's depressed.”

However, Anna admitted that she did not find out whether her associate teacher followed up on their suspicion that their student may be depressed.

Theme 2: Teacher candidates' perceptions of stigma. All teacher candidates shared the belief that mental illness continues to be stigmatized. When defining or describing their experiences with stigma, teacher candidates were most likely to describe three stereotypes associated with mental illness: incompetence, dangerousness, and personal responsibility for the mental illness (blame). While teacher candidates acknowledged that more people today were aware of the impact of mental illness, they believed that more needed to be done to decrease the stigma associated with it. Teacher candidates identified 'talking about it', using a biomedical model to highlight similarities between mental illness and physical illness, and uncovering a personal connection with mental illness as three strategies to decrease the stigma of mental illness.

An unexpected finding was the number of teacher candidates who were confused about the definition of mental health and mental illness. They often used the word "mental health" when they meant "mental illness", "mental health problem", or "mental disorder". In order to authentically capture teacher candidates' comments, I present this data using the words that they used, even when a different term might have been more appropriate. I begin this section with a discussion of teacher candidates' views about the significance of the "label" of mental health.

Avoiding – or embracing – the label. Pauline and Lindsay described how people continue to avoid the label of "mental health" when describing their own struggles with their mental health. In contrast, Alan believed that people embrace the label to escape personal responsibility. Like Link, Cullen, Struening, Shrout, and Dohrenwend (1989) argued in their modified labelling theory, Pauline agreed that "it seems to be more stigmatized when it's labelled," causing people to increase their social distance.

Totally. It changes everything. If I say to someone: "I'm really anxious today," they're like: "Oh my God, it's ok, so breathe, it's alright." If I say to someone: "My diagnosis is flaring up and I can't breathe properly right now," it's a completely different flip. It's like one's really supportive and the other one's like "Oh well I'm not qualified to handle that."

Pauline added that in addition to people feeling that they could no longer help a person with a mental illness, hearing that a person has a “diagnosis from a doctor” – for example, an anxiety disorder rather than personal struggles with worry – adds “preconceived notions” to how the person is perceived.

If we call it: “Oh, she has a mental health issue,”, there is a negative stigma that goes along with it – there’s preconceived notions about what that means. There’s: “Oh, she won’t be able to handle herself, she’s not reliable, she may have a breakdown.” Other the other hand [if there is no diagnosis, people react by saying], “Oh, she’s nervous, she’ll get over it, we just need to give her this little bit of extra support, and then it will be fine”...when it’s the exact same thing!

Lindsay opined that there is a “fear of acknowledging” struggling with mental health “because it’s a loaded word.” Like youth participant Quinn – as well as researchers Fisher and Freshwater (2014) – argued, Lindsay felt that accepting the label of mental illness forces individuals to classify themselves as abnormal. However, Lindsay believed that stigma would decrease when people realized that struggling with mental health was part of the human experience.

I think sometimes people may experience that themselves, or they may have a family member going through that. And they are reluctant to call it what it is because on one hand, there is still a fear, like that makes you different, that makes you defective, that makes you not normal. As opposed to just going: “That’s part of being human!”

In contrast, Alan believed that people with mental illness often chose to adopt the label of mental illness because

some people like being miserable...and no, I mean it! And if you give them a choice and you give them a label they don’t mind putting: “Oh, I’m depressed.”

He believed that many people who claimed to have a mental illness were doing so to evade their responsibilities.

I think sometimes there's personal accountability – and this is maybe in my own personal thing – a lot of people just use it as a crutch. You know what I mean? “Well I have this, I can get a doctor’s note...” and so they just sit there! And I think one of the things [in] the education system is the crutch that, you know, a kid doesn't have to [receiving a passing grade to progress through school] so they don't have to try, so there's no accountability.

Stigma stereotypes: Dangerousness. Similar to Link, Struening, Neese-Todd, Asmussen, and Phelan (2002)’s theory, Pauline opined that the stigma of mental illness stems from beliefs about people with mental illness that are developed from cultural sources including “your family, it could be in your community, or school” as well as from personal experiences.

And if people have *had* a negative experience, or *seen* a negative experience, or *heard* a negative experience about someone who’s been officially diagnosed with depression, has been suicidal, or someone that’s self-harmed, their belief systems may change about the level of severity and level of danger associated with those people.

In the quote above, Pauline named the three experiences that youth participant John described in his video for teacher candidates. As I described in Chapter 4, John’s video was the least well-received of all of the youth stories. It could be that teacher candidates’ belief systems about the level of severity and danger of a student with mental illness were reinforced when they viewed John’s story. Teacher candidates may not have considered John’s video as a way to decrease stigma because there was not enough content in the video that disconfirmed stereotypes about students living with mental illness.

In correspondence with Corrigan et al.’s (2002) theory that fear leads people to stigmatize people with mental illness, Pauline also gave the example of schizophrenia being perceived as “scary.” Pauline cautioned that it was important to decrease stigma because it impacts teachers’ perceptions of their ability to help students with mental illness.

I think a good example is schizophrenia. A lot of people see that one as way more extreme than someone who is bipolar or has multiple personality disorder. Schizophrenia seems to be a scary thing to talk about for some people, so in terms of the knowledge and beliefs, I think depending on what those are, and your personal experiences with it, it's going to impact your abilities.

In contrast, when I explained Corrigan's theory to Patricia, I interrupted the interview to interject: "So yeah. I wish I could describe the face you made. [laughter]" Patricia did not agree with the theory, and insisted that she would not regularly consider a person with mental illness to be dangerous.

That doesn't seem to make any sense to me because unless I have... I can't imagine. Unless I was immediately in physical danger, I cannot picture myself being like that.

Still, teacher candidates who completed the quantitative survey in this study considered a student with schizophrenia to be significantly more dangerous than a student with depression or anxiety.

Stigma stereotypes: Incompetence. Teacher candidates who identified as having a mental illness described resisting stereotypes of incompetence when coming to terms with their mental illness. For Jessie, resisting stereotypes were important to developing her self-esteem. She said that to her, stigma means

that people do see it as a negative or...what's the opposite of empowering? That it can crush you. That mental health is like a negative thing and it's like if you have a problem, then you're crushed by it. And it's like "no. I don't believe in that at all."

Simon also struggled with stereotypes of incompetence before seeking help for his depression because

I didn't want that associated with me because I always...I think I always thought I was stronger than I was. Not that this made me less strong, but I think when I first was dealing with it, I thought that it was going to make me less...I guess...tough.

However, like youth participants Quinn and Madison discussed, Simon explained that resisting stereotypes of incompetence was a barrier to seeking help: “I’m in the [armed forces], and for me, that was kind of like [...] ‘I don’t need any help – I got this.’” Like Quinn, Simon had to come to terms with the fact that he *was* experiencing symptoms that made him feel incapable of controlling his emotions – this realization allowed him to seek help.

And it was kind of like the realization that: “No, I do need help, and I don’t understand what’s happening to me, and I’m in a pattern where I’m thinking negatively and thinking not healthily”. And I was crying for no reason, and I was like...I didn’t understand and I knew something was wrong, but yeah, I didn’t know what it was.

On the other hand, Alan did not describe personally experiencing mental illness, but he did associate mental illness with incompetence or a weak character, where either a) a mental illness renders the person less competent, causing a person to shirk his or her responsibilities, or (b) a person will co-opt a diagnosis of mental illness in order to shirk his responsibilities.

I think that there are people who use it as a crutch. And it’s just: “Oh, I don’t feel...” and I think that might be my old cultural ways of where I came from that “Yeah, okay if you’ve got a problem, you’ve got to recognize it” but part of my thing is if you’ve got the problem, you deal with it.

These prejudicial attitudes are what Simon feared when he received a diagnosis of depression. He “didn’t want people to think that I was weak”, or have people say: “Oh, that guy, you know, there’s something wrong with him.”

Work is the first place I sought help and I was worried that people at work would think that yes, I’m not as able or, “Oh, we can’t give that guy anything to do because it’s going to push him over the edge” or that sort of thing.

Stigma stereotypes: Personal responsibility for the cause or prolongation of mental illness. While Patricia did not believe that stigma was due to fears of

dangerousness, she did believe that stigma was due to stereotypical beliefs about the ability to control mental illness.

I think that we believe that we can control our mental health the way that we can control our physical health. Because somehow people believe that you can have mind over matter where mental health is concerned, even though we fully accept that it's not mind over matter.

Similarly, Anna believed that “people are much more understanding if it’s a physical thing, definitely. Because they think you have control over it” when it is a mental illness. She expressed frustration towards the belief that her husband could control his depression using willpower: “I don't know how many times people said to him: “Just snap out of it!” when he was growing up – they just don't understand that he can't!”

Alan conflated symptoms of mental illness with normal, fleeting fluctuations in mood and experiences with self-pity to explain why he believed that mental illness was controllable.

And maybe I'm wrong because some people just aren't ready to, or whatever, but, see, if it was me and I found myself [struggling] at times, and then I'm like: “I've got kids, I've got this, I don't have time to be that.” And it's not like I'm sitting here with a big wave of depression and these [kinds of] feelings, but there's times where I do feel sorry for myself and I recognize it and I'll be like “Oh well, I hate this.” But I don't look at it and say: “Well, you know what? I could stay in bed and say ‘I'm not doing this’ or ‘I'm not doing that because I really don't want to.’” So I think that there's that part of it which kind of troubles me, I guess. I don't know, maybe that's a different perspective.

In the face of these troubling stereotypes about people with mental illness, teacher candidates described three main strategies to decrease the stigma of mental illness: ‘talking about it’, using a biomedical model to highlight similarities between mental illness and physical illness, and uncovering a personal connection with mental illness.

Anti-stigma strategies: Endorse a biomedical model to emphasize that mental illness is uncontrollable. Anna explained that promoting the understanding that mental illness was comparable to physical diseases would decrease stigma.

I think people associate with mental illness with someone who is either lazy or crazy. I don't think they understand that it's just as comparable [with] diseases [such] as cancer or any other physiological disease... But it's a disease of the mind – of the brain – and I don't think people understand that.

Lindsay wanted to normalize the experience of living with mental illness by comparing it to living with type 1 diabetes:

It might be the same thing as someone who's diabetic. It's something you have, you're born with, and it's part of you, and that's okay. And there's ways to treat that and deal with that either through medication or CBT or whatever supports that are available. But there's also going to be times that maybe you'll go through a mental health crisis, and that's totally normal too.

On the other hand, Patricia argued that mental illness continues to be stigmatized more than most physical illnesses

because we don't understand it half as well as we understand physical illness. Now a lot of people who study cancer will say: “Well we don't understand physical illness either,” but we seem to have it so much easier [with physical illness]. To study the body, you can take apart the body – you can examine it, you can do a lot of tests on it. But any test that you do on mental health is colored by the person's personality and the fact that they're giving you answers, or you're seeing behavior but you can't actually see the mechanisms that are causing that behavior except maybe under an fMRI or something like that. But for the most part, [mental illness is] invisible to the people who are studying it.

Patricia added that the biomedical model may not decrease stigma because culturally, we are realizing that we can control aspects of our physical health as well. Therefore, comparing a mental illness to a physical illness may no longer promote the idea that mental illness is uncontrollable. What's more, Patricia points out that regardless

of logical or scientific connections between mental illness and physical illness, we continue to believe that mental illness should be controllable.

Which is kind of funny when you consider it, because a lot of personal choices we make in our lives affect our physical health. So we do have more control over our physical health than we let ourselves believe, but our beliefs about it is that we should have more control over our mental health than our physical health.

Anti-stigma strategies: Uncover or develop a personal connection with mental illness. Anna felt that teacher candidates who did not participate in Mental Health Literacy Day lacked a personal connection with mental illness.

I was sitting around a number of people, and some people were just reluctant to be there, [as if it was just] something else we had to do, and just didn't get the sense of how important it was because they clearly hadn't experienced it themselves. It was just another topic.

Lindsay argued that thinking that mental health was 'just another topic' allowed teacher candidates to keep the topic at arm's length. She worried that keeping their distance from the topic would also encourage teacher candidates to increase their social distance towards students in their classroom with mental illness because they saw experiences of mental illness as outside the norm.

I know I keep saying this – I think there's some people who really see [mental illness] as this box. And they don't fit within that box, and it's like an arm-length topic for them that they don't really get or really understand. Even though they say: "No, I am open to the fact that kids are going through things or people are going through things." But they still don't really get it because they have never witnessed or experienced it sort of close-up. And so they maybe don't have that appreciation that it is something that is so normal.

Jessie also witnessed teacher candidates dismissing the importance of Mental Health Literacy Day because they did not have a personal connection with mental illness. Anna hypothesized that "maybe it will take someone having a child in the class with a mental health issue to actually, you know, become more educated. I didn't get the sense

that people took it that seriously.” Jessie explained that these teacher candidates believed that they would never encounter students with mental illness in their classrooms. If one of these students was placed in their classroom, teacher candidates believed –or hoped – that they would not be expected to play a role in their care.

It was along the lines of: “This shouldn't even be a day”, like: “I would have taken the course if this mattered.” Or just something like that. As well as: “Oh, I hope I never have to deal with mental health problems – I was just going to avoid this.” They would just say stuff like that, and I was like: “Okay that's silly. We have to learn about it.” And...it was such a silly comment, it was something like: “People always talk about the importance of mental health, but I've never seen it.”

Lindsay agreed that teacher candidates with attitudes like this lacked a personal connection, but she contended that teachers had to understand that it was highly likely that they would have to teach and promote the mental health of students with mental illness in their classroom. Therefore, she believed “that there is still a need for us as adults and future educators to talk about the fact that this isn't a ‘them’ problem.”

Because there's people who probably have never experienced this personally – any kind of mental health problem or issue or challenge. Either they've never faced it personally, or they've never seen or witnessed someone close in their family or whatever go through it. So they very much think of it as a 'them' issue. And if they want to be teachers in our education system, they need to understand that this is something that is very common.

Jessie also explained that because of their positions of power and influence over their students, it was important for teacher to openly acknowledge the importance of mental health in their classrooms to demonstrate to students with mental illness that they were valued in the classroom.

So if there's a teacher that's not at all accepting, or doesn't vocalize anything about respecting it or bringing it up at all, like just that it's *there*, and you're the teacher! People respect you! It is a source of power, and if power isn't telling you [as a student in the classroom] that it matters, or it's valued, then you feel worse.

Emma “wish[ed] that there was a way to make everybody care about it – [laughs] like, a lot!” but acknowledged that this was “impossible” without a personal connection to mental health. However, both Emma and Lindsay also argued that everyone *does* have a personal connection with mental health – it is a matter of uncovering this connection. Lindsay believed that “there's not really anyone who's untouched by mental health at in some way, shape or form in their lifetime.” Emma explained that “whether you've experienced a mental health issue or know somebody who has, or you have an experience at all, we're still part of it and you can't escape it, because we are all have mental health.” Still, Anna contended that a personal connection could not be forced through education – it could only be developed through personal experience.

I think until it really happens to you or someone that you love, people just will think of it as some other disease on the list of... do you know what I mean? Or not even that – they'll just think of it as some other issue that they can't connect with.

Anti-stigma strategies: Talk about it! Teacher candidates were most likely to cite “talking about it” as a strategy to decrease the stigma of mental illness. Some described “it” as talking about feelings or emotions, while others described “it” as struggling with mental health, mental illness, mental health problems, or mental health issues.

Talk about feelings. Alan, Lindsay, and Brian agreed that encouraging students from a young age to talk about their feelings would decrease stigma and promote resilience. Alan believed that helping children become more comfortable with emotions earlier would help them develop healthy coping skills.

So I think if we start recognizing that kids...[asking them]: “How do you feel today?” and talk to them about it when they are young, they may get it [their feelings] out, and they may not wallow in it. Wallow's probably not the right word because it's pitiful, but you know what I mean!

Lindsay also believed that talking about feelings would help students to also discover their

self-care needs. And that is a really good tool I think we need to start teaching kids at a young age. Like, when you're having a bad day, or you're feeling this, [you can say:] “Are you feeling bad? It’s ok to remove yourself. It’s ok to go have some quiet time in your room with a book.”

Alan believed that talking about feelings allowed teachers to help normalize experiencing both positive and negative emotions.

Well, I guess it justifies their feelings? Even as a teacher saying, “Oh yeah, I have those days too.” And you can say: “You know what, this is what happened in your weekend? Here's what happened in my weekend too. And I'm not too... I'm a little down about it.” And I think if you create a conversation *with* them, and you confide in them a little bit, maybe they'll confide and they're a little more comfortable.

Similarly, Brian believed that all communities deserved the opportunity to talk about their feelings, because experiencing emotions is a normal part of the human experience.

There isn't that place we can talk about emotions and feelings. And then it becomes problematic because we're human beings! We feel, we have all these things, and we want to talk about them.

Alan concluded that helping students learn how to talk to each other about their feelings contributed to a positive classroom culture of communication and support, where each student could accept or reject the opportunity to give or receive help from others.

I think it creates a culture, like I said, [from a] very young age of talking about your feelings. And some kids just aren't going to, right? And some are “Just leave me alone – I'm not...” and they're not that type of person. And that's who they are: “I'm fine, leave me alone, I don't want to talk about it, but I'm fine.” But there is kids that do need that. And so I think the idea is that it’s differentiated learning in a way, right? Differentiated caring, I guess, or compassion.

Talk about “mental health”. A note of clarification: In the title of this section, I have substituted the word “mental health” for “it” to distinguish this section from what

teacher candidates had to say about talking about feelings. Simon, Pauline, Anna, and Brian all discussed how “talking about it” could contribute to decreased stigma. However, while Alan supported talking about feelings, he feared that talking about “mental health” would create or enable false positive diagnoses or false claims of mental illness.

Reflecting on his experiences on “the stigma which played a role in me not seeking help”, Simon believes that “it’s important to talk about it” to do his part to decrease the stigma of seeking help for mental illness. Therefore, he “tr[ies] to be more open with it now. I’d like to spare somebody the pain that I went through.” He adds that unlike when he was in the armed forces, he no longer hides the fact that he experienced depression, but he does not tell people indiscriminately. If he senses a ‘teachable moment’, he will share his experience.

I don’t necessarily go out of my way to tell people about it, but if it comes up – I guess we’ve been learning about teachable moments, and that, I guess, is how I see it. If it’s going to help somebody, that’s when I try to share my experience. I try not to make it like a preachy thing, but I also try to say ‘You know, this really helped me when I was really down.

Anna agrees that her husband is “really slowly opening up” to other people about his depression because “he’s really happy to help” others who are struggling. For example, Anna herself struggled when caring for her husband before he sought help: “When it was really bad, I just needed to talk to somebody. So I would talk to whoever would listen.” She explained that people who are caring for loved ones with mental illness also need people to talk about it, and they appreciate talking to people who have lived through mental illness. She has noticed that the more that she her husband and are open about their experience with mental illness, “it seems like almost everybody we tell has a personal connection. So it's just a matter of keeping those conversations going.” Pauline agrees that “the more we talk about it, the more we can expand our horizons and open our minds.” Brian adds that talking about it became liberating once he was in recovery. He describes recovery as

messy. But the message is [that] it can become beautiful at the same time. And it's hard work through it, but once you actually do work through it – once you do talk

[about it], it's liberating. I feel like my heart feels less heavier, and that's good to feel that way.

Jessie also described the experience during practicum of a fellow teacher candidate at a high-SES secondary school. This teacher candidate designed an art project to help her students to talk about the anxiety that they were experiencing.

It was like: “Yes they're well-off, but with tons of academic pressure from their parents.” – these were students that [had] like, severe, severe anxiety and couldn't say anything. And so she was the art teacher for it, so it was really cool because she was like: “And I embraced it, and then we made projects about our anxiety.” I was like: “That's badass!”

While Anna and Lindsay did believe that “talking about it” decreases the stigma of mental illness, they were cognizant of the drawbacks of ‘coming out’ as a person who has experienced mental illness. Anna was impressed with the sympathetic media coverage of celebrities who have shared their story of mental illness, but she recognized that talking about it cannot be the only strategy to decrease stigma.

I've really been following what a lot of the media have been covering and I've been really impressed with what I've been seeing. And a lot of celebrities have come out...especially with [the] Robin Williams thing this year, and that was really sad. I think it's improving, but it's like anything – it's going to take time and a lot of effort and a lot of people's parts to make it change, like what you're doing.

Despite Lindsay’s passion to have everyone “talk about it”, she admitted being surprised that a guest on the CBC Radio One show *Writers & Company* named her mental illness – depression – on air.

I remember being shocked that she had used that word on the radio about herself! And it's funny because I'm not someone...you know, I would never think of that as a pejorative word and I've gone through my own things, but I think it was just...even for me I found that it was still surprising to hear people to say: “You know, I've been depressed.” Like, to actually use that language! Because I think

there's still a hesitation around that. And I don't know why that is, because we've got like these publicity things...

Lindsay described the ambivalence involved for people in positions of power when they consider sharing their story about mental illness. One hand, she felt that this would decrease the fear associated with sharing a diagnosis of mental illness: “I think we need more people in those positions of power or celebrity or teachers to give their own personal story to it so that people really understand it isn't something you should be afraid to talk about.” On the other hand, she acknowledged the social consequences of disclosure – in particular, discrimination and devaluation (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Moses, 2009) – that make people hesitant to share such a personal story: “But it’s personal. There are people who will not want to do that. And I think there's a few people who will look at you differently or think less of you.”

Alan had a different view about the impact of talking about mental illness. He conceded that sharing stories about mental illness may help some people, but he also believed that sharing these stories was harming other people: “We are helping people, but we are also putting ideas in people's heads that may not have been there before.” Alan pointed to statistics indicating a rise in mental illness as evidence that hearing stories about mental illness may be causing false diagnoses, or worse, allowing people to fake illness in order to escape responsibility or to obtain unearned advantages. He gave the example of a former coworker who he perceived to use a claim of suffering from mental health problems to take time off from work:

But it does seem there's a lot more people diagnosed with it at this stage if you get what I'm saying? So I think then it's easy for people to use that as...let me put it this way: I worked in a place where somebody got had problems at the same time of the year every year. And he always had stress problems at the same time of the year, every year.

He explained that an “offshoot” of decreasing stigma through talking about mental illness is that people like his former coworker now use mental illness as an excuse to avoid working through negative emotions.

There's the people that [say]: "I'm so depressed" and they're not...They're just tired or they just had a rough...or life's not treating them perfect the way it's supposed to work out. And it's like they can use that as an excuse or... But because of all the discussion about it and trying to eliminate the stigma, you know, there's that offshoot.

Furthermore, he argued that the discourse about encouraging people to talk about their mental illness has gone so far that we have silenced the people who want to question the legitimacy of others' claims of suffering from a mental illness: "It's weird because you wouldn't talk about it before, but now certain people may have it but you can't really talk about it and say: 'Are you sure you have the problem?'" Alan's honest feedback about his perspective provide insight into working with teacher candidates who have a personal connection with mental illness, recognize its legitimacy in some cases, but continue to hold stigmatizing views towards people with mental illness.

Theme 3: Teacher candidates' perceptions of and experience with mental health literacy. In this theme, I contrast teacher candidates' positive perceptions of the importance of mental health literacy with how teacher candidates struggled to demonstrate knowledge of key elements of mental health literacy, including: (a) "the recognition, management, and prevention of mental health problems" (Bourget & Chenier, 2007, p. 4), and (b) "mental disorders and treatments" (Wei, Kutcher, Hines, and MacKay, 2014, p. 1158).

Emma described mental health literacy as "a win-win. Like, you can't do anything but become a better teacher [by learning about mental health literacy] if I'm looking at it through it from a teacher's perspective – like, there is no lose in this." Jessie explained that the benefit of mental health literacy was that it "makes you more aware of yourself, and the people you're with, and the world." She described the term "mental health problem" as "scary-sounding when you don't know the definition," but that "having the literacy to know that it's a norm, to know that it [...] affects yourself and the others around you" allows people to "raise conversation with your peers – whether you're a teacher candidate or a student – and [with] your parents."

For some teacher candidates with lived experience like Simon and Jessie, learning about mental health and mental illness helped them explain troubling thoughts and behaviours in their lives, and helped them discover where, how, and why to seek help. Because Simon was already confident about his abilities to help students with mental illness in his classroom, he confided that he attended Mental Health Literacy Day to learn more about himself, in particular how to better manage “dealing with emotions and how to react, because I tend to shut down.” He acknowledged that “understand[ing] that better” “would probably help myself, but it could help others as well. So I guess that was kind of what I wanted to learn more about.” In fact, he also attended the interview to learn about how to better recognize signs that students could be struggling with a mental health problem.

I don't think I'm well-versed enough in looking for signs in others yet. I think I want to get better at that. Which I guess is another reason why I want to come [to this interview] and maybe talk about things more.

Pauline also observed that students and teachers at her practicum school did not recognize how mental health played a daily role in their lives.

Well you hear it in the hallways, but people don't look at it as mental health. You know, “I'm so stressed, I have so much anxiety, I just threw up because I'm so nervous” – well that's part of mental health! And preparedness or... deep breathing, self-recognition, calming techniques, grounding, body scans – you know, like all the things we need to do as human beings to take care of not only our physical selves but our emotional selves. And somebody who's throwing up before having to do a presentation may not notice that that could be an anxiety issue related to mental health.

While all of the teacher candidates I interviewed described mental health literacy as essential for teachers, many teacher candidates – including those with lived experience – consistently demonstrated confusion and a lack of knowledge about mental illness. As I mentioned earlier, teacher candidates including Lindsay had trouble distinguishing

mental health from mental illness when describing differences between reactions to schizophrenia, depression, and anxiety,

Lindsay: ...okay so there's all different forms of mental health...I guess, um, illness. Mental illness. Is that the term?

Melanie-Anne: Mental illness? Yeah!

Lindsay: So mental illness...

while Nicole, Patricia, and Lindsay had trouble classifying mental illnesses.

Nicole: I think he had ADD...is that considered mental health?

Patricia: And you know we talked about ADHD and ODD and stuff like that which I'm not sure even constitutes a mental health issue or not because I don't know enough...

Lindsay: He's not been assessed so there's no diagnosis if it was an intellectual disability or if it was an attention deficit disorder. And I don't know if attention deficit disorder... Would that fall under a mental health issue? I'm not even sure! Like I don't even know – I have a lot to learn!

Lindsay was also hesitant to use the word “stigma” when she told me that “people don't realize that they're still exuding a bit of...I don't want to say stigma...”

Melanie-Anne: What makes you hesitate to use the word stigma?

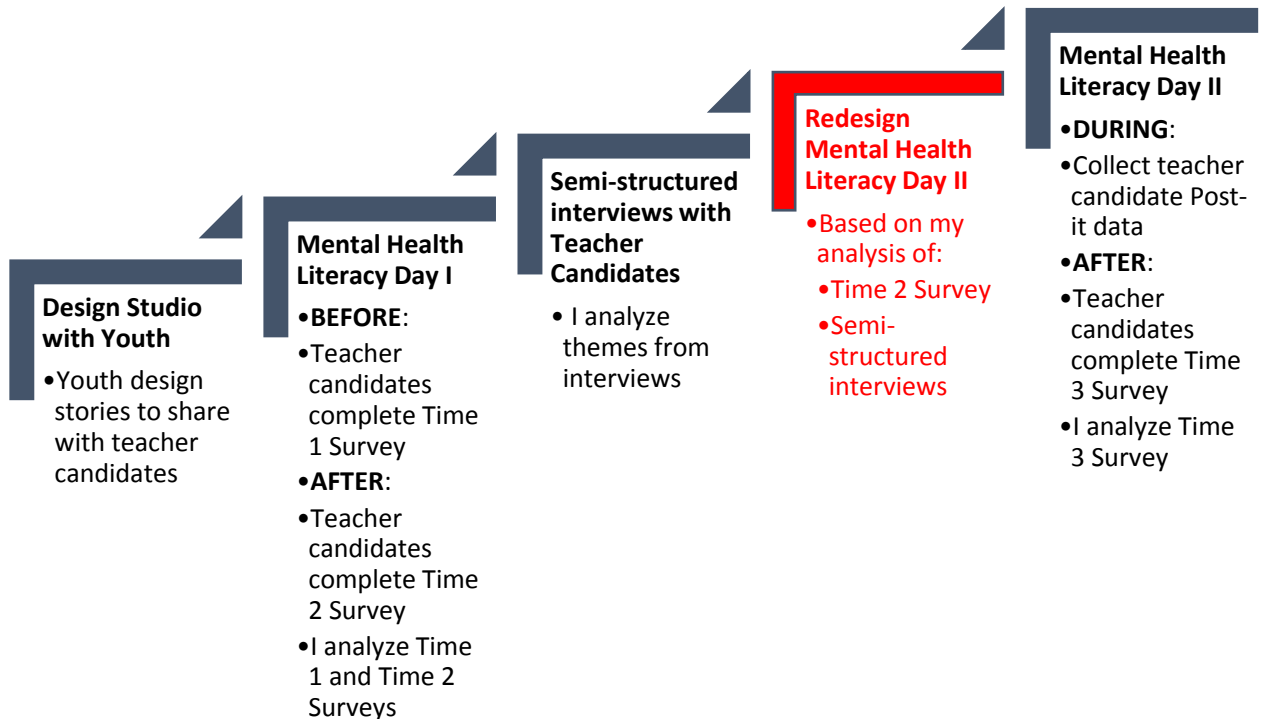
Lindsay: Um, well, I don't know if that's the word I'm trying to use [laughs] I'm on a lot of lack of sleep this week so...but, um yeah – I don't know! I think the other thing is too, we really...maybe I would have appreciated it if we really defined it a little bit.

Melanie-Anne: Defined...?

Lindsay: Defined mental health, and what is mental health? And how, maybe... I don't even know how you would define it but I am imagining some of the things that would be encompassed in that.

This provided me with guidance on the specific topics that had to be covered – or repeated – during Mental Health Literacy Day II.

Redesigning Mental Health Literacy Day



After analysing the results from the quantitative surveys at Time 1 and Time 2, and the eleven semi-structured interviews after Time 2, I gathered local graduate students and faculty members who had research or practical experience in the main areas requested by teacher candidates. This team developed and presented one-hour workshops on the afternoon of Mental Health Literacy Day II. Teacher candidates were given a list of these workshops in advance, and used an online system to register for one workshop. In general, teacher candidates requested more *stories* and more *strategies*.

More stories. Teacher candidates asked for everyone to have the opportunity to listen to youth, as well as other people with lived experience. Anna described how teacher candidates in her session were engaged and affected by Sandra's story:

If you could do more stories like [Sandra], that would...everybody in the room that I was in, like, it was...you could hear a pin drop – everybody was attentive, listening, and I'm sure she affected everybody in that room. I don't think everybody else got that experience.

Although Patricia did not cite youth stories as the most memorable to her during Mental Health Literacy Day, she also requested more stories during Mental Health Literacy Day II:

I don't know how this would be possible, but if there were people who were willing to come share their own personal stories that were adults that are working and existing, and how the family lives and are sort of functioning and living with a mental health illness...

Like youth participant Sandra's comments on academia producing information in "a language that nobody else can speak", Brian felt that mental health literacy education was incomplete without real-life stories from people living with mental illness:

[Information about mental health and mental illness is] coming from academia and all these superpowers like universities and researchers, and it's great, but sometimes I feel like we're missing the actual people who are... which is hard – I'm not here to be like "Tell your story" because it might be a little difficult, but I want to hear those real life stories.

Therefore, we invited a parent of a son with a mental illness to be the keynote speaker, responding to Jacqueline's request to hear from a parent's perspective,

I think the parent perspective is important because you want to be able to talk to the parents, and be sensitive to how they're feeling. Because we're sitting on the other side of the fence so to speak, and for a lot of teacher candidates, they're not parents yet so they can't relate - they don't have their own children. I guess to read a case study is one thing if it's a good case study, but it would be great to talk to someone.

and we replaced the 'John' video with a new story from Samantha, an undergraduate student who struggled with mental illness during middle school and high school.

Samantha had prior experience telling her story to decrease the stigma of mental illness through her involvement with a Canadian network of youth anti-stigma advocates dedicated to reducing youth suicide and increasing youth well-being. I worked with her to ensure that her story achieved what Reinke et al. (2004) call a “moderate disconfirmation” (p. 380) of stereotypes about students living with mental illness, where Samantha spoke honestly about her struggle with mental illness, but described what she was able to achieve as a result of seeking help.

More strategies. Some teacher candidates wanted to learn “tools and strategies” from educators who had experience promoting mental health in the local context. Jacqueline spoke candidly about her desire to hear from local people:

And to be honest, I'm sure you paid a lot of money for that lady to come from the States, but she had a US perspective. And I want to respect the fact that she went to a lot of trouble to come here and I respect her research, but she didn't have perspective on what is London. So maybe have someone with a bit more a local perspectives. We are not impressed, so to speak, by her credentials because it doesn't mean anything to us, really. Just bring in any person who can speak to the subject.

Therefore, we invited educators with experience supporting students with mental illness in the local community. Two sessions during Mental Health Literacy Day II featured an elementary teacher and a high school teacher speaking about their experience promoting mental health and well-being in their classrooms, responding to Nicole’s suggestion to feature “real life experiences of what other beginning teachers have had to deal with in the past within their classroom” and Lindsay’s request to “have actual teachers talk about their personal experiences.”

Patricia explained that differentiating elementary school from secondary school was important because strategies for supporting students differed depending on their age groups:

Because you're going to be dealing with different issues as you get older. First of all, mental health issues – different ones – will come out as students age, and the way others students in the classroom will react [will differ] [...] So different things happen

at different levels and so how to deal with that depending on which age group you're teaching.

Other teacher candidates wanted basic mental health literacy information, including the signs and symptoms of common mental illnesses that teacher candidates might encounter in their classroom. Jacqueline explained that “because everyone's coming from such a range of experiences and backgrounds”, “some people aren't going to be able to tell you what some signs of depression are.” Anna agreed that she wanted Mental Health Literacy Day II to “educate me more and more about the specific mental health issues like depression and that, because people don't understand that kids can go through that.”

Jacqueline also asked for more strategies to help teacher candidates start difficult conversations about mental health with students,

Maybe strategies on how to talk to students – how to have that guidance-type of talk. [For example, should I say:] “I see something's bothering you” or do you say “How are you feeling?” What are those kind of leading questions you can ask students...and different ages, too, because I'm sure you would talk to a Grade 12 [differently] than you would talk to a 4-year-old. So based on age groups, how do you talk to students? How do you get them to open up? And then when do you realize: “Okay I'm backing off,” you know? Where's the boundary?

and parents.

I mean, how do you say “Your child looks hungry today? Why aren't you feeding them? Your child is exhausted – didn't you...” – you know? Like, you can't accuse the parents and you can't be blaming the parents. How do you start those difficult conversations with the parents?

Jacqueline also wanted to know how to support students when they return to school after leaving to seek treatment,

Let's say a child is coming to school with some depression. So now we figure it out – “okay they've got depression.” You're back at school. What does that look like? Does that mean... I don't know... is there an IEP for that? I don't know... does that mean

you give them time if they need to be by themselves, or you don't want them to be by themselves? Do you have a buddy system, somehow find a peer or mentor at the school for them? Then what do you do? Once they're so-called 'recognized' or 'noticed', now how do you support them for the rest of the year? How you continue to support that student?

and procedures for teachers to follow when reporting incidents related to mental health.

I just can't believe there isn't [a protocol that all teachers must follow] in such a regulated industry. There's gotta be something else that has...like, if you suspect this, then talk to this person, and this is the next step and the next step... Or if you think it's just a "maybe I just want to have an off the record conversation about it," what are the steps? Because I think when we all go out there, we'll all be brand-new teachers and we may not...well, we're not going to know what to do. We don't feel we'll know what to do.

Some teacher candidates asked for certain principles to be incorporated into multiple sessions, including self-reflection. Pauline wanted all teacher candidates to explore how their beliefs and experiences influence teaching practices,

I think the exploration about [mental health] from a personal perspective so that we know what we're bringing with us into the classroom is huge. And whether we have bias, or whether we have some things that we need to leave at the door before we walk in. Because, for example, if I didn't think that those with poor mental health could you know do X, Y, and Z, then I'm not going to expect X, Y, and Z – I'm going to ignore it. If I leave that at the door, then it ruins equal [opportunities]

while Brian wanted more discussion of intersectionality during Mental Health Literacy Day II.

I'm always wondering about the lack of intersectionality especially with race and mental health [...] because I feel like in a lot of workshops at this university – this program especially – it is not spoken about. Even the presenters, their own experiences don't reflect my experiences. So I'm just left being like "Ok I like what

you shared, but I'm going to go home and do my own extra research on this.” And especially if I want to work in schools and environments that have [a] highly racialized student body, I want to know what I can do.

Finally, many teacher candidates commented on the unexpected usefulness of their semi-structured interview, and asked to recreate certain elements of our conversation into a session for all teacher candidates. For example, Alan found that the interview helped clarify some of his ideas about mental health, and wanted other teacher candidates to have the opportunity to discuss their ideas about mental health in order to learn from each other and be inspired by their ideas.

...something where it was more like a conversation. [...] Almost like taking this [interview] and putting it into that big place [the auditorium]. And actually having people saying “Oh yeah!” and sharing stories, and making connections and posing questions. [...] And if they're having a really vibrant open conversation about this, you might light some fires, create some ideas [...] Because not everybody is willing to come in [to an interview] and talk like this, and not everybody out there is willing to talk like that there, but I think that there's enough people and once you get enough people taking questions and they say something, someone will say: “Wait a minute, I've got something on that!”

Therefore, we developed two workshops where teacher candidates could discuss and receive feedback from each other about how they supported students during their first practicum, also responding to Jessie's suggestion to have teacher candidates answer the question: “Now that you had your practicum, where did you see mental health arise?”

Jessie's suggestion of giving teacher candidates the opportunity to discuss their experiences during practicum led us to design a new activity for the morning of Mental Health Literacy Day II. Teacher candidates used Post-it® notes to write down the answers to the following prompts, and to display them on the walls of the auditorium:

TAKE OUT YOUR POST-IT NOTES, AND...

- 1. WRITE...**

 - *One thing you did during practicum that makes you feel proud.*

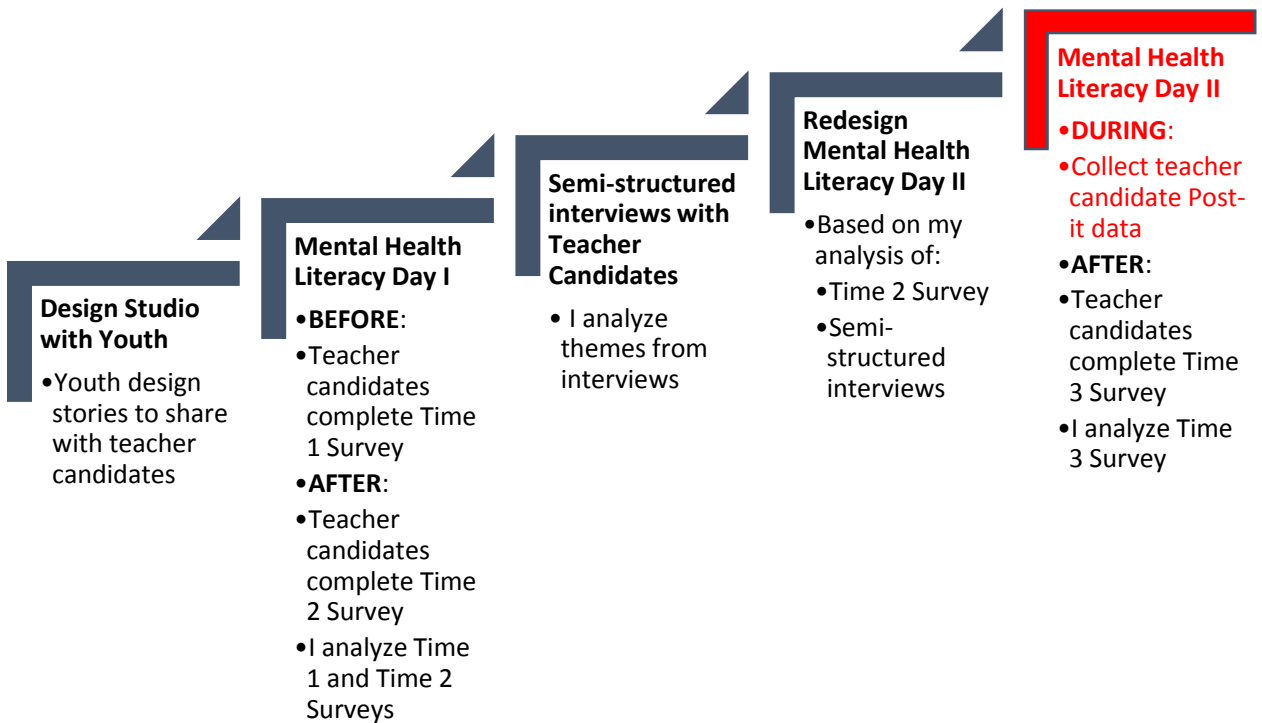
← **POST IT ON THE LEFT WALL**

2. WRITE...

 - *One question you're still wondering about after Mental Health Literacy Day 2014.*

POST IT ON THE RIGHT WALL →

Figure 20. PowerPoint slide presented on Mental Health Literacy Day II.



I categorized teacher candidates' responses to the first prompt into four themes. Please note that all of these responses are transcribed here verbatim, including original punctuation, capitalization, and spelling.

Theme 1: Helping specific students ($n = 13$), where teacher candidates had one particular student in mind when describing their practicum experience. Here, most students described helping a student find success in a particular area for the first time,

I helped a student succeed in my French class, He felt proud of himself for the first time.

I helped students achieve things they hadn't before. I made them smile.

or being the catalyst to help a student overcome a challenge.

I helped a student who was struggling/failing and everyone gave up on him – he succeeded in all of his classes when I left.

Believed in a student everyone gave up on.

Helped a kid to believe in himself enough to write and pass math exam.

Theme 2: Personal goals and achievements ($n = 9$), where teacher candidates described success maintaining positive attitudes,

Maintained a willingness to learn & be open to new strategies.

Went in with an open mind and stayed positive throughout the entire process

I WAS AWESOME EVERY DAY

completing specific tasks,

I kept up my council duties during practicum and still had a social life.

I was proud of my classroom management!

receiving positive feedback from staff and students,

I owned my class environment & got a superstar practicum report

I had students tell me I was the best teacher they had ever had!

or simply completing practicum.

Made it through!

proud I completed it.

Theme 3: Contributing positively to the classroom environment ($n = 18$), where teacher candidates described the steps they took to get to know their students,

I LEARNED ALL MY STUDENT'S NAMES!

said hello to students every day

Coached team and connected w/ students on a different level

integrate students' ideas into their lessons,

I innovated a lesson plan based on student feedback to immediate success.

Incorporated student's interests into the lesson

and to be a positive influence at their practicum schools.

Building Community! Brightening Days!

I made my kids laugh! 😊

– maintained a good relationship with students and staff

Theme 4: Curricular and extra-curricular accomplishments ($n = 17$), where teacher candidates described activities they led in the classroom,

Planned a perfect + successful 3-part lesson in family life + math crosscurricular.

My creative activities for assessment

Got students to know more about (+ interested in) space exploration!

Taught my gr. 5/6 students modular origami. It was challenging, but they enjoyed it very much.

and outside the classroom at their practicum schools.

Volunteered to coach school teams, sports are great for promoting mental health

Conducted a piece at the school music sharing night

Conduct Senior Band in their Winter Concert

Running an Art Club during lunch. The posters are up around school.

Teacher candidates also provided responses to the second prompt: *One question you're still wondering about after Mental Health Literacy Day 2014*. I categorized their responses into themes in order to evaluate whether the planned sessions corresponded to the topics teacher candidates wanted to learn about. I found that for all but the fifth theme, the majority of questions were answered by one or more of the workshops that we had planned. Similar to what Rothi et al. (2008) found, teacher candidates in my study had remaining questions about “how to manage children with mental health problems in the classroom” (p. 1223). This theme, labelled here as *How Can I Help?* was the largest and most diverse theme, with 21 teacher candidates asking questions about how they could support students with mental illness in their classroom.

Seven teacher candidates also had questions about “recognition and sources of support” (Rothi et al., 2008), here represented by the theme *What Are The Signs?* Because Mental Health Literacy Day I featured a resource fair, only three teacher candidates requested more “information on appropriate referral agencies” (Rothi et al., 2008), asking *What Are The Resources?* In addition to what Rothi et al. found, seven teacher candidates also had questions about taking care of their own mental health (*What About Teacher Mental Health?*) and seven teacher candidates questioned the value of another Mental Health Literacy Day (*Why Am I Here Again?*)

Theme 1: How Can I Help? ($n = 21$) As illustrated in Figure 21, the majority of teacher candidate questions in this theme corresponded to two workshops. There were five additional questions, two covered by other workshops, and three not covered by any workshops we planned. The question:

How can I help a student who is really sensitive? Is vulnerable to bullying/isolation

was addressed in the workshop called *What Are They Trying To Tell Us? Understanding mental health in the elementary years*. The question:

How can I create a positive atmosphere (regarding mental health) in my class

was addressed in the workshop called *How to Really Keep Calm and Carry On: What makes a mentally healthy classroom?*

However, we did not design any workshops that specifically answered the following questions:

how to help loved ones

Strategies to modify and differentiate for non-compliant/behavioural students

How can you ensure your differentiated lesson was effective?

Active Listening, Empathy, & Empowerment: Supporting high school students in crisis	What Mental Health Looks Like in the Classroom
<ul style="list-style-type: none"> • <i>What to do if you suspect a child is depressed</i> • <i>How can we be more approachable to struggling older teen students?</i> • <i>How do I help a student without making them feel isolated, ostracized, and sad?</i> • <i>How to cope with students who don't show up because of depression?</i> • <i>What is the best way to deal with students who are suffering from a traumatic experience</i> • <i>Is it ok to directly ask if someone is depressed or suicidal</i> • <i>If a student discusses problems and feelings that reflect issues with their mental health, How do you go about helping them?</i> 	<ul style="list-style-type: none"> • <i>What's the best and/or most effective way to address Mental Health issues?</i> • <i>How do we help student coap if we don't know</i> • <i>How do you address students w/ mental illness in positive ways?</i> • <i>How can I effectively accommodate without making the student feel isolated?</i> • <i>What are my roles as a teacher when dealing with students struggling with their mental health?</i> • <i>What borders and limitations do we have when talking to parents about mental health</i>

Figure 21. Teacher candidate questions answered by Mental Health Literacy Day II workshops

Theme 2: What Are The Resources? ($n = 3$). Although Mental Health Literacy Day I featured a mental health resource fair, three teacher candidates wanted to know about the resources available for teachers:

What resources are available to me?

What resources are available to teachers?

Need useful list of resources for self & students.

The workshop called *Nurturing Mental Health Literacy in Canadian School Contexts: What teachers need to know to support student mental well-being* gave teacher candidates the opportunity to work together to create an “online database of shareable resources, tools, and teaching strategies to eliminate stigma and promote the well-being of students, families, and communities.”

Theme 3: What Are The Signs? ($n = 7$). The workshop called *What Mental Health Looks Like in the Classroom* helped teacher candidates answer the majority of questions in this category, including:

How to identify mental health issues in the classroom

How am I going to recognize signs of mental health issues + what to do about it.

I wonder about warning signs

Bad day vs mental health

The workshop called *What Are They Trying To Tell Us? Understanding mental health in the elementary years* addressed the question:

I wonder what mental illness looks like in p/j students...

Theme 4: What About Teachers' Mental Health? ($n = 7$). The majority of teacher candidates' questions about how to support their own mental health, such as:

– What About Teacher Burnout?

How about our mental health?

How can we help TEACHERS with their own mental health?

As a teacher, if you struggle with feeling overwhelmed what are your options?

were addressed in the workshop called *How to Really Keep Calm and Carry On: What makes a mentally healthy classroom?* and in the end-of-day talk about self-care that was repeated from Mental Health Literacy Day I.

However, we did not precisely address the question:

Do teachers get actual “mental health” days off?

Theme 5: Why Am I Here Again? ($n = 8$). Some teacher candidates questioned why they were required to attend another mandatory Mental Health Literacy Day,

Why?

Why am I here?

Why are we here again?

what they would learn,

How much will I ACTUALLY learn here?

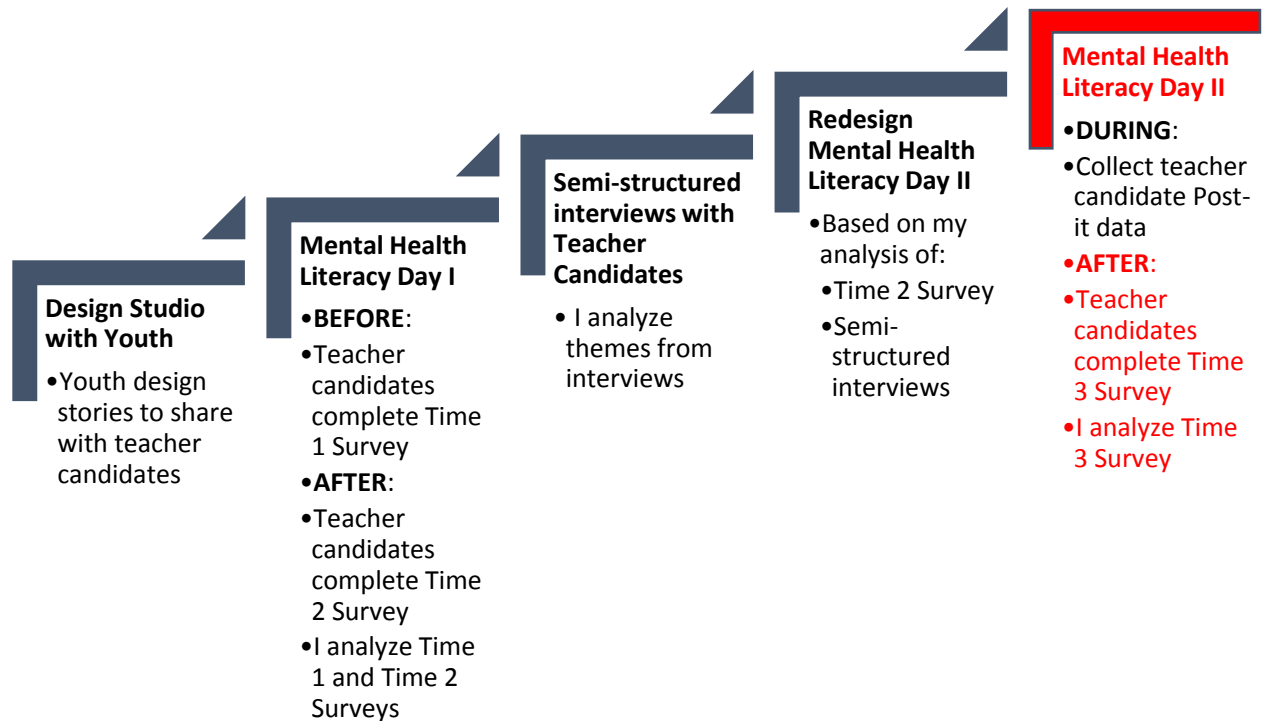
and how Mental Health Literacy Day II would be different from the last one.

Why are we here again and having mental health during Ed. Psych.

What is different about this mental health day from the last one?

What differs today from the previous mental health day ☺

We did not design any workshop to specifically answer these questions, but I posed the question to the group, and teacher candidates took turns at the microphone to speak about why they felt that mental health literacy was important for teachers to learn about. These responses were not recorded because they were not part of the ethics protocol.



Like Mental Health Literacy Day I, most teacher candidates did not attend the afternoon portion of the day. However, the afternoon attendance numbers were even lower for Mental Health Literacy Day II: on average, between four and eight teacher candidates attended each afternoon workshop. The workshop with highest attendance was *What Mental Health Looks Like in the Classroom*, where approximately 25 teacher candidates attended. No teacher candidates attended the workshop called *Cross Talk: Building Mental Health Strategies through Dialogue*. Of the 46 teacher candidates who completed the survey after Mental Health Literacy Day II, four teacher candidates reported that they did not attend the morning session to hear youth stories, and five reported that they did not attend an afternoon workshop.

Of the 28 teacher candidates who described the biggest impact on them during Mental Health Literacy Day II, 19 (68%) specifically mentioned stories of lived experience. Again, all comments from teacher candidates are transcribed here verbatim. Ten teacher candidates chose youth stories,

The first section where we moved to different rooms. I was in Dr. [facilitator]'s room. It was amazing to hear the speaker talk about her life.

[Samantha]'s video was very impactful. I learned a lot from it.

The speaker who was so strong while discussing her experience with the school and PTSD. I felt a lot of the teachers listening were curious and had little to no knowledge regarding this disorder, and although many uncomfortable, line-crossing, near inappropriate questions were asked she handled the room with grace, and intelligence and was really an inspiration. I regret not saying this to her more explicitly after her speech that she conducted herself unfathomably well. She is the reason I saw today why this type of learning is so essential. She dealt with ignorance very well, especially given how personally difficult and sensitive the topic is.

six teacher candidates chose the keynote speaker's story of being a parent of a son with mental illness,

The mothers story. I am amazed by her dedication to her son. Mental health affects the whole family

I was reminded (by [the keynote speaker]) that mental illness doesn't discriminate - it can happen to anybody.

the perspective of a parent of a student with a mental illness. I hadn't realized how difficult it can be for the family, or how much a student with mental illness has accomplished, even if they have simply completed a task.

and three teacher candidates wrote that both stories had the biggest impact on them that day.

Candy! Just kidding! The first hand experiences of the keynote speaker in dealing with the mental health issues of her children and how it affects the whole family. Also the video of [Samantha]'s story.

Of the 28 teacher candidates who chose to describe the most important thing they learned during Mental Health Literacy Day II, the majority of teacher candidates described resources they uncovered,

That there are many different resources available in London and outside areas that I can use to create a supportive classroom with my future students.

suicide intervention workshops in London this summer.

strategies they learned,

Too many things to write. I liked the keep calm session and the practical ways to make a mentally healthy classroom ideas she provided.

How to approach someone who may be struggling with mental health issue. The importance of developing a trusting relationship with all my students and knowing how to listen when they talk.

The importance of not brushing anxiety aside but rather talk about it so the child learns to self monitor

-the importance of listening to parents about their children and working cooperatively with parents - not to diagnose but to be subtle, supportive, and gather information when you suspect a child may have a mental illness

or a combination of both.

Listen with compassion and be aware of community resources to connect students with.

Some resources for self care. Awesome gym time at lunch for techniques!

That showing you care can be so helpful even if you don't know what to say. You can follow up with them when you have the resources to refer a student to.

One teacher candidate concluded that mental health literacy should be embedded into a course – rather than taught during two professional development days – because it was essential for all teachers to learn.

The this type of learning is essential. I felt as though a lot of the questions asked today were inappropriate for teachers about to go into professional practice, and that this learning should be embedded into our courses and lives everyday rather than just two professional days. It is clear to me that I will be teaching this to my students when i leave here, but I know see it is essential for it to be taught in the faculty of ed. a psych course should me mandatory.

Overall Summary of Quantitative and Qualitative Results

In conclusion, the contact-based intervention was not associated with a decrease in public stigma among teacher candidates. At the same time, teacher candidates did use qualitative methods to describe the benefits they felt they received from listening to youth stories. Teacher candidates who completed semi-structured interviews offered candid insights into their perceptions of and personal experiences with the stigma of mental illness. Although many teacher candidates struggled to take care of their mental health during practicum, they appreciated the awareness raised during Mental Health Literacy Day about the central role of mental health in their lives and in the lives of their students.

Most teacher candidates felt motivated by this increased awareness to further pursue independent learning, but some teacher candidates hoped that their teacher education program could provide them with more concrete strategies about how to create and sustain a mentally healthy classroom. The final Mental Health Literacy Day was well-received but poorly attended. The topics presented during the Day closely matched the remaining questions that teacher candidates raised, and teacher candidates who did attend the newly-designed workshops reported satisfaction by the mental health literacy education they received.

Chapter 6: Summary, Implications, and Conclusion

The purpose of this study was to examine the issue of mental illness stigma in Canada. While awareness about mental illness has increased, stigma has not followed with a concurrent decrease. I wanted to investigate the stigma of mental illness specifically in the context of schools, in order to find a way to decrease the stigma of mental illness in the education context. Examining the literature revealed that personal contact with individuals who have the lived experience of mental illness was a promising way to decrease stigma. Based on this research, I hypothesized that simply learning *about* mental illness might not be enough to change attitudes about the cost of decreasing social distance to people with lived experience – perhaps the general public must interact with and learn *from* these individuals in order to experience a more permanent shift in their conceptualization of mental illness. In fact, Angermeyer and Dietrich (2006) found in their population studies review that people who viewed individuals with schizophrenia as “particularly intelligent and gifted” (p. 171) were most likely to decrease their social distance towards these individuals. I wanted to know whether the same principle could apply to the classroom, where youth with lived experience telling their own stories could shift the view of students with mental illness from a deficit model to a strengths-based model. It was my aim that these strength-based stories would positively influence the way that teachers responded to students living with mental illness in their classroom.

Therefore, I formulated a multi-stage study in the context of schools to examine the effect of personal contact with youth who identify as having a mental illness on the stigma of mental illness among teacher candidates. In the summer, I used qualitative research to document the progression of the knowledge, ideas, and community that developed among youth with lived experience while they worked through an anti-stigma workbook and formulated their stories for teacher candidates. In the fall, I used quantitative instruments to measure changes in teacher candidates’ mental illness stigma as a result of adding an anti-stigma intervention to their mental health literacy professional development day. I also used qualitative methods in the form of written short-answer questions and semi-structured interviews to investigate how teacher candidates developed practices to promote their own and their students’ mental health

during practicum. In the winter, I incorporated the feedback from teacher candidates to reformulate the second and final mental health literacy professional development day.

Youth Living with Mental Illness

Seven youth with lived experience participated in a design studio and two focus groups that I facilitated to complete a program designed by Dr Patrick Corrigan, a prolific scholar in the field of mental illness stigma research. Corrigan's program included a workbook, *Coming Out Proud to Eliminate the Stigma of Mental Illness* (2014), which guides adults with mental illness through the decision of 'coming out' about their mental illness, and then the action of preparing their story.

Using focus groups. I added two focus groups to the program so that youth participants could speak about their experiences in the design studio or discuss any additional topics that were not covered during the design studio. Kitzinger (1995) agrees that focus groups are an especially appropriate method when the researcher "wishes to encourage research participants to explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities. When group dynamics work well the participants work alongside the research, taking the research in new and often unexpected directions." (p. 299). These goals are reflective of the affirming attitudes I described in Chapter 2, and align with the philosophy of the design studio. Therefore, I worked alongside youth participants to establish group dynamics such that youth participants felt encouraged to pursue their own priorities when: (a) driving the agenda of workbook-related activities, (b) making decisions about whether and when to share their stories with the group, and (c) shaping the format of the stories they chose to share with teacher candidates.

According to Barbour (2014), researchers who primarily examine the content of focus group discussions tend to "emphasize outputs, such as the development of appropriate health promotion materials (often for disadvantaged or marginalized groups with specific cultural needs)" (p. 315). This appears to be the primary use of focus groups in design studios, where the interaction between participants serves the purpose of a high-quality, relevant output, such as a workbook for youth seeking to tell their story about mental illness. In contrast, other researchers use focus groups to "address theoretical or disciplinary concerns. Here the focus is on form and process, rather than content or

outputs. In this iteration, focus groups are prized for their capacity to illuminate empirically a theoretical construct” (Barbour, 2014, p. 315). In this study, the theoretical construct under investigation was the experience of – and response to – stigma among youth who identified as having the lived experience of mental illness. Youth participants in this study shed light on how constructing their identity as advocates with lived experience counteracted public and private stigma. Using focus groups allowed me as the researcher “to access the process through which participants simultaneously manage their individual identities and make a collective representation to the researcher.” (Barbour, 2014, p. 315)

Using the design studio. I used a design studio with youth in order to: (1) co-create curriculum for teacher candidates based on what they had learned from their experiences with the stigma of mental illness during their years at school, and (2) have youth contribute to the current dearth of research examining how youth with mental illness reflect on, formulate, and share their stories with the purpose of decreasing the stigma of mental illness.

Co-creation. The process of the co-creation with youth involved a gradual development of trust between youth participants from Organization X and myself as the facilitator/researcher. Initially, our plan was to use Corrigan’s workbook in two ways: (a) to participate in all of the readings, discussions, and activities listed in the workbook in order to thoroughly consider the costs of benefits of sharing their story with teacher candidates, and (b) to evaluate the suitability of the workbook as a basis for a future project where the same youth would design their own version of a manual written for youth, by youth.

One hour into the first day of the study, the second goal came into direct conflict with the first goal: Youth decided that Corrigan’s workbook was not suitable for their purposes, and one participant even described the workbook as “harmful” for youth deciding whether or not to share their story. I followed Barbour’s (2014) recommendation for researchers to pay attention to the way that participants “‘problematize’ our questions and language” (p. 319) – for example, the way that youth reacted strongly to the underlying assumptions in the use of the word “secret” to describe

concealing a diagnosis. The concerns that youth participants raised in my study revealed a tension between fulfilling the expectations of my study's ethics protocol and promoting self-determination in youth living with mental illness. Sutton & Kemp (2006) explain that researchers who wish to engage in collaboratory research with members of the community must work to bridge "the social and spatial lines that separate academia from its surroundings." (Sutton & Kemp, 2006, p. 125) Sutton and Kemp (2006) explain that this separation can occur through misunderstandings between researchers and community members, when, for example, researchers fail to recognize community members as equal partners in the inquiry process, or when community members "perceive the university as 'ivory towerish' and disinterested in embracing the knowledge [community members] have of their own circumstances." (Sutton & Kemp, 2006, p. 125)

Recall that in Chapter 2, I introduced self-determination as a goal underlying the way that I conducted research with youth participants. Therefore, I had to take an active role in resolving the tension between fulfilling the ethics protocol and promoting youth participants' self-determination. Fisher and Freshwater (2014) agree that self-determination is "vital" (p. 204) when working with individuals with lived experience. They explain that promoting self-determination "requires people with mental health problems to gain epistemic authority in the public sphere through the telling of stories and the development of new narrative templates" (Fisher & Freshwater, 2014, p. 204).

Youth participants and I resolved, then, to continue examining of the costs and benefits of telling their story, while *at the same time* working on alternative activities to supplement or replace troubling sections in the workbook. For example, youth participants replaced the template included in the workbook with another one that better suited their needs, then later replaced the workbook completely as a basis for building their youth-oriented workbook. Instead, they developed an infographic and a video to help youth consider the costs and benefits of sharing their story.

The process of designing alternative activities provided youth with the opportunity to engage in more than just creation. It allowed youth participants to also critically analyse the text of the workbook. Youth took the lead during each day of the process to apply a critical lens to the workbook. Many youth explained that they were motivated to participate in this project in order to restore a sense of dignity to the process

of telling their story. Roberge (2013) says that “[t]o become critically aware readers, students must move beyond simple comprehension of text to a deeper understanding of the underlying meanings, a critical reflection on the text’s purpose and an awareness of the techniques use to influence the reader.”(p. 2) For example, the youth in this study answered questions suggested by Roberge (2013) to encourage critical literacy, including:

- Is the author trying to send a deeper message? Who might agree/disagree with this message?
- Are other viewpoints missing?
- What technique(s) has the author used in this story to influence the reader?
- How might the text differ if it had been written by someone else?
- Who is marginalized in this text? Who is empowered? (Roberge, 2013, p. 2)

Roberge (2013) notes that “deepening students’ understanding of social justice through critical literacy equips them with knowledge that may help them to perceive and take action against injustice.”(p. 1) Youth in this study, who were already members of an advocacy group for youth with mental illness, recognized this project as an opportunity to mobilize social change by joining forces with teacher candidates to show them the very real impact that teachers’ actions can have in the lives of their students.

Contributing knowledge. In addition to co-creating curriculum for teacher candidates, youth also contributed their voices to the dearth of research examining the perspectives of youth living with mental illness. Sutton and Kemp (2006) argue that the perspectives of people with lived experience are “essential to implementing any interventions academics may propose.” (p. 125) Because youth spoke about their experiences of marginalization, where they often had less power and less agency than the adults who often made decisions for them at school, I followed Saldana’s (2013) recommendation to use in vivo coding as a method to analyze the design studio and focus group transcripts, where as often as possible, I used words and phrases “from the actual language found in the qualitative data record” (p. 91). Using the words of youth participants to code their transcripts allowed me to add to the body of language that researchers use to speak about people with lived experience, because it is derived from

their language and their experience, rather than from researchers studying their experience and naming it according to their interpretations. For example, tracking the use of “old school” and “secrets” deepened my understanding of what youth in my study considered to be representative and unrepresentative of youth culture, and helped me understand why they believed that Corrigan’s workbook was written for adults, by adults. Using in vivo coding was a purposeful way to honour the voice of the youth with lived experience as having the most knowledge about their experience.

Youth participants in my study told me that their opinions and self-knowledge were often devalued because of the disempowering stereotypes associated with people living with mental illness. They expressed frustration at finding their voices missing from documents, policies, and practices intended to serve them. Youth argued that their lived experience gave them a *higher* amount of mental health literacy than the average population because living with mental illness motivated them to research their illness in order to better understand and advocate for themselves. They saw my study as an opportunity to pass on the pride of that self-knowledge to others who were still struggling with coming to terms with a diagnosis of mental illness. None of the youth participants considered themselves to be cured of their mental illness, and most described coming to a place of acceptance that they live every day with mental illness.

Youth’s stories have often been told without their consent, which for many led to instances of marginalization because of what others assumed about their identity. However, youth responded to public stigma by taking ownership of their story, reconceptualizing their identity around their unique strengths, and positioning themselves as mental health advocates with vital, insider knowledge about what it is like to live with mental illness. Therefore, youth who chose to share their story judged the benefits of disclosure to greatly outweigh the stigmatizing costs. At the same time, they did not minimize the significant costs and complications to disclosure, some of which continue to be stigmatizing in their personal lives. In response, youth developed protective responses to situations in which disclosure resulted in increased social distance.

On the other hand, youth participants in this study also affirmed the decisions of those who chose not to disclose their diagnosis of mental illness, and strongly objected to

assumptions that non-disclosure was motivated by shame. Instead, these youth advocated for every person's right to privacy. In fact, the one participant who completed the design studio and both focus groups but did not share her story continues to work in the field of mental health advocacy. In contrast to other youth participants who described their participation in mental health advocacy as an outgrowth of their identity as a person living with mental illness, this youth participant has chosen to position herself as an *ally* of people with mental illness in her professional life.

The result of the design studio was that five of the seven youth chose to share their story with teacher candidates. Two youth shared their story anonymously – one through a spoken word video performed by a third party, and one through an audio recording and drawings that I arranged into a [video](#). Three youth shared their stories using speeches – two presented in person and one pre-recorded a YouTube video. Corrigan (2014) proposes that “[s]tories of recovery that contrast one’s mental health challenges with hopeful consequences and personal accomplishments are most effective” (p.56) in decreasing the stigma of mental illness. Therefore, youth used a template to craft personal stories that followed these principles.

Most of the youth’s stories tended not to confirm many stereotypes, because they viewed themselves from a strengths-based perspective where they considered events that were precipitated by, or resulted from, their mental illness as strengths. At the same time, youth avoided presenting their stories as what Reinke et al. (2004) call “markedly ‘atypical’” (p. 379): Reinke and her colleagues explain that contact experiences where individuals with mental illness appear exceptional tend to make public stereotypes about people with mental illness more extreme, rather than diminishing them. Therefore, Reinke et al. recommend a contact experience featuring “moderate disconfirmation” of mental illness stereotypes (p. 380). Although all of the youth considered their stories to represent moderate disconfirmation, some teacher candidates felt that one youth’s story confirmed too many stereotypes. This story was replaced with another youth story for Mental Health Literacy Day II.

In conclusion, youth reflected that they participated in this study to encourage others to reclaim and remake their story, and thus their identity, on their own terms.

Being mindful of the costs of sharing their stories, they put limits and parameters around their disclosure, in order to protect themselves and others. They saw telling their story as a new, vital kind of education for teacher candidates, and felt satisfaction in being able to help decrease the stigma of mental illness among teacher candidates through education.

Teacher Candidates at the Faculty of Education

I chose teacher candidates as the audience for youth stories because in an environment where there is an increased awareness of the prevalence of mental health problems in schools, teacher candidates continue to be underserved in opportunities to learn how to meet the needs of students living with mental illness. My hypothesis was that teacher candidates would report lower levels of public stigma as a result of listening to the story of a young person living with mental illness.

This study design is similar to other contact-based interventions (see Dalky, 2012), where a person with lived experience shares his or her story with an audience, and takes questions afterwards. Most of these studies are based on Weiner's Attribution Theory, where people are driven to discriminatory behaviour because they believe that mental illness stems from individuals failing to take personal responsibility for their illness. In other words, they believe that individuals continue to have mental illnesses because they do not try hard enough to stop their symptoms. Newer studies are also influenced by Corrigan's work, where Corrigan argues that people's drive to discriminate also comes from their perception that individuals with mental illnesses are dangerous.

However, examining the literature testing these theories revealed inconsistent results. For example, Phelan (2005) found that attributing the cause of a mental illness to genes – an uncontrollable cause – led to decreased agreement with punishment towards a person with a mental illness. This finding was in accordance with Weiner's theory, which predicts that discriminatory behaviours will decrease when the general public attributes mental illness to an uncontrollable cause. However in the same study, Phelan (2005) also found that attribution had no effect on social distance: Participants randomly assigned to read a vignette about a person whose mental illness was either "due to genetic factors", "partly due to genetic or hereditary factors", or "not due to genetic or hereditary factors" (p. 312) showed no significant difference towards the person with the mental illness.

Worse still, attributing the cause of a mental illness to genes (called “geneticization”) *increased* social distance towards the *sibling* of the person with the mental illness. This finding contradicted Weiner’s theory that an uncontrollable attribution would lead to decreased social distance.

Phelan (2005) reasoned that on one hand, attributing mental illness to genetics avoids blaming the parent’s behaviours as the cause of his or her child’s mental illness. This is an important finding because historically, parents were often blamed for causing or heavily contributing to their child’s mental illness. On the other hand, attributing the mental illness to a genetic cause did not appear to be the solution to decreased public stigma either: geneticization in Phelan’s study shifted the painful consequences of social distance to the younger relatives of the person with the mental illness because they were seen as more likely to also inherit a mental illness. Participants who attributed mental illness to genetics were less likely to want a child of theirs to date, marry, or have a baby with a sibling of a person with mental illness. Phelan determined that fears surrounding “genetic contamination are most salient for younger relatives [of the person with mental illness], individuals who will be seeking mates and who may be seen as squarely in the risk period for developing the illness themselves” (Phelan, 2005, p. 318).

These ambivalent results led Phelan (2005) to conclude that “the processes described by attribution theory and genetic essentialism are not mutually exclusive, and these findings support the idea that the effects of geneticization on stigma are complex, ameliorating stigma along some dimensions while exacerbating it along others.” (p. 318) These studies provide good examples of instances where a mixed methods approach could have provided the researchers with “deeper levels of explanation and understanding” (McEvoy & Richards, 2006, p. 69). Using qualitative research in the form of interviews or focus groups in addition to their quantitative measures could have given this study’s participants the opportunity to challenge or explain their interpretations of the meaning behind their responses on quantitative scales.

Therefore in my study, I used mixed methods to test my hypothesis. Teacher candidates completed a survey that included: (a) the AQ-9, a 9-item quantitative scale that measures nine aspects of public stigma, including people’s perceptions about the personal responsibility and level of dangerousness of an individual with mental illness;

(b) two short-answer questions where teacher candidates reflected on their experience at Mental Health Literacy Day by completing the sentences: “The most important thing I learned today was...” and “What made the biggest impact on me today was...”; and (c) a modified version of the Opening Minds Scale for Health Care Providers (OMS-HC), a 12-item quantitative scale that in addition to measuring public stigma, also measures two aspects of private stigma: (1) self-perceptions of having a mental illness and (2) attitudes towards disclosing one’s own mental illness.

Using mixed methods reflected my pragmatic approach to answering the research questions posed in this study and acknowledging my personal biases as a researcher. This suggests an axiological dimension to pragmatic research – researchers are called to be ethical to our participants, our community of academic scholars, and to the community with which we share our research findings (Johnson and Onwuegbuzie, 2004). Therefore, in this study, I used statistical analyses, triangulation, and negative case sampling as validity checks to keep myself and my research accountable to my participants (Johnson and Onwuegbuzie, 2004). I used triangulation to compare and contrast the impact of youth stories on teacher candidates by examining the data provided by teacher candidates’ responses to the quantitative measures of public and private stigma, the qualitative short-answer questions in the online survey, and the semi-structured interviews. I used negative case sampling to capture the perspective of one teacher candidate who, unlike other interviewees, was extremely dissatisfied with Mental Health Literacy Day I. As a pragmatic researcher, I acknowledge that my findings and conclusions are temporal, tentative, and ultimately fallible, where there are always alternate explanations to the same set of data (Johnson and Onwuegbuzie, 2004).

Results from Mental Health Literacy Day I. Quantitative methods of analysis revealed that the contact-based intervention was not significantly associated with a decrease in public or private stigma. In other words, there was no significant difference between stigmatizing attitudes for teacher candidates who were in the control group compared with teacher candidates who listened to youth stories. Corrigan et al. (2012), writing about the advantage of contact over education, observed that “[m]eeting people with serious mental illness seems to do more to challenge stigma than educationally

contrasting myths versus facts of mental illness” (p. 969). However, the quantitative analysis in this study revealed that, like Papish et al.’s (2013) study with medical students, education was just as effective as contact in challenging stigma. This could be because the education we provided to teacher candidates in the control group went beyond simply contrasting myths versus facts.

In our control condition, teacher candidates learned about: the context of mental health in Canadian schools; the experience of students struggling with emotional distress in the classroom; the detrimental effects of stigma as a barrier to help-seeking; the Keyes two-factor model (dispelling the myth that students with mental illness cannot have mental health, and promoting the view that everyone has mental health. This helped teacher candidates uncouple the concept of mental illness with mental health); the individual, family, and environmental factors that contribute to mental health (dispelling the myth that mental health is only or primarily determined by internal factors); the influence of mental health on all aspects of human development and well-being; and the reasons, roles, and responsibility of teachers and schools in being actively involved in mental health. In designing Mental Health Literacy Day, we also led by example, choosing presenters and facilitators who demonstrated to teacher candidates how they as fellow educators were contributing positively to the welfare of students with mental illness. Teacher candidates may have been able to better imagine their role in their students’ lives because of the information they received about *how* they could contribute.

In contrast to the non-significant quantitative results, teacher candidates’ qualitative responses in the survey revealed that a majority found youth stories especially impactful: 74% of the teacher candidates who were placed in an intervention group specifically cited youth stories as having the greatest impact on them during Mental Health Literacy Day. This also corresponds to Papish et al.’s (2013) study, where students viewed contact-based education as the most effective teaching method and cited contact-based education as “having the greatest impact on increasing their confidence in working with people with mental illness” (p. 6).

What was the impact on teacher candidates? Semi-structured interviews with the nine teacher candidates who were placed in intervention groups revealed that they

respected the bravery, honesty, professionalism, and agency of youth telling their stories about mental illness. Hearing about the consequences of encountering teachers who acted – or failed to act – in the lives of youth struggling with mental illness spoke to the sense of calling that many teacher candidates felt to the teaching profession by reinforcing their sense of duty to care for struggling students. Hearing directly from a youth's experience with mental illness in school also personalized the role that these teacher candidates hoped to play in the lives of their students. Teacher candidates appreciated that youth themselves were opening a dialogue with teacher candidates about what teachers could do to better support students with mental illness in the classroom. Having a frank discussion about teacher roles with youth and discussion facilitators boosted teacher candidates' confidence about their ability to support these students, especially for teacher candidates who had personal experience with mental illness.

Personal contact may have also promoted teacher candidates' sense of empathy when relating to students struggling with mental illness. As I described in Chapter 2, one of the behavioural consequences of stigma involves increasing social distance, where people become less willing to engage in relationships with individuals perceived to have a mental illness. In contrast, connecting with the story of a young person who struggled with the negative emotions accompanying his or her mental illness prompted many teacher candidates to recall a time in their life when they also felt emotional distress, regardless of whether or not it led to a diagnosed mental illness. Sharing in common experiences of sadness, preoccupation, anxiety, or fear may have contributed to disrupting the tendency to 'Other' individuals with mental illnesses (e.g., see Kumashiro, 2002) because teacher candidates recognized aspects of themselves in the stories of youth with lived experience. What's more, some teacher candidates described how hearing about youth's road to recovery in spite of prejudicial barriers, marginalizing practices, and discriminatory obstacles motivated teacher candidates to take a more active role in the lives of their students or in advocating for mentally healthy practices at school (Corrigan, Roe, & Tsang, 2011).

Results from Mental Health Literacy Day II. Although teacher candidates felt more aware of the importance of meeting the needs of students who struggle with poor

mental health, some teacher candidates did not feel that they had learned about enough tools to help these students. Other teacher candidates admitted during semi-structured interviews that they continued to hold stigmatizing attitudes towards students with mental illness despite what they learned at Mental Health Literacy Day I. Uncovering these stigmatizing attitudes in teacher candidates required me as the researcher to adopt a non-judgmental stance during the semi-structured interviews (DiCicco-Bloom & Crabtree, 2006). Because of the amount of missing data from the quantitative measures of public stigma, I needed to be attentive, understanding, and empathetic when teacher candidates revealed stigmatizing attitudes in order to gain more insight into why teacher candidates continued to struggle with public or private stigma.

Teacher candidates would often begin by testing my reaction: They would tell me about an experience with a person who seemed to confirm a negative stereotype about people with mental illness. When I affirmed – rather than minimized – their experience and asked follow-up questions to learn more information (rather than to provoke an argument), they would gradually reveal that this experience was actually indicative of a stigmatizing belief that they held. They knew that as future teachers, they “should” not be prejudiced, but they struggled to reconcile that professional obligation with their personal beliefs. For teacher candidates holding stigmatizing attitudes, we entered the co-operative phase of the semi-structured interview (DiCicco-Bloom & Crabtree, 2006) as teacher candidates realized that this interview was their opportunity to discuss challenging topics without condemnation, and to contribute to the design of a second professional development workshop – Mental Health Literacy Day II – that would better address their concerns.

Therefore I assembled a team of graduate students, teachers, and mental health professionals to redesign the second Mental Health Literacy Day. This second day provided teacher candidates with: (a) more stories of lived experience from multiple perspectives, and (b) more strategies to help teacher candidates create a mentally healthy classroom. The progression of the design and delivery of Mental Health Literacy Day for teacher candidates also reflected a gradual shift towards co-production. Slay and Stephens (2013) have adapted Arnstein’s (1969) *Ladder of Participation* to show how this process can occur (see Figure 22).

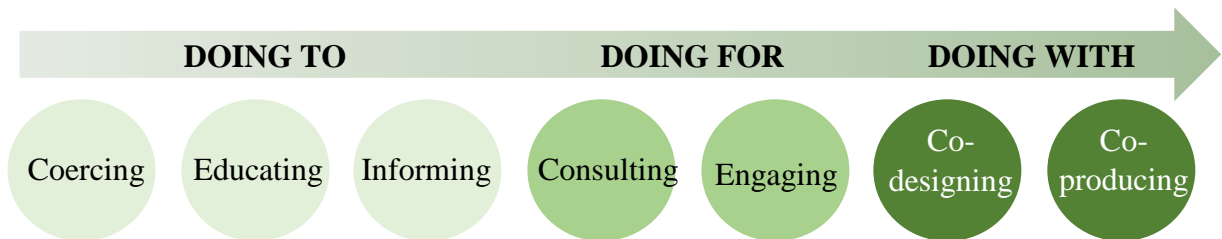


Figure 22. Slay and Stephens' (2013) adaptation of Arnstein's (1969) Ladder of Participation.

Slay and Stephens (2013) explain that services delivered at the *Doing To* stage are intended to educate the service recipients so that they conform to the service providers' norms and standards. Here, recipients “are not invited to participate in the design or delivery of the service; they are simply supposed to agree that it will do them good and let the service ‘happen to them’.”(p. 3) This is also the model most often used when delivering curriculum and professional development to teacher candidates. In this case study, teacher candidates were required to attend Mental Health Literacy Day as part of their mandatory professional development. Extensive consultation to plan and deliver curriculum happened between mental health service providers, researchers, and professors, but teacher candidates were not given a primary role in planning the curriculum delivered on the day. However, teacher candidates were given the opportunity to teach and learn from each other throughout the day, during breakout sessions and at the debrief at the end of the day, where teacher candidates shared best practices for self-care during practicum.

Over the course of this case study, the curriculum design gradually progressed towards the *Doing With* stage. “Co-designing a service involves sharing decision-making power with people. This means that people’s voices must be heard, valued, debated, and then – most importantly – acted upon.” (Slay & Stephens, 2013, p. 4) When I used mixed methods to consult with teacher candidates, I acted on their recommendations to revamp and then co-produce the curriculum proposed by teacher candidates. Future iterations of Mental Health Literacy Day can engage in the *Doing With* process even further by having

teacher candidates deliver professional development workshops of their own design to their peers.

During the second Mental Health Literacy Day, all teacher candidates had the opportunity to listen to youth stories. Teacher candidates were also able to choose one workshop that corresponded to the needs teacher candidates identified after the first Mental Health Literacy Day. For some teacher candidates, this second Mental Health Literacy Day raised their awareness about the importance of addressing mental health in the classroom, and it motivated them to continue their learning about mental health in the classroom. For other teacher candidates, the second Mental Health Literacy Day helped them feel more empowered and less hopeless about their role in creating a healthy environment for students living with mental illness.

Study Limitations

A large amount of attrition (especially in the second Mental Health Literacy Day) occurred in the number of teacher candidates who actually attended the breakout sessions they registered for. This greatly limited the number of teacher candidates who could truthfully complete the quantitative measures, but also limited the number of teacher candidates who experienced mental health literacy education before their practicums. Both Mental Health Literacy Days I and II occurred on the last day before the end of the terms, so many final assignments were due. For most teacher candidates, the practical urgency of completing school assignments may have outweighed imagined future benefits of attending Mental Health Literacy Day workshops. The timing of the professional development day should be revisited, and mandatory sign-in for afternoon workshop sessions should be considered.

In the quantitative data, there was a large amount of missing data for the AQ-9 measure. This could have been because teacher candidates were permitted to skip any questions that they did not want to answer, which severely limited the reliability of the data and greatly compromised the power of the statistical analyses. Therefore, a study that depends on quantitative data to examine the effect of an intervention should consider ways to encourage participants to answer all – or a larger amount – of the items in the questionnaire. However, there was very little missing data in the Opening Minds Scale.

This could have been because of the more indirect nature of the questions asked, as compared to the AQ-9: The AQ-9 asked teacher candidates to respond directly to a specific student with mental illness, while the Opening Minds Scale took a more indirect route, asking about people with mental illness in general.

On the other hand, I found a distinct floor effect in the Opening Minds Scale data, where teacher candidates professed to have extremely low levels of public and personal stigma (see Table 4). Therefore, a measure of social desirability and/or an implicit measure of stigma such as the Implicit Association Test or the Go/No-Go Association Task (e.g., see Kopera et al., 2015) should be considered to be used alongside explicit measures of stigma, if the goal of the study is to use quantitative measures to assess a topic such as stigma, where most study participants – especially members of helping professions – will aspire to hold non-stigmatizing attitudes, and may therefore be reluctant to report or be unaware of stigmatizing attitudes that remain.

Finally, the quantitative measures used in this study may not have captured the variables that corresponded to the impact that youth stories had on teacher candidates. For example, a measure like the one that Clement et al. (2012) used may have better captured the emotional impact that teacher candidates in my study described in the qualitative data.

Implications from the Interaction between Teacher Candidates and Youth: Mutual Effects

Recall that in Chapter 1, I argued that from a relational-cultural theory perspective, the ultimate benefit of personal contact lies in the *mutual effects* of engaging in a growth-fostering relationship. As partners in the relationship grow towards each other, they develop mutual “empathy and mutual empowerment” (Duffey & Somody, 2011, p. 226). Darling-Hammond (2000), writing about teacher education, argues “[a] commitment to open inquiry, the enlargement of perspectives, and the crossing of boundaries are critical features of the ideal university education.” (p. 171) Let us explore these three principles, in reverse order.

Crossing boundaries. During teacher’s college, teacher candidates are positioned as students learning from experienced educators when they attend classes at the Faculty

of Education. However, during practicum, teacher candidates are expected to take on the role of knowledge disseminators in more traditional classrooms, and facilitators to learning in more modern classrooms. In either case, the teacher candidate is positioned as the one in charge of the classroom who dictates what, how, and when the learning will occur. In contrast, teacher candidates' students during practicum are positioned as the ones who will receive or participate in the learning. In this study, boundaries between the lived experience of teacher candidates and youth were crossed when it was the youth who acted as co-facilitators of a session where they themselves embodied the knowledge that teacher candidates needed to learn. In this situation, the youth were the experts in the room, while the teacher candidates were positioned as the learners who required the insight of the youth with lived experience.

Enlarging perspectives. The anti-stigma intervention during Mental Health Literacy Day allowed both teacher candidates and youth with lived experience to enlarge their perspectives about each other. Unlike a static case study, youth complicated stereotypes and taken-for granted assumptions about mental illness by describing the ups and downs and ultimately unfinished story of a young person with a mental illness. Hearing first-hand from one particular young person about what it is really like to be a student living with a mental illness, teacher candidates enlarged their perspective from detachment – theorizing about a fictional student in a case study – to emotional investment through empathy. This reflects the reality of teaching, which eventually requires the emotional investment of all who continue in the profession.

This process also required emotional investment and empathy from the youth who told their stories. The youth participants in this study had to work through the emotional burden of reliving some of the most difficult times in their lives in order to put themselves in the shoes of a teacher to consider how best to craft a relevant and impactful message to that particular audience. Youth who told their story in person to teacher candidates had to go through this process another time as teacher candidates reacted to youth's stories, and youth responded to teacher candidates' questions, concerns, and ideas about their challenges, confusion, and hope for their teaching careers.

Open inquiry. This study also served as an initial opportunity to promote open inquiry for both youth with lived experience and teacher candidates. Youth explored this process in the summer when they saw the need for a resource to help other young people better prepare to ‘come out’ about their experiences with mental illness. They used Corrigan’s (2014) anti-stigma workbook as a starting point for this inquiry, and then extended this inquiry process into what could make the workbook more relevant for youth. After we worked through the manual, youth had to tailor their message specifically to teachers. There were no guidelines or best practices to follow – instead youth spoke from the heart about what they thought teachers needed to hear. Teacher candidates responded to the youth in kind, sharing their own experiences with stigma and inquiring about what they could do to make their classroom a better place for students struggling with mental illness.

In conclusion, the focus of educational interventions to decrease the stigma of mental illness must evolve beyond raising awareness about mental health or presenting myths and facts about mental illness. This generation’s teacher candidates are ready to move towards more complex content, including identifying the signs and symptoms of specific mental illness, developing strategies to create and sustain a mentally healthy classroom, decreasing the stigma associated with mental illness, increasing knowledge about how to seek help for mental health problems, and investigating additional resources to support all of these areas. Youth and other people with lived experience are also ready and willing to contribute their voices to shaping mental health literacy education. However, teacher candidates should not be the only ones receiving mental health literacy education – only when mental health is a shared responsibility among all school stakeholders will we be able to move beyond small gains in decreasing interpersonal stigma towards larger structural changes that truly improve the lives of students living with mental illness.

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Appendix A



Western
Research

Research Ethics

Western University Health Science Research Ethics Board
NMREB Amendment Approval Notice

Principal Investigator: Dr. Susan Rodger
Department & Institution: Education\Faculty of Education, Western University

NMREB File Number: 105261
Study Title: In My Own Words: Youth with Lived Experience Sharing Their Stories of Mental Health
Sponsor:

NMREB Revision Approval Date: June 16, 2014
NMREB Expiry Date: March 31, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Revised Western University Protocol	Audio recording now mandatory for working sessions, Program schedule change, Compensation change (from \$10 to \$20 per day), Data collection location change (from mindyourmind to the Faculty of Education)	2014/06/16
Revised Letter of Information & Consent		2014/06/16
Recruitment Items		2014/06/16

The Western University Non-Medical Science Research Ethics Board (NMREB) has reviewed and approved the amendment to the above named study, as of the NMREB Amendment Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000941.

Ethics Officer, on behalf of Ritey Hinson, NMREB Chair

Ethics Officer to Contact for Further Information

This is an official document. Please retain the original in your files.

Western University, Research, Support Services Bldg., Rm. 5150

Appendix B



In My Own Words: Youth with Lived Experience Sharing Their Stories of Mental Health

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Introduction

We are a research team from The Centre for School-Based Mental Health at Western University's Faculty of Education. Dr. Susan Rodger is a professor and Melanie-Anne Atkins is a PhD student at the Faculty of Education. We are seeking to gain an understanding of the process by which youth with lived experience create, share, and reflect on their own experiences with mental health. As a young person who has had prior experience with *Organization X*, a nonprofit organization that works alongside youth to support their mental health, we the research team would like to invite you to participate in this study.

Purpose of the study

Youth with lived experience are often called to speak about their experiences with mental illness. However, no guidelines are commonly used that describe how to tailor this process to be in the best interests of youth during the process of telling. This study is designed so that we (the researchers) can collaborate with you (youth with lived experience) to participate in the process from beginning to end, including: making a decision about whether or not to tell your story; if you decide to tell your story, then formulating it; evaluating your experiences during the process; and providing recommendations for other youth who are considering sharing their stories, and who go on to decide that they will or will not, and for the organizations that invite them to do so.

If you agree to participate

If you choose to participate, we will ask for your permission to participate in a 2-week group that includes the researchers and 6-10 other participants. During Week 1, we will meet for 4 hours per day, for **three** days in a row. During Week 2, we will meet for 4 hours per day, for **two** days in a row. Each day, we will meet at the Faculty of Education (1137 Western Road) in a private room. At the start of each session, you will receive two bus tickets and \$20 to assist you with transportation to and from the Faculty. You are under no obligation to stay for the session after receiving your bus tickets and \$20.

During Week 1 (3 days, 4 hours per day), we will work through a workbook called *Coming Out Proud to Eliminate the Stigma of Mental Illness* by Blythe A. Buchholz and Patrick W. Corrigan. This workbook is designed as a guide through the process of coming to the decision of whether or not to share your story. While working through this workbook, we will ask for your feedback on how to improve it to meet the needs of youth specifically. Each session will be audio-recorded.

At the end of Week 1, you will be invited to participate in an audio-recorded interview or focus group, describing your experiences working with the workbook, and making the decision to share (or not to share) your story. You can choose whether or not to participate in this interview or focus group.

During Week 2 (2 days, 4 hours per day), you will be invited to create your story about your experience with mental illness in your own words, using whatever format you choose, including artwork, prose, poems, etc.

At the end of Week 2, you will be invited to participate in an audio-recorded interview or focus group describing your experiences creating your story, in order to formulate recommendations for other youth storytellers and for the organizations who invite youth to tell their stories. Again, you can choose whether or not to participate in this interview or focus group.

This totals five, 4-hour sessions, over a two-week period if you decide to complete the whole process. You can withdraw your participation and stop attending the sessions at any time. You can decide not to come to a session, decide not to participate in the research taking place during any of the sessions, or refuse to answer any particular questions as you choose.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your academic status. If you choose to withdraw from the study, any data collected from you will not be used or published.

Confidentiality

The information collected will be used for research purposes only, and neither your name nor any identifying information will be used in any publication or presentation of the study results. We cannot guarantee confidentiality of information stemming from the group experience or focus group, but all members of the group will be reminded of the confidential nature of the study and asked to not talk about the group conversation outside of the group. All written information collected (story creations, survey responses, and interview/focus group transcripts) for the study will be kept confidential in the possession of Western's research team; only whole group findings and themes will be shared.

Risks & Benefits

There are minimal risks to this study; however, while reflecting on your experiences with mental health you might find that you need some support for your mental health. Therefore, at the beginning of each session, we the researchers will review the mental health resources available to you at Organization X and in your community. If you experience psychological distress at any time during the program, you should leave the program and seek help immediately. As Organization X says on their website, "Sharing your story is important, however, if you are in crisis it may not be the right time. Your safety comes first. Get the help you need and deserve, and come back to submit your story at a better time."

This research can benefit organizations that seek out youth with lived experience by providing them with youth-informed recommendations that better speak to the needs of the young people they desire to support.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, refuse to share your story, or withdraw from the study at any time. If you withdraw from the study at any time, you are not obligated to attend any of the remaining sessions. Deciding to not participate, or withdrawing at any point from participating, will not have any negative consequences for you with respect to your relationship with Organization X.

Questions

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, The University of Western Ontario at xxx-xxx-xxxx or xxx@uwo.ca. If you have any questions about this study, please contact Dr. Susan Rodger (Phone: xxx-xxx-xxxx or Email: xxx@uwo.ca). This letter is yours to keep for future reference.

Sincerely,

The Research Team

Dr. Susan Rodger & Ms. Melanie-Anne Atkins



In My Own Words: Youth with Lived Experience Sharing Their Stories of Mental Health

Dr. Susan Rodger & Melanie-Anne Atkins

Faculty of Education

Western University

I have read the Letter of Information, have had the nature of the study explained to me by a member of the research team listed above, and I agree to participate. All questions or concerns have been addressed to my satisfaction.

***Please initial your choice of the options below:

_____ YES, I agree to participate, to be audio-recorded, and to have my words transcribed from the audio recording during the 2-week program.

_____ YES, I am willing to participate in a **focus group** for research purposes during the 2- week program

_____ YES, I am willing to participate in an **interview** for research purposes during the 2- week program

_____ NO, I am not willing to participate in a **focus group or interview** for research purposes during the 2-week program.

Printed Name: _____

Signature: _____ Date: _____

Name of Person Obtaining Informed Consent: _____

Signature of Person Obtaining Informed Consent: _____

Date: _____

Appendix C



Western
Research

Research Ethics

Western University Health Science Research Ethics Board
NMREB Delegated Initial Approval Notice

Principal Investigator: Dr. Susan Rodger
Department & Institution: Education\Faculty of Education, Western University

NMREB File Number: 105667
Study Title: Evaluating Bachelor of Education Students' Learnings: Mental Health Day Fall 2014
Sponsor:

NMREB Initial Approval Date: September 23, 2014
NMREB Expiry Date: April 30, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Western University Protocol		2014/09/15
Letter of Information & Consent	LOI with changes in accordance with Board recommendations	2014/09/15
Recruitment Items	recruitment email for the post-event survey	2014/09/15
Recruitment Items	recruitment email for the Pre-event survey	2014/09/15
Instruments	online survey	2014/09/15

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

[Redacted Signature]
Ethics Officer on behalf of Riley Hinson, NMREB Chair, or Board Member designee

Ethics Officer to Contact for Further Information

This is an official document. Please retain the original in your files.

Western University, Research, Support Services Bldg., Rm. 5150
[Redacted Contact Information]

Appendix D

Email Message Pre Mental Health Literacy Day I

SUBJECT: Mental Health Literacy Day Survey

BODY: Dear Teacher Education Candidates:

On October 3rd, you will attend the Mental Health Literacy Day as part of your professional development at the Faculty of Education. We invite you to fill out a survey *before* and *after* the day in order to evaluate how effective the day was. If you would like to participate, please click on the link below – it will take you to an online survey about your mental health knowledge, skills, and attitudes. If you choose to participate, please complete this survey before October 3rd.

The survey takes approximately 25 minutes, and if you choose to participate your name will be entered into a draw to win one of five \$50 bookstore gift cards. Participation is voluntary and will have no effect on your grades or status as a student in the Teacher Education Program. If you would like to participate, please click on the link below. You will be asked to sign in with your UWO sign-on and password, and will be taken to the Letter of Information and the survey. We have also attached the Letter of Information here, which provides further details about your rights as a participant and confidentiality. Thanks for considering this request, and have a terrific day,

Susan Rodger and Melanie-Anne Atkins, Western University

Email Message Post Mental Health Literacy Day I

SUBJECT: Survey to evaluate the Mental Health Literacy Day

BODY: Dear Teacher Education Candidates:

If you have attended the Mental Health Literacy Day today (October 3rd), we would like to invite you to participate in a survey about what you heard, saw, and learned. The survey takes approximately 25 minutes, and if you choose to participate your name will be entered into a draw to win one of five \$50 bookstore gift cards. Participation is voluntary and will have no effect on your grades or status as a student in the Teacher Education Program. If you would like to participate, please click on the link below. You will be asked to sign in with your UWO sign-on and password, and will be taken to the Letter of Information, and the survey. Thanks for considering this request, and have a terrific day,

Susan Rodger and Melanie-Anne Atkins, Western University

Email Message Post Mental Health Literacy Day II

SUBJECT: Survey to evaluate the Mental Health Literacy Day

BODY: Dear Teacher Education Candidates:

If you have attended the Mental Health Literacy Day today (February 27), we would like to invite you to participate in a survey about what you heard, saw, and learned. The survey takes approximately 25 minutes, and if you choose to participate your name will be entered into a draw to win one of five \$50 bookstore gift cards. Participation is voluntary and will have no effect on your grades or status as a student in the Teacher Education Program. If you would like to participate, please click on the link below. You will be asked to sign in with your UWO sign-on and password, and will be taken to the Letter of Information, and the survey. Thanks for considering this request, and have a terrific day,

Susan Rodger and Melanie-Anne Atkins, Western University

Appendix E



**Western
Education**

LETTER OF INFORMATION

**Evaluating Bachelor of Education Students' Learnings:
Mental Health Day Fall 2014**

Introduction

Our names are Susan Rodger (PhD., C. Psych.) and Melanie-Anne Atkins (PhD Candidate). We are a research team from the Faculty of Education at Western University and are currently conducting research on teacher mental health literacy and we invite you to participate in this study.

Purpose of the study

The aim of this study is to determine the effectiveness of a mental health workshop day related to student and teacher mental health and education.

If you agree to participate

If you agree to participate in this study, you will be asked in September to fill out an electronic survey, where you will be asked to reflect on your knowledge, skills, and attitudes about mental health, and to complete the survey as accurately as possible. After mental health day is complete, a link to a post-workshop evaluation in the form of a *second* electronic survey will be emailed to you. In that second survey, you will also be asked if you would like to be contacted after the workshop to participate in an interview or focus group about the workshop. Each survey should take no more than 25 minutes to complete. Completion of the surveys will help us to determine how helpful this effort was, and areas that we can focus improvement on to provide future teachers with needed mental health resources. Your name will be entered into a draw for one of five (5) \$50 bookstore gift cards. Winners will be drawn randomly from all participants, and notified via email after the workshop day.

Confidentiality

The information collected will be used for research purposes only, and neither your name nor any identifying information will be used in any publication or presentation of the study results. All information collected for the study will be kept confidential and will not impact your grades in any way.

Risks & Benefits

There are no known risks to participating in this study.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your academic status. Completion of the survey implies your consent to participate.

Questions

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, The University of Western Ontario at xxx-xxx-xxxx or xxx@uwo.ca. If you have any questions about this study, please contact Dr. Susan Rodger (Phone: xxx xxx-xxxx, ext. xxxxx or Email: xxx@uwo.ca). This letter is yours to keep for future reference.

Appendix F

Mental Health Literacy Day I Schedule

Time	Activity
8:45-9:00	Students enter the Auditorium, swipe student cards
9:00-9:15	Welcome remarks and introductions
9:15-10:15	Morning Keynote Session
10:15-10:20	Intro to the next session: students choose candy to be assigned to groups
10:20-10:35	Break- transition to breakout session
10:35-11:45	Intervention vs control session- Session will either be (I): small group presentation and discussion with a youth with lived experience of mental illness; or (Usual) a presentation in the auditorium.
11:45-12:30	Nutrition break and Resource Fair (gym): granola bars and apples will be available in the gym
11:45-12:30	Break for lunch
12:30-12:45	Welcome back and introductions
12:45-1:45	Afternoon Keynote Session: Ways that teachers can get involved and make a difference
1:45-2:30	Tips for wellness and self-care for teacher candidates, summary of the day, and evaluation; prize draws for those present, and encouragement to do the post-survey

Appendix G

Questions for Mental Health Literacy Day Discussion Facilitators**General questions suitable for any video**

- What were the main issues presented in the video?
- If you were in this student's shoes, how would you have reacted?
- What signs and symptoms did the student show?
 - Which were obvious? Which were hidden?
- What support was the student looking for?
- What kind of support did this student need? How do you know?
- What support did this student need from his/her teachers specifically?
- What prevented the student from getting the support s/he needed?

Joan

- Joan says that not only did her school fail to support her, but didn't have the means to. What did her school need to support her?
- What can you do in a school that lacks ideal resources? As a teacher, where do you start?
 - What could you recommend?
 - What could you implement?
- How did Joan's school get things right?
- How did Joan's school get things wrong?
- How do you think her private information got 'leaked'?
 - How could this happen among students?
 - How could this happen among teachers?
 - Is it a 'violation' of her confidentiality? Why or why not?
- What might have caused a teacher to tell Joan to drop out?
 - What should have been done?
 - What would you as a teacher say?
- What message did Joan have for students?
 - Do you agree? Disagree?
 - Is there a more important message that you think your students need to hear?
 - Why is this message hard to hear or understand?
 - How can you communicate this message to your students?
- What message did Joan have for teachers?
- Joan described two kinds of teachers she encountered at school. What were they like?
- What did Joan mean when she said that some teachers "don't believe that mental health is an actual thing"?
 - Have you ever encountered anyone who shared this view?
 - What did you do? What did you say?
- What was on Joan's wishlist?
 - Which items do you agree with? Which do you disagree with?
 - What items can you affect?

- What did Joan say was the best support you can give? Why?

Raina

- What were the main issues that Raina presented in her video?
- How did Raina school get things right?
- How did Raina school get things wrong?
- Why do you think Raina decided to tell her story?
- When Raina decided to ask a teacher for help, what did the teacher do?
 - If you were in Raina's shoes, how would you have reacted as a result?
 - Imagine that you were the teacher who heard the Raina's teacher call Raina "the crazy girl". What would you do next?
- What signs and symptoms did Raina experience?
 - Which were obvious? Which were hidden?
 - What signs would you expect a depressed student to show?
 - How was Raina's behavior similar and different to what you would expect?
 - Do you think Raina would have received more support if her behavior had not made her a 'challenging' student? Why?
 - As a teacher, how do you plan to confront challenging behavior from your students? What have you been taught? What have you seen? What you have experienced? What will you do differently?
- What support was Raina looking for?
- What prevented Raina from getting the support she needed?
- What kind of support did Raina need? How do you know?
- What support did Raina need from her teachers specifically?
- What kind of support from teachers made a difference in Raina's life?
- How will you support a student like Raina?

John

- Why do you think John chose to tell his story this way?
- What did his story mean to you?
- While making this video, John also discussed some differences between 'how it is for guys' vs how depression and anxiety is seen and treated for women and girls. What do you think? Is there a difference between how depression, anxiety, and/or suicide are seen in boys and girls?
 - How about how it is treated or handled or discussed?
 - Would you discuss it in your classroom? Why or why not?
- After watching this video, do you think John belongs in your classroom? Why or why not? What things would you like to find out more about?
- What kind of support does John need as a student in your class? How do you know? How will you find out?
- What kind of support can you provide?
- What kind of support should you provide?
- Imagine that John has just submitted this project as a creative writing assignment in your class. What do you do next?

Appendix H



Evaluating Bachelor of Education Students' Learnings:
Mental Health Day Fall 2014

**LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN
RESEARCH**

Introduction

My name is Melanie-Anne Atkins and I am a PhD student at the Faculty of Education at Western University, and Dr Susan Rodger (PhD., C. Psych.) is my supervisor. We are conducting research on teacher mental health literacy, and invite you to participate in this study.

Purpose of the study

The aim of this study is to determine the effectiveness of a mental health literacy workshop day related to student and teacher mental health and education.

If you agree to participate

If you agree to participate in the study, you will be asked to take part in an interview at a time and place convenient to you. The interview will take no more than one hour to complete, during which you will be asked to reflect on what you think about mental health literacy, and what you heard, saw, and learned at the mental health literacy workshop day. This interview will be audio recorded.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your academic status. If you choose to withdraw from the study, any data collected from you will not be used or published.

Confidentiality

The information collected will be used for research purposes only, and neither your name nor any identifying information will be used in any publication or presentation of the

study results. All information collected for the study will be kept confidential and will not impact your grades in any way.

Risks & Benefits

While there are no known risks to participating in this study, you might find that talking about your experience participating in the mental health workshop day is upsetting. At the beginning of the interview, you will be provided with a list of local mental health resources that you may find useful.

Ethics and Privacy Considerations

The data you provide will be kept confidential. No names or identifying information will be attached to the data or included in the final study report. Transcribed data will be destroyed after a period of 5 years (electronic data will be deleted and hard copies will be shredded). The electronic transcript data will be kept on a password-protected computer. Hard copies of transcripts from interviews and field notes will be kept in a locked filing cabinet in the researcher's office for five years.

Publication

The results of this study are intended for publication. Your name will not be used. If you wish to receive a summary of the research, and/or access to the entire thesis once completed, please provide your email address and grant permission to be contacted.

Questions

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, The University of Western Ontario at xxx-xxx-xxxx or xxx@uwo.ca. If you have any questions about this study, please contact Dr. Susan Rodger (Phone: xxx-xxx-xxxx or Email: xxx@uwo.ca). This letter is yours to keep for future reference.

Thank you,

Susan Rodger, PhD., C. Psych
Associate Professor, Faculty of Education
Western University

Melanie-Anne Atkins,
PhD Candidate, Faculty of Education
Western University
Email: xxx@uwo.ca



Evaluating Bachelor of Education Students' Learnings:

Mental Health Day Fall 2014

Dr. Susan Rodger (PhD., C. Psych.)
Faculty of Education
Western University

Melanie-Anne Atkins (PhD Candidate)
Faculty of Education
Western University

I have read the Letter of Information, have had the nature of the study explained to me by a member of the research team listed above, and I agree to participate. All questions or concerns have been addressed to my satisfaction.

_____ YES, I agree to participate and be audio-recorded during the interview.

I provide consent to be contacted for the purposes of:

_____ YES, I agree to be contacted via email with a summary of results from present study

_____ YES, I agree to be contacted via email when the completed thesis is available on Scholarship Western.

If answering YES to further contact, my email address:

Printed Name: _____

Signature: _____ Date: _____

Name of Person Obtaining Informed Consent:

Signature of Person Obtaining Informed Consent: _____

Date: _____

Appendix I

Mental Health Literacy Day II Schedule

8:30-9:00am	Auditorium	Students sign in, facilitators pass out Post-it® notes.
9:00-9:15am	Auditorium	Welcome remarks and introductions of all facilitators & presenters
9:15-10:15am	Auditorium	Keynote Speaker: [Parent of student with mental illness]
10:15-10:30am	Auditorium	Melanie-Anne Atkins explains transition; all facilitators lead groups to breakout rooms
10:30-11:45am	Room 1	[Quinn] and [facilitator]
	Room 2	[Sandra] and [facilitator]
	Room 3	[Samantha]'s video with [two facilitators]
	Room 4	[Raina]'s video with [two facilitators]
	Room 5	Joan's video with [two facilitators]
	Gym	<i>Take a Minute for Your Mind</i> with [two facilitators]
12:45pm-1:00pm	Auditorium	Welcome back and instructions for afternoon sessions
1:00-2:00pm	Auditorium	<i>What Mental Health Looks Like in the Classroom</i>
	Room 1	<i>Active Listening, Empathy, & Empowerment: Supporting high school students in crisis</i>
	Room 2	<i>What Are They Trying To Tell Us? Understanding mental health in the elementary years</i>
	Room 3	<i>Cross talk: Building mental health strategies through dialogue</i>
	Room 4	<i>Practicum Experiences: Let's chat!</i>
	Room 5	<i>Nurturing Mental Health Literacy in Canadian School Contexts: What teachers need to know to support student mental well-being</i>
	Room 6	<i>How to Really Keep Calm and Carry On: What makes a mentally healthy classroom?</i>
	Room 7	<i>Conversation Hour with [Classroom teachers]</i>
2:00-2:20pm	Auditorium	Teacher candidates play Jeopardy-style game with [Quinn and facilitator] as summary of the day's learnings
2:20-2:30pm	Auditorium	Wrap up

Appendix J

Interview Guide for Teacher Candidate Participants

1. What drew you to participate in this interview?
2. You recently attended a “mental health literacy” workshop here at the Faculty of Education. The *Canadian Alliance on Mental Illness and Mental Health* defines mental health literacy as: “the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems. Enhanced mental health literacy appears to confer a range of benefits: prevention, early recognition and intervention, and reduction of stigma associated with mental illness.” (http://camimh.ca/wp-content/uploads/2012/04/Mental-Health-Literacy_-_Full-Final-Report_EN.pdf)
 - a. What do you think of this definition?
 - b. Is mental health literacy important for teachers?
 - i. Why or why not?
 - c. Has this workshop helped enhance your mental health literacy?
 - i. If so, how?
 - What was most helpful?
 - What was most meaningful?
 - What did you want more of?
 - How does it relate to what you think you’ll encounter in your classroom(s)?
 - ii. If not (or if some parts were not helpful), how can we improve?
3. What are some of the biggest challenges we face in meeting the mental health needs of children and youth?
 - a. How should we address them?
 - i. What have you already seen being done?
 - ii. What still needs to be done?
 - b. What about the mental health needs of teachers?
 - i. How should we address them?
 1. What have you already seen being done?
 2. What still needs to be done?

Appendix K

Main Issues Raised by Youth Participants Responding to the “COMING OUT PROUD to Eliminate the Stigma of Mental Illness” Workbook

Main issue raised by youth participants: This title unnecessarily co-opts the experiences and perspectives of LGBT youth. A better title is “Telling Your Story”.

LESSON 1: Considering the Pros and Cons of Disclosing

Part 1: Do You Identify Yourself as a Person With Mental Illness?

Main issues:

1. An **introduction** to this manual needs to be written, including:
 - a. The **Canadian context** of mental illness stigma, education, and resources in Canada.
 - b. The **reasons why this manual was rewritten for youth**.
2. **Remove** or generalize all **religious examples** used in the manual/workbook.
3. Two problems with the examples of Marie and John:
 - a. The representations of their identities were **too binary**. They agreed more with the statement on page 14 of the manual: “Self-Identification is Not a Yes-No Question”
 - b. The examples should be **redrawn using examples of youth** – not adults. For example, most youth don’t have prestigious jobs, so this is not relatable or aspirational.
4. It’s important to **affirm one’s personal choice and honour diverse perspectives**, regardless of whether the individual chooses to identify with mental illness.
5. The manual fails to consider **the impact of personality** (rather than the degree of shame or sorrow over the person’s experience with mental illness) on the way a person might identify with their mental illness.

Part 2: Secrets are Part of Life

Main issue:

1. Youth participants could not understand why this even needed to be said. They strongly advocated for the **elimination of this section** because of the degree of shame associated with the word ‘secret’. They recommended it be replaced by a statement that affirms **everyone’s right to privacy**.

Part 3: Considering the Pros and Cons of Disclosing

Main issues:

1. Two statements need to be added or emphasized:

- a. **Disclosure is not a one-time process** – it is an ongoing journey that changes at each point of disclosure.
 - b. **Disclosure is a two-way street:** Both parties have rights, responsibilities, and expectations.
2. Phase 1 participants recommended that this section cover the following, in this order:
 - a. **Your Disclosure Goal**
 - i. This should come first because it influences how you weigh the costs and benefits of disclosing
 - b. **Costs and Benefits** to disclosing (but they disliked the chart contrasting costs and benefits – they had no suggestion on how to improve this)
 3. Youth participants disagreed with the **overall negative tone** of this section. They felt that participants would almost certainly decide not to disclose as a result of completing this section.

What Phase 1 Participants listed as Disclosure Goals:

- **Changing the face of mental illness:** decreasing the stigma of mental illness by challenging stereotypes and assumptions about what a person with mental illness looks like and is capable of achieving.
- **Changing the world:** Sharing your context and how the system has affected you can change the system...and the world!
- **Self-education:** To learn more about your own mental illness.
- **Necessity:** “I have to tell someone right now because I’m out of options to solve this problem myself”
- **Navigation:** Sharing your personal experience in order to find the ‘right’ kind of help that is better tailored to your needs.
- **Providing support to others.**
- **Advocacy:** For yourself and others.
- **Empathy:** Sharing your story to break down barriers to empathy.
- **Deepening emotional intimacy:** Between friends, family members, romantic partners, etc.
- **Catharsis:** Sometimes it’s a relief “just to say it out loud”. Phase 1 participants felt that ‘coming out’ with your story allows you to acknowledge your humanity – that no one is immune to difficult times.
- **It comes up:** When your personal experience is relevant and can help inform the topic of conversation.
- **To take control of your story:** “If they’re going to have a story, I prefer it to be the real one”

What Youth Participants listed as Costs and Benefits to Disclosing:

Costs	Benefits
“You can’t take it back” (presumably, the revised manual is positioned to mitigate the	People understand you better (e.g., a greater feeling of authenticity. After

costs of this. This is also related to a goal of disclosure: Taking control of your story)	‘coming out’, youth feel freer to <i>be more of themselves</i>)
Exploitation of your story by others with competing interests	Validation
Feeling “permanently vulnerable” as a result of others knowing your story	Getting support
Discrimination (e.g., when an employer uncovers your story and is making a hiring decision)	Being able to “provide navigation” to resources for those who hear your story.
“ Getting too many stories back ” and feeling unequipped to respond appropriately	New friends
Emotional cost of re-experiencing difficult periods in your life while recounting your story.	New opportunities to tell your story (because youth continue to be in demand to tell their story)
Unfair comparisons to other youth with lived experience who had an easier or more straightforward road to recovery.	
Friends self-select out of your life	
People mistake you for having a lack of agency (e.g., ‘fighting your battles’ for you, treating you as broken or fragile)	
Feeling like you owe the audience a “happy ending.”	

LESSON 2: There are Different Ways to Disclose

Part 1: Different Ways to Disclose

Main Issues:

1. Make it clearer that the 5 *ways* **are not steps**.
2. Add a discussion of how **it is not necessary** (and realistic!) **to live** one’s life completely **in way #5** (‘broadcast your experience’) 24/7. Could include a case study of youth who move between #4 (‘indiscriminant disclosure’) and #5 regularly.

Part 2: To Whom Might You Disclose?

Main Issues:

1. Again, emphasizing that **disclosure involves more than just the youth** disclosing.

- **Disclosing is entering into a relationship** with the listener.
 - Some Phase 1 participants felt strongly that when you decide to disclose, “it’s your job to tell someone how you want them to help you...or not.”
2. Add parents, coaches, and guidance counsellors to the list of functional relationships in Table 2.4 (Table 2.2 in the workbook).
 3. Main problem with Worksheet 2.3 (the “Testing a Person for Disclosure” activity) is that **it relies on a genuine response to a hypothetical question.**
 - A person’s answer to the “what do you think about people...?” may not correspond at all to how the person will actually react to your own disclosure.
 - i. Phase 1 participants suggested basing the decision on how the listener has handled sensitive topics in the past.
 4. For youth considering public speaking, **create a survey or scale that gauges** “the social or political context and sensitivity” of **the audience.**
 - **How ready is your audience to hear from the speaker?**
 - i. What do they know about mental health issues?
 - ii. Why is the youth speaker required?
 - iii. What do they expect to happen as a result of the youth speaking?
How will they determine whether this has occurred?

Part 3: How Might Others Respond to Your Disclosure?

Main Issues:

1. Yes it is hurtful when people respond negatively to your disclosure, **but what should weigh more heavily** on a youth’s decision to disclose is the potential **benefit(s)** of disclosing, i.e., **the level of necessity**, or the function that the youth will receive as a result of disclosing.
 - a. Therefore, **prioritize:**
 - i. Need
 - ii. Benefit
 - iii. Behavioural reactions

above:

 - iv. Emotional reactions
2. The end of this lesson is too abrupt and potentially discouraging, especially if youth score very highly on Worksheet 2.4 (“Are You Able to Cope With Disclosure?”), where high numbers indicate high levels of anxiety, sadness, anger, and shame). It’s likely to leave youth more resolved in their decision not to disclose.
 - a. Instead, provide an opportunity for the youth to unpack the experience of a disclosure ‘going badly’, including four things:
 - i. **A statement acknowledging the strength** it took to disclose.

- ii. Some **guidance on possible reasons why** people don't always respond in a desirable way. (e.g., "even if you didn't ask for support, your friend may be worried about how to support you anyway. As your friend, they might be scared of making a commitment to you (even a simple one like "I will be there for you") that they're not sure they can follow through with")
- iii. **A flowchart that links** the youth's reason/need for disclosure to **alternate resources** available in their area.
- iv. **A statement that affirms the youth's decision not to disclose.**
 - "If you decide not to tell a friend, it's not the end!" It doesn't mean that s/he is a bad friend; "it might just mean that they're not ready to hear your story, or they might not be the kind of support you're looking for."

LESSON 3: Telling Your Story

Main Issues:

1. Youth participants preferred the story template from *The Center for Dignity, Recovery, and Stigma Elimination* because it is less restrictive and does not require all speakers to come to the conclusion that: "I, like all people with mental illness, live, work, and play just like you. So, please treat me the same. Do not view me based on any unfair stereotypes."
2. In Kyle's story, she does not acknowledge the ongoing process of recovery, which Phase 1 participants viewed as a critical flaw in the use of her story as an example for youth to base their story on. "Sometimes things are still hard" – for many people with lived experience, mental illness is never just a "thing of the past".
3. Because of time constraints, we did not get to cover Part 2 ("Coming Out Proud through SOLIDARITY and Peer Support") and Part 3 ("How Did It Go?")

Appendix L

Teacher Candidate Participant Biographies

Simon identifies as male, and first experienced symptoms of depression during his previous career in the Canadian Armed Forces. He named stigma as a barrier to seeking help, but he believes that stigma has decreased because of respected public figures speaking to the media about their experiences with mental illness. This has made him more comfortable with disclosing his mental illness to others. He considers himself to have low mental health literacy, and wants to learn more including how to express and manage his emotions. At the same time, he believes that his lived experience allows him to help students who are struggling with mental illness. During Mental Health Literacy Day, he found Sandra's story to be the most memorable and engaging part of the day because of the opportunity to ask questions and receive feedback from a young person with lived experience. He was a P/J teacher candidate at the Faculty of Education.

Pauline identifies as female, and has family members with "mental health issues." She had a previous career as a social worker in a cooperative living environment for teens, and as a frontline worker – progressing to the executive director – of a distress centre with a crisis line. Despite regularly working with youth "experiencing the most severe symptoms of mental illness" (Covarrubias & Han, 2011, p. 318), during the interview Pauline conveyed affirming attitudes towards students with mental illness, because this approach was vital to youth's growth and development when she worked with them in the cooperative living environment. In fact, Pauline believes that all teacher candidates need to explore, acknowledge, and challenge their stigmatizing beliefs in order to effectively support students with mental illness because "your own personal belief systems come with you. They don't disappear when you walk into the classroom." During Mental Health Literacy Day, Pauline found Sandra's story to be the most impactful and engaging. She was a P/J teacher candidate at the Faculty of Education.

Jessie identifies as female, and "an anxious person" who struggled to accept her diagnosis of an anxiety disorder because she wanted to be considered "normal." Growing up, she experienced symptoms of anxiety somatically:

I always wondered why I felt so sick in school from Grade 2 until now – until now, I still feel sick sometimes, and then I found out last year that both my parents have anxiety and depression. I was like: "Oh! That's why!"

Jessie is passionate about the importance of teacher mental health literacy because she was impacted greatly an unsupportive teacher in elementary school.

I know that if there was more mental health literacy of my Grade [4] teacher, she wouldn't have yelled at me. Those were things that I remember forever and it was like: "Why did I feel that sick? And why did she yell at me?" And then I felt way worse after.

Of all of the teacher candidates who disclosed during the interview that they had a mental illness, Jessie was the only teacher candidate to reframe some symptoms of her mental illness as strengths:

I'm anxious. And it's like...I embrace certain things about [it]. Like, yes I'm super anal but that makes me fantastic at certain things [and] I'm trying to see it more positively. And I do really believe in coping strategies, and I got through it...

Jessie is a recent graduate without a career before teaching, but received “phenomenal” mental health and suicide prevention training from her undergraduate employment in university residence. During Mental Health Literacy Day, Jessie was in the control group, but out of all of the semi-structured interviews, Jessie was the most enthusiastic about Mental Health Literacy Day because she felt that it demonstrated to teacher candidates that mental health was important to the Faculty of Education, and she enjoyed hearing from others who were also passionate about mental health. Jessie was an I/S teacher candidate at the Faculty of Education.

Anna identifies as female, and she says that her “husband suffers from anxiety and depression, and he kept it to himself for a long time, except I was the only one who knew.” She explains how her husband sought help and recovered despite dealing with the stigma of mental illness:

Last year he had a breakdown, and I was pregnant with my second child. He had his lowest [moment] and it was very scary, and I was afraid to leave him alone. So we had to reach out and get his mom and my mom involved, and he started seeing a [...] psychiatrist. He's doing much better, and it's still a manageable thing, but the stigma is definitely the hardest thing because you don't feel comfortable talking about it with the majority of people in our lives - just certain people that I know I can confide in, so they know what's going on, but not a lot of people – because they just don't understand.

During Mental Health Literacy Day, she found Sandra's story to be the most impactful because “hearing everything she's been through and everything that she overcame and how strong she was and... That was very emotional, and having the personal experience with my husband, that was the thing that stuck out the most.” She was a P/J teacher at the Faculty of Education.

Jacqueline identifies as female, and had a previous career in the business sector. Jacqueline was in the control group, and participated in the semi-structured interview because she was disappointed by Mental Health Literacy Day: “While you raised incredible awareness about the prevalence of mental health, I felt – and I know a lot of my peers felt – the ‘what to do about it’ part was very much lacking.” Unlike other teacher candidates who wanted their past experiences living or working with people with mental illness to guide their actions during classroom, Jacqueline wanted more direct instruction about strategies to support students with mental illness, and wanted more protocols to be created about what to do when teachers suspect that a student may be struggling with their mental health: “Amongst the group that I associate with, it was that: ‘They are not telling us what to do. So I'm not getting anything out of this.’” She feels

overwhelmed by the responsibilities of a teacher, therefore she appreciated hearing about the importance of self-care during Mental Health Literacy Day. She was a P/J teacher at the Faculty of Education.

Emma identifies as female, and struggled with her mental health during high school, when her

parents got divorced. And I thought that I was dealing with it pretty well, but then one day I was acting uncharacteristic of how I normally act and didn't realize. And then my teacher – I still remember her for this reason; she's amazing – but she took me into the hall because I was arguing with her in class about a due date. And it was really not like me, and even during that moment I was like: “I don't know why I'm doing this.” So she took me in the hallway and I thought she was going to get me in trouble, but she just asked “What's wrong? Is something going on?” And I started crying, and I had no idea that it was bothering me until she asked. And she was just so in tune with my mental well-being that she knew something was wrong, and then we went from there. And it was a transformative experience. And from that point on, I knew I wanted to be a high school teacher. And from that moment forward, I just had this vision of how important it is for teachers to be aware and in tune with their students' mental health.

Emma believes that mental health literacy is essential for all teachers: “I think it's an absolute necessity for everybody. [...] I think everybody needs to see how important it is.” However, she was one of two teacher candidates who felt that one Mental Health Literacy Day was sufficient, because the first day provided her with enough of a foundation to continue learning independently about mental health. She felt that teacher candidates needed the other professional development days to learn about other equally important issues:

I mean, I always feel like there can be more done, but I think that we already had this Friday day. And then I just feel like there's just so many issues that we have to touch upon this year. I wish that there could be more mental health literacy activities, workshops, or whatever, but I do feel like people will feel like “Okay, we've already done it – let's move on to the next thing because there's so much to catch up on.”

Emma viewed John's story, and identified the discussions about John's story as the most memorable part of Mental Health Literacy Day. Emma was an I/S teacher candidate at the Faculty of Education.

Alan identifies as male, and participated in the semi-structured interview to discuss his ambivalence about approaches to decrease the stigma of mental illness. He describes coming

from a different generation where you didn't really [talk about mental health]. And it wasn't: “You were depressed” – [it was]: “You are just miserable.” You are anti-social, and you just, you know, “You're being a baby, get on with it” sort of an attitude. And so they got on with it.

On one hand, he agrees with this approach, but on the other hand, he struggles with the reality of several loved ones dying by suicide:

I come from a culture of just, “Shut up and get on with it – you've got responsibilities” And I recognize that sometimes that idea doesn't work. I had a few close personal friends and family members that did commit suicide, so I do get the idea that if they had [the opportunity to] talk about it, there may have been a bit more...so I do have that. I understand that fear.

Alan explains that his cultural background influences his perceptions about when it is acceptable to express emotions or discuss problems.

My family, I'm from a Scottish Newfie [family] and very working class and you don't talk about your problems in Scotland unless you're really drunk. [laughs] And it's true – they are the most strong people until they get drunk. And they get very emotional and it's a cultural stereotype, but it's true. And that was one of the things with my aunt who committed suicide in Scotland. And I think that was part of the thing too – you don't admit it or talk about it.

Alan named John's story as the most memorable part of Mental Health Literacy Day, but Alan was dissatisfied with the way John's story was presented. He appreciated the discussion that followed, and wants more opportunities to discuss how to support students living with mental illness. Alan was a P/J teacher candidate at the Faculty of Education.

Patricia identifies as female, and describes herself as having low mental health literacy (“I don't know an awful lot about mental health literacy”) and no personal experience with mental illness (“I couldn't tell you that I know anybody who has a mental health issue”). Unlike all of the other teacher candidate interviewees who heard Sandra's story, Patricia did not find Sandra's story to be the most memorable part of Mental Health Literacy Day. Instead, she found the talk about self-care to be the most memorable “only because I'm having a terrible time doing it right now”, juggling schoolwork and her responsibilities as a mother of three children. Unlike other teacher candidates, she did not feel that the Faculty of Education communicated expectations about caring for students' mental health, or at least that “it's not really addressed in any explicit way.” Instead, she felt that the focus was on curriculum and classroom management, because classroom management allows teachers to teach the curriculum to their students.

We are so involved in getting our curriculum, we are so involved in getting classroom management, because without classroom management you can't even begin to teach the curriculum. Now mental health can certainly play a role in classroom management because if you've got people with mental health issues they can affect the ability to manage your classroom effectively, I get that, but it hasn't been separated out necessarily.

Like Emma, Patricia felt that one Mental Health Literacy Day was sufficient – “anything else would be overkill.” Patricia was a J/I teacher candidate.

Lindsay identifies as female, and is passionate about normalizing the experience of struggling with mental health by “mak[ing] it something that is talked about.” Lindsay has “suffered with depression throughout my life, and my family has too” but Lindsay did not disclose this to anyone during her former career in law enforcement, especially after she witnessed “a quite capable” coworker lose her job after disclosing that she was struggling with her mental health while going through a divorce.

It was [a] bizzare experience that happened when she was let go, because everyone was like “What? She didn't pass?” And it was like [whispers]: “She didn't pass the psychological test! What does that mean? Is she crazy?” There was rumors around the office.

This experience made Lindsay lose confidence that her coworkers would not respond with discrimination and devaluation: “Even among educated adult professionals like that, those whisperings of...you know...What does that say about someone?” She acknowledged having low mental health literacy but felt motivated to learn more: “I myself feel like I need to go home and read, because I keep thinking about depression and anxiety, and I’m like: “What else is there?” That’s my lack of knowledge and experience.”

During Mental Health Literacy Day, Lindsay viewed John’s video and felt “mildly disappointed by [Mental Health Literacy Day] because I didn’t really get out what I thought I would, for what I expected to get out of it.” She “didn’t really feel like there was anything new that I was hearing” because she expected to learn more about the “tools available” and “organizations out there” to decrease stigma and support students living with mental illness. She wanted the second Mental Health Literacy Day to have a stronger focus on how to “bring [mental health] into the mainstream in your classroom.” Lindsay was a P/J teacher candidate at the Faculty of Education.

Nicole identifies as female, and is a recent graduate who acknowledges that she has low mental health literacy and no personal experience with mental illness.

Some people may have come from a psych background, or may have come from a background where they saw that or dealt with that on a daily basis, whereas I didn't. Also, coming from right out of undergrad, I didn't have any real life experiences to apply to my classes.

Nicole was in the control group during Mental Health Literacy Day, and enjoyed it because it increased her awareness and knowledge of the importance of mental health.

I thought that the professionals Friday did make me aware of [mental health] a lot more than I had ever really considered it before. And it was really helpful to go into practicum with that background knowledge.

The most memorable part of Mental Health Literacy Day for Nicole was learning from professors about the statistics of “how *so* many children go undiagnosed with mental health issues, or they're not receiving the support they need at home, and things like that.” Nicole was a J/I teacher candidate at the Faculty of Education.

Brian identifies as male, and as a student who is fluent in the French language, he experienced anxiety during elementary school when he moved to an English-speaking school: “I remember I used to be so anxious to speak English. I would never ever talk...like, speak English.” “So when I first went to my first English school, I was... I think that's where one of my biggest anxiety came from.” He then realized that his anxiety

goes above languages. Then you start seeing how if you're being made fun of because you have an accent, or you're pronouncing this [word incorrectly] at a young age, you grow up and you still have these little insecurities speaking in public.

When Brian tried to tell his parents about his anxiety, “I used to be really frustrated with my parents if I were to express [my feelings].” “They were just like: “Just...Whatever, you're being silly. Pray...” “At first I would just be really annoyed and angry, but then now, I'm questioning. Like, where did they get that from?” He believes that his parents’ difficult experiences as immigrants must have affected their mental health, but they did not speak about it because their focus was on survival.

Because my parents came to [North America] as immigrants – they were just, like, working, working, working. And I'm sure they had some sort of mental health issues, like coming to a different place, not speaking the language, not knowing the culture, all of these things I'm sure affected them in a certain way. But that was never expressed. So for me to express that to them, they're just like [...] “We survived.”

Brian’s experience with his family prompted him to investigate the cultural influences of attitudes towards mental illness. He found that because mental health research has traditionally been studied from “a very Eurocentric view and a very westernized view”, some non-Eurocentric, non-western cultures – like the culture he identifies with – have tended to reject ideas and approaches stemming from that research. At the same time, he acknowledges the “detrimental” consequences: that in some “marginalized communities”, “the work of mental health is not being done.” “We don't have those resources in places to talk about these feelings, and that hinders our growth, I think, in general as a people, and as a community. We need to have those spaces.” He believes that

the work should be started within our own communities, because we know better what we're going through. Then we can find ways to cope with it. Yes, we can access all this information that's been done on it, but I know how we function is also different. We all have different views in life and everything and experiences. So I can't just pick up a book that was written by somebody and try to fit myself in as an immigrant. It's like, “No, my thing is so much more complex.” So I want to be working with those communities that have similar experiences.

Brian was a P/J teacher candidate at the Faculty of Education.

VITA

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