Sharing Narratives to Foster Mental Health Literacy in Teacher Candidates

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Abstract

This study explored the nature of teacher candidates' mental health narratives in the context of completing an elective course in mental health and wellness. How students deconstructed their narratives and the narratives of their peers over time was also explored. Participants included 67 fourth-year students completing a five-year concurrent teacher education program. Data was collected over two academic years and consisted of students' beginning-of-course and end-of-course narratives. The narratives were analyzed using content and thematic analysis. The findings are discussed in the context of using shared narratives as case study to promote self-reflection, discussion, problem-solving and mental health literacy within undergraduate courses.
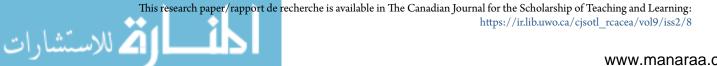
Cette étude explore la nature des récits sur la santé mentale racontés par des étudiants à l'enseignement en train de terminer un cours sur la santé mentale et le bien-être. Nous avons exploré la manière dont les étudiants ont décortiqué leurs récits ainsi que les récits de leurs pairs au fil du temps. Les participants consistaient de 67 étudiants de quatrième année inscrits dans un programme concomitant de formation des enseignants de cinq ans. Nous avons recueilli des données au cours de deux années universitaires; ces données représentaient des récits d'étudiants racontés au début du cours et à la fin du cours. Les récits ont été étudiés grâce à une analyse du contenu et des thèmes. Les résultats sont discutés dans le contexte du partage des récits en tant qu'études de cas afin de promouvoir l'auto-réflexion, la discussion, la résolution de problèmes et la compréhension de la santé mentale dans les cours de premier cycle.

Keywords
case study, mental health literacy, teacher education, content analysis, thematic analysis

Approximately 10% of Canadians 15 years of age and older have experienced a mental health disorder within the last year, with over one-third of these individuals predicted to experience a mental health concern within their lifetime (Pearson, Janz, & Ali, 2013; Statistics Canada, 2012). Adolescence and early adulthood often mark the onset of these challenges, with almost 75% of these disorders being diagnosable before 25 years of age (Kessler et al., 2005; Kutcher, Wei, & Morgan, 2016). For these reasons, early adulthood marks a critical time for the development of mental health awareness and literacy. This critical time is also marked as the interval in which many young adults engage in postsecondary studies, prompting postsecondary institutes to promote and support the mental health literacy and well-being of their students. Young adults who acquire mental health literacy while completing postsecondary studies presumably will continue to engage in effective self-care and related practices upon graduation and throughout their adult and professional lives (MacKean, 2011).

Mental health literacy is complex and multifaceted. It includes facilitating knowledge of mental disorders and associated treatments in order to challenge and minimize stigma (self and other) while simultaneously developing and sustaining mental wellness through engagement in evidence-based self-care, self-regulation, and help-seeking behaviours. In these ways, possessing mental health literacy can also promote a sense of agency, encouraging individuals to seek out treatment and supports or encouraging others to do so (Kutcher et al., 2016). Similarly, postsecondary students can also benefit (emotionally, socially, academically) from direct engagement in on-campus mental health and general services (learning support services, peer support programs) as well as mental health awareness and literacy initiatives (e.g., MacKean, 2011).

These positive results are tempered, however, with findings that many postsecondary students, especially those in their first year, are largely unaware of issues related to mental health and wellness including where to seek information and support services (e.g., Armstrong & Young, 2015; Kutcher et al., 2016). Even when students possess this knowledge, the majority of those who may benefit from engagement with professional services do not seek them out (e.g., MacKean, 2011; Marsh & Wilcoxon, 2015). To this end, there are calls for the systematic inclusion of mental health and wellness courses within academic programs. The need for systematic instruction is especially pronounced in teacher preparation programs where graduates will be expected to assume some responsibility for the mental well-being of themselves and the youth they work with (PHE Canada, 2014).

Questions thus arise about effective pedagogical methods for delivering mental health promotion and literacy to teacher candidates, many of whom may hold either inaccurate or incomplete knowledge and beliefs about mental health and wellness. It is well accepted that learners' prior knowledge and experiences can greatly influence their abilities to acquire and apply new information (Fyfe & Rittle-Johnson, 2016; Roelle, Lehmkuhl, Beyer, & Berthold, 2015). While learning typically is facilitated when prior knowledge and experience is consistent with new information, the reverse may hold when learners' background knowledge and/or experiences are inconsistent with new information, incomplete, or inaccurate. For these reasons, activating and deconstructing students' existing beliefs can be critical elements of effective instruction (Crooks & Alibali, 2013).

Using case studies is one instructional approach that can promote students' perspective taking, critical thinking, and problem-solving abilities. While cases may vary in terms of their format, they typically consist of narratives that present provocative and/or unresolved issues (Gartmeier et al., 2015; Schwartz, n.d.). Case study analysis is multilayered and typically involves identifying critical elements, events, and perspectives, contemplating multiple response options, and

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selecting an action plan (Smart & Thompson, 2017; Snowman, 2013). Instructor-facilitated, small-group deconstruction of case narratives can promote theory-to-practice connections, perspective taking, collaborative problem solving, and the transfer and application of relevant information and skills (Rosen, 2008). Recently, narratives and vignettes have been used in teacher preparation to assess, disrupt, and promote future educators' mental health literacy (e.g., Armstrong, Price, & Crowley, 2015). Having students explore and deconstruct self-generated narratives based on personal experiences may be especially powerful as they are likely to hold inherent meaning and interest. Finally, analyzing students' narratives can provide educators with critical instructional insights related to incomplete or erroneous beliefs, fears, and/or concerns.

In the study reported here, we explored the nature of fourth-year undergraduate students' mental health narratives in the context of completing an elective course in mental health and wellness as part of their concurrent teacher education program. We also explored how students deconstruct their narratives and the narratives of their peers over time, noting differences in their beginning and end-of-course reflections. We discuss these findings in the context of using case study to encourage and promote self-reflection, discussion, and problem-solving within undergraduate courses. The following research questions guided our inquiry:

a. What is the nature of students' mental health experiences as expressed through their self-selected/ self-generated mental health narratives?
b. How do students deconstruct and make meaning of the shared narratives, and do these meanings change as a function of course completion?
c. What insights or perspectives do students carry forward from the deconstruction of their shared narratives upon course completion?

Method

Research Design

The study is contextualized within a longitudinal case study exploration of concurrent students' experiences completing an elective course in mental health and wellness. Case studies provide an opportunity for in-depth description and exploration of participant experiences within authentic contexts that are bounded by time and place (Creswell, 2011, p. 97). The use of case studies is appropriate when there is a desire to understand phenomenon from the perspectives of those who experience them. In the study reported here, we use content and thematic analysis to deconstruct students' beginning and end-of-course mental health narratives within the boundaries of a same-topic course. The study received ethics clearance from a university Research Ethics Board.

Participants

All participants were fourth-year students completing a five-year concurrent teacher education program at a medium-sized university (approximately 17,000 undergraduate students). The course was offered over two years with 30 out of 40 students (75% of all potential participants) electing to participate in the study in year one and 37 out of 40 students (93% of all potential participants) electing to do so in year two. Twenty-seven and 34 students self-identified as female in years 1 and 2, respectively, with three self-identifying as males.

Course Context and Mental Health and Wellness Narratives

Participants engaged in a 12-week (36-hour), fourth-year undergraduate elective course in mental health and wellness. The course was designed to explore and promote concepts related to mental health literacy, self-care strategies, and awareness. Course enrollment was capped at 40 students in order to support discussion-based pedagogy (small group, whole class), as well as a person-centered, holistic approach to mental health and wellness. Course activities included the exploration and deconstruction of mental health narratives, peer presentations, and a community awareness project.

The course syllabus, which outlines the course requirements and activities, was posted online prior to course commencement. The requirements and activities were also reviewed and discussed during the first class so that students could make informed decisions about their enrolment in the course. In addition, on-campus and community-based mental health resources were listed on the course syllabus with information about how to access them provided in the first class. Finally, students were encouraged to approach either of the authors should they experience distress with any aspect of the course content or the research study described here as both authors possess relevant clinical psychological training and experience in mental health and wellness.

Mental Health Narratives

Data for this study consisted of the participants' beginning-of-course and end-of-course mental health narratives. Students completed their first narrative as part of a "homework activity" assigned at the end of the first class. Specifically, participants were invited to generate a narrative related to a mental health challenge experienced either by themselves or another person (family, friend, peer, colleague, unknown person) and to upload their response to a shared course site where they could be anonymized and printed by the course instructor. Participants were encouraged to provide a "rich description" of events related to the mental health challenge, as well as reflect on their thoughts and feelings associated with this event. Narratives were to be a minimum of 250-300 words in length (or one, single-spaced typed page). Participants were informed that their narratives would be discussed anonymously as part of two, in-class small group discussion forums.

The first discussion forum occurred during the second class and lasted for three hours. Students were instructed to form small groups and were provided with anonymous mental health narratives (one per student). Students took turns reading the anonymized narratives aloud and shared their initial reactions and responses to each narrative. They were encouraged to consider each narrative in context of their prior knowledge and experiences, including any beliefs or assumptions that they may have had in relation to the described events. As students continued to discuss these narratives, they were encouraged to identify similarities and differences across the narratives as well as in their individual and shared responses and reactions. Finally, students were asked to conceptualize the essence of mental health and wellness in context of insights gained from the narratives and discussions. Students then collectively shared their responses as part of a whole class discussion, where students were encouraged to reflect on broader, collective trends and responses.

The same process unfolded for the second discussion forum. Students were again provided with narratives from the anonymized stories generated during the second class. They worked in small groups to deconstruct and share responses to the narratives. As part of these discussions, students were encouraged to discuss new perspectives or insights that they held about the narratives as well as consider whether their current reactions differed from their previous perspectives and beliefs.

Students then engaged in a whole class discussion where they discussed collective insights, perspectives and responses.

Finally, students were asked to record a final reflection (approximately 200 words) in which they documented their current response to their initial narratives. Specifically, students were instructed to record their current perspective, understanding, and/or response to their initial narrative (including references to course content as relevant) in context of their current understandings. They were invited to record any other experiences and/or insights that they believed were especially meaningful and relevant.

The completion of the beginning-of-course and end-of-course mental health narratives comprised part of students' participation grades. There was no specific evaluation or assessment of the narratives per se. Rather, participants received course participation credit for the anonymous submission of their narratives and their engagement in related class and small group discussions. Students provided informed consent for their anonymized narratives and associated reflections to be analyzed as part of the research study here.

Data Analysis

We adopted a multi-layered approach to data analysis, recognizing the strengths and limitations of any single approach (Nagy Hesse-Biber & Johnson, 2015). To that end, we used content analysis and thematic analysis to systematically identify trends, patterns, commonalities, and distinctions in participants' beginning-of-course and end-of-course mental health narratives (Krippendorff, 2013).

First, we independently reviewed each of the beginning-of-course and end-of-course narratives (i.e., content analysis) and were careful to remain within the frameworks of participants' stated language. We then explored the narratives with respect to whether participants engaged in a central storyline, identifying all the persons associated with that story. These persons were identified as participants (self), family members (parent, grandparent, sibling, cousin), friends or less well-known others. We also noted the inclusion of any alternative storyline and persons included in them. Participants' language was then used to categorize types of mental health challenges (e.g., depression, anxiety, stress, bullying, social anxiety, sadness). Similarly, stories were coded for diagnosis, with only participants' explicit reference to a diagnostic status being noted affirmatively. Any reference to formal treatments were coded as involving hospitalization, medication, psychotherapy/counselling or a combination, with these references also being coded as either positive, negative, or mixed. Participants' end-of-term narratives and reflections were reviewed for the inclusion of additional details and storylines. In sum, narratives were coded across the following categories: central storyline and person(s), time, mental health challenge, diagnostic process, treatment type, and treatment satisfaction.

At the same time, we engaged in thematic analysis of these narratives. Thematic analysis consisted of reading and rereading the narratives independently and holistically to seek out evidence of participants' responses to their described mental health challenges. Line-by-line analysis followed, allowing for the emergence of in-vivo codes as well as those corresponding to the research questions (Creswell, 2011). We then met to discuss our interpretations and to arrive at a shared understanding of the emergent themes (Bogdan & Biklen, 2007; Merriam, 2002). In this way, we were able to negotiate a collective sense of participants' interpretations of their mental health experiences over time.

Results

The findings are presented in two phases. The first phase discusses the results of the content analysis, where the substance of the narratives is reviewed, while the second phase presents the thematic analysis, where participants' meaning-making of these experiences was analyzed.

Content Analysis

We began our analysis by categorizing participants' narratives according to person of focus and identified mental health challenge. Of the 30 first-year narratives, 11 (36%) were focused on self, six (20%) were focused on family members, six (20%) were focused on friends (e.g., best friend, close family friend), and seven (23%) were focused on other, less-known individuals (e.g., camper, student in school, friend's sibling, child on public transport, unknown person). Of those narratives that involved family, two (33%) included references to grandparents and/or parents, one (17%) to a sibling, and three (50%) to an unidentified member. One participant discussed a second narrative involving a family member that was not included in the analysis here due to incompleteness.

Four (13%) narratives were situated during participants' childhood years (birth-grade 8), seven (23%) during secondary school years, 16 (53%) during postsecondary years, one (3%) throughout the lifetime, and two (7%) were unspecified. Eight (27%) narrations made explicit reference to formal diagnoses, while the remaining 22 narratives (73%) either included references to self-described mental health challenges or did not specify a diagnostic process.

A similar pattern emerged among the 37 second-year narratives, 14 (38%) focused on the self, 10 (27%) focused on family (30% involving parents, 30% involving siblings), seven (19%) focused on friends, and the remaining six (16%) focused on other individuals. Five participants also discussed a secondary narrative that pertained to either self (n=1) or family (n=4). These narratives were not analyzed due to incompleteness. Eighteen narratives (49%) were situated in a postsecondary setting, with three (8%) situated within participants' childhood years (birth-grade 8), eight (22%) within their secondary school years or as a continuation from childhood to secondary, seven (19%) throughout their lifetime, and one (3%) as unspecified. Seventeen (46%) narratives made reference to formal diagnoses, with the remaining mental health descriptors and identifiers being self-generated.

Across both years, participants tended to share stories related to the self most often, with the distribution across the three remaining foci being fairly equitable. The majority of narratives occurred during participants' postsecondary studies. In part, the sharing of these particular narratives may reflect participants' increased knowledge and abilities to recognize mental health challenges, chronological proximity to the onset of mental health challenges, relational proximity to relevant details and events, and recency effects (i.e., high memory for recent events; Plonsky & Erev, 2017).

Depression and anxiety were the most frequently described mental health challenges across all narrative types (i.e., self, family, other, friend). In Year 1, 16 of the 30 narratives (53%) referenced depression, and 14 of the 30 stories referenced anxiety (46%). In Year 2, 26 of the 37 stories (70%) referenced depression and 14 of the 37 stories referenced anxiety (38%). Interestingly, in Year 2 no stories referenced anxiety that focused on a friend. We do not know why this was the case. In Year 1, stress and panic attacks were the next most frequently cited phenomenon and were almost always referenced with respect to narratives of the self.

Several narratives contained references to multiple mental health challenges, with participants most frequently describing combinations of depression and anxiety (Year 1=27%; Year

2=22%), depression and suicide/suicide behaviour/suicide ideation, (Year 1=20%; Year 2=11%), stress and anxiety (Year 1=17%; Year 2=5%), anxiety and panic attacks (Year 1=17%; Year 2 = 3%) and stress and depression (Year 1=7%; Year 2=5%). One student (3%) in Year 2 made reference to combined concerns related to depression and self-harm.

Participants' reporting of depression, anxiety, and stress within family, friends, and others was relatively comparable, albeit slightly higher, than those associated with national statistics (Langlois, Samokhvalov, Rehm, Spence, & Connor Gorber, 2011; Pearson et al., 2013). In part, participants' relatively high reporting of depression and anxiety in others, especially family, may reflect high degrees of certainty and insider knowledge, with 10 out of 11 Year 1 narratives and 12 out of 14 Year 2 narratives referencing a formal diagnosis of depression and/or anxiety among family, friends, or others.

Participants' self-reported experiences also mirror those of other Canadian postsecondary students who report similarly high levels of depression, stress, and anxiety while completing their studies (American College Health Association, 2013; Villatte, Marcotte, & Potvin, 2017), with high incidents of depression reported by students worldwide (Ibrahim, Kelly, Adams, & Glazebrook, 2013).

Fewer students made reference to formal diagnoses when describing scenarios of the self than when describing narratives of friends and families. Specifically, two narratives made reference to a diagnosis of anxiety in Year 1 and four made reference to co-morbid diagnoses of depression and anxiety in Year 2. While the seemingly general use of language and the breadth of experiences encompassed in students' self-descriptions of depression (e.g., sadness, unhappiness), anxiety, and stress make it difficult to ascertain the severity of participants' mental health experiences per se, the high incidents of self-reported challenges and distressing experiences reaffirm concerns for students' mental well-being while on campus. This supports calls for proactive efforts to promote effective wellness and coping techniques in postsecondary institutions.

Suicide ideation and suicide behaviour were the next most frequently identified mental health challenges. Of the 30 Year 1 stories, nine (30.0%) referenced suicide, suicidal ideation or suicide attempt. Of the 37 Year 2 stories, six (16%) referenced suicide, suicidal ideation, or suicide attempt. Suicide and suicide-related references were restricted to narratives of friends and others in Year 1, with challenges most often discussed within family narratives in Year 2. There were no references to self in the context of suicide-related behaviours or ideations in either year. The absence of self-referencing is in contrast to the general reporting of suicide ideation among postsecondary students, with up to 13% of postsecondary students indicating that they had seriously considered suicide within a 12-month interval (American College Health Association, 2013). It is possible that participants were reluctant to disclose such information for fear of stigmatization (either self or other), knowing that the narratives would be deconstructed within the context of the course. Suicide is among the leading causes of death among Canadians between 15-24 years of age (Findlay, 2017; MacKean, 2011). However, social norms largely continue to relegate open discussion of this topic as taboo or even harmful (e.g., Chapple, Ziebland, & Hawton, 2015; Richardson, 2015), potentially increasing participants' unwillingness to disclose and/or deconstruct these thoughts and behaviours within the parameters of the course.

Participants made less frequent reference to instances of bullying (Year 1=3%, Year 2= 8%), self-harm (Year 1=7%, Year 2=8%), substance abuse (Year 1=3%, Year 2=11%), and grief (Year 1=7%, Year 2=5%). When discussing bullying and grief, participants referred to narratives of the self while they referred to family or others only when describing challenges related to substance abuse, usually with additional themes related to mood disorders. With evidence that some students

continue to be bullied in postsecondary settings (Adams & Lawrence, 2011), and an estimated 35% of individuals experiencing school-based bullying, and 15% experiencing cyber-bullying (Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014), it is not surprising that some participants reported being bullied. A number of negative outcomes have been found to result from being bullied, including high levels of anxiety, depression, and suicidality (Holt et al, 2015; Reid, Holt, Bowman, Espelage, & Green, 2016), with these risks persisting into adulthood (Ttofi, Farlington, Losel, & Loeber, 2011).

Participants provided limited references to other specific mental health illnesses including schizophrenia (Year 1=10%, Year 2=8%), bipolar disorder (Year 1=7%, Year 2= 8%), and post-traumatic stress disorder (PTSD; Year 1= 3%, Year 2 = 3%), with all but one of these narratives including reference to a formal diagnosis. There was a single reference to borderline personality disorder in Year 1 (3%), and attention deficit disorder with hyperactivity, eating disorders, and body image in Year 2 (3% respectively). With the exception to two, self-focused narratives involving PTSD, all references to psychosis and personality disorders were restricted to narratives of family (Year 1) or family, friends, and others (Year 2). The low reporting of self-focused psychosis and personality disorders is unsurprising given the relative severity and disruption potentials of these mental health challenges for daily functioning, including academic studies.

Stigmatization processes may offer another possible explanation for the limited self-references with respect to these mental health illnesses and substance abuse. Stigma is the phenomenon where negative stereotypes about mental health challenges, often related to dangerousness, incompetence, and inability to recover, are held by the individuals experiencing the challenge (self-stigma) or are by others (public stigma). These two forms of stigma then interact, serving to strengthen each other, and to decrease the likelihood of an individual reporting mental health challenges or engaging in help-seeking behaviours (Yanos, Lucksted, Drapalski, Roe & Lysaker, 2015).

Thematic Analysis

Several themes emerged within and across participants' beginning and end-of-course narratives with respect to increased knowledge and coping strategies, increased comfort and sense of agency, and enhanced willingness to break silence and challenge stigma. Caution is required, however, when interpreting participants' mental health narratives as just over a third included any reference to a formal diagnosis either in the first (n=11, 37%) or second year (n=14, 38%). Thus, a high degree of subjectively in participants' use of mental health descriptors can be assumed here. Participants' descriptors do, however, provide important insights about how postsecondary students interpret and refer to their personal mental health experiences and the mental health experiences of others.

Increased knowledge and coping strategies. When first introducing their narratives, most participants provided detailed accounts of the nature of mental health challenges and their potential disruptive force on daily functioning. They also expressed sensitivity about how such disruptions could impact the well-being and functioning of relevant others, including family and friends.

> By the time I reached my third year (university), these episodes (panic attacks) had expanded and began to occur on campus…. I began to feel severe panic on a daily basis. (Participant 7, Year 1, Time 1)

The dysfunction is constant and the fluctuations in their (family member) health have been a constant stressor on the entire family. (Participant 20, Year 1, Time 1)

By the end of the course, participants were able to apply course content to contextualize and derive greater understanding of their mental health narratives. For instance, they were able to identify and discuss environmental stressors and individual vulnerabilities that may contribute to their described mental health challenges.

I have also come to gain an understanding and awareness of stressors that escalate my anxiety and depression and the coping skills that I can use. (Participant 21, Year 1, Time 2)

I noticed that my response to situations derived from fear, pain and a lack of self-worth. This ultimately stemmed from how I perceived myself in light of social situations and experiences with others. (Participant 22, Year 2, Time 2)

Looking back at the mental health story I wrote at the beginning of class, I can see that what I was dealing with was … a difficulty coping and adjusting to a new setting. The stress and anxiety I was dealing with was largely due to being in an unfamiliar scenario without my usual support group. (Participant 7, Year 2, Time 2)

For narratives involving the self, some participants qualified their enhanced understandings as ones that were without judgement and consistent with practices of acceptance and self-compassion.

I noticed that my response to situations derived from fear, pain and a lack of self-worth. This ultimately stemmed from how I perceived myself in light of social situations and experiences with others. In relation to the course [it] has shown me how I can better cope and manage my social anxiety as well as the fact that I am better able to understand what I am experiencing in order to identify these symptoms within myself without judgement. (Participant 22, Year 1, Time 2)

Participants also discussed increased knowledge of effective coping strategies for managing their mental health challenges as well as increased recognition of ineffective ones. In many instances, these strategies related to addressing anxiety and depression, as well as stress typically associated with postsecondary studies.

I've come to realize that I use avoidant-coping strategies (calling off work, closing myself off from friends and family, sleeping the majority of the day) in the hopes that the problem will go away. (Participant 18, Year 1, Time 2)

I have become more mindful of productive coping strategies such as physical activity, meditation, and journaling in order to manage my anxiety and depression. (Participant 21, Year 1, Time 2)

I now realize that being mindful of what causes me to feel negative and altering this will help me improve my mental health. (Participant 12, Year 2, Time 2)

In the same ways, participants expressed increased awareness of professional and community resources, as well as a willingness to seek them out when necessary.

> The course … exposed me to new resources. (Participant 25, Year 1, Time 2)

> Especially with the help of this class I was able to reflect and realize that I was becoming too overwhelmed and take note of my stresses. From the point of realizing this, I went to my own support systems for help and was ready to go to use counseling if things continued to get worse. The thought of counseling would never have crossed my mind in the past … knowing they were there for me to use was comforting. (Participant 28, Year 2, Time 2)

Overall, the development of coping strategies provided some of the participants with an enhanced sense of personal agency. These participants recognized the importance of self-care and the benefits of sustaining a repertoire of self-care and coping strategies that can be called up when experiencing distress. In these ways, participants suggested that they needed to be proactive in their approach to mental health, including being vigilant in the monitoring of their ongoing states of being.

> I have learned some coping methods. I realize I have been calling my sister … and seeing my family more often. I think they help to reduce some of my stress. (Participant 19, Year 1, Time 2)

> As a result [of the course] I am able to identify when I am feeling stressed and not just simply observe it but use these strategies to actively cope against feeling this way. (Participant 22, Year 1, Time 2)

> I now realize that being mindful of what causes me to feel negative and altering this will help me improve my mental health. In addition, by being mindful of how I portray my negative feelings onto other people should be reflected upon so I do not regret my decisions later. (Participant 12, Year 2, Time 2)

> I have learned that it is possible to overcome a traumatic experience … I have also learned that I have developed a sense of agency in the sense that I am now more aware and believe I can achieve my goals and take charge of my life. (Participant 18, Year 2, Time 2)

Collectively, participants also indicated that they developed more nuanced understandings of mental health and wellness, suggesting that mental health and wellness is a dynamic state of being versus an absolute or constant state. In this way, their perceptions generally mirrored contemporary theories that posit wellness as a multifaceted and dynamic state (Dodge, Daly, Huyton, & Sanders, 2012; Keyes, 2005). They demonstrated awareness of external and internal factors that can influence individuals' states of mental wellness, being especially sensitive to biological vulnerabilities and environmental stressors consistent with diathesis stress models (e.g., Ingram & Luxton, 2005). In these ways, participants appeared to reject ideas of absolute wellness or absolute illness, adopting instead notions of continuums where individuals (including themselves) present differing levels of wellness across time and context. Participants seemed aware they could optimize their current states of wellness regardless of whether they experienced a mental health challenge. They also recognized that their current states of wellness did not preclude possibilities of experiencing mental health

challenges and vice versa. In these ways, participants practiced compassion and demonstrated increased empathy for self and others. The ability to be kind when understanding self, recognize difficulties as inherent to the human condition, and form a mindful, balanced perspective about such challenges can promote resiliency and serve as protective factors for well-being (Neff, 2015).

Increased comfort and sense of agency. Many participants began the course expressing a desire to support individuals experiencing mental health challenges. Their intentions to be supportive, however, were qualified by fears and/or uncertainties about how to engage appropriately. For instance, they expressed uncertainty about whether they should engage in discussions with others about their mental health experiences for fear of exacerbating psychological distress. This was most notable with suicidal ideations and behaviours. In these ways, participants described experiencing a sense of helplessness.

> I felt helpless… that there was nothing I could personally do to help…no one wanted to talk about the issue, which was frustrating. (Participant 19, Year 1, Time 1)

> I used to believe that discussing suicide was a delicate and sensitive topic. (Participant 2, Year 2, Time 2)

> When I first started witnessing the anxiety and panic attacks, I didn't know what to do. I felt so helpless trying to comfort her when I didn't even know what was wrong… When she was happy, I didn't want to bring anything up that might make her sad. But when she was sad, it was difficult to talk to her because she shut everyone out… There was nothing I could do … . (Participant 27, Year 2, Time 1)

More encouragingly, by the end of course, participants indicated increased comfort with engaging in open discussions about wellness and mental health challenges. Specifically, most participants indicated increased recognition of the importance of engaging directly in supportive discussions. Especially relevant, participants spoke about the importance of being empathetic and active listeners. They felt empowered by the realization that they could provide critical support to those with mental health challenges by engaging in active listening, with many perceiving the latter as a skill set that they already possessed or could develop readily. Participants who continued to experience uncertainty about their abilities to listen and/or engage in discussion, indicated a desire to develop these skills.

> I can help others …. by simply being a support system in their life to listen and show that I value and care about them and their health ... I have realized that it is important to talk about these issues and ask questions. (Participant 21, Year 1, Time 2)

> My thoughts have changed from being embarrassed to talk about it to the idea that it is good to discuss mental health and raise awareness in order to break the stigma… I feel proud and happy that I am willing to talk about issues. (Participant 28, Year 1, Time 2)

> After learning about the importance of talking about it [mental health] and learning about all of the resources available, I now feel much more comfortable talking about it, and feel I am much more approachable because of it. (Participant 21, Year 2, Time 2)

The ability to engage in open discussions about mental health and wellness is an important first step in reducing misconceptions and stigmatization of those who experience mental health challenges (Yanos et al., 2015). Engagement in the course provided participants with enhanced confidence and minimized their fears related to engaging in informal discussions or what are otherwise referred to as troubles talk (Linden & Jurdi-Hage, 2017). Disclosing information about mental health can be a distressing experience. Focusing on troubles may escalate associated fears and anxieties, especially when there is a perception that listeners are judgmental or when they provide erroneous or unhelpful information (Carver, Schierer, & Weintraub, 1989; Chao, 2012). On the other hand, improved affect and emotional awareness are often associated with engaging in empathic non-judgmental discussions where listeners employ basic verbal and nonverbal active listening skills (Linden & Jurdi-Hage, 2017) and may prompt help-seeking behaviours (Gagnon, Gelinas, & Friesen, 2017).

Breaking secrecy and challenging stigma. Many participants' beginning-of-course narratives made reference to the largely invisible nature of mental health challenges and societal norms that discouraged discussion, empathy, and informed understanding. In response, some participants described active efforts to hide personal states of psychological distress or what they equated to as acts of "secrecy."

> In high school classmates complained about my anxiety-related behaviour, and my teacher told me to "knock it off" and that "some people have real problems", completely disregarding that I was really struggling. (Participant 7, Year 1, Time 1)

> My friends and family said I could not be depressed because I still have moments when I am smiling and happy. (Participant 21, Year 2, Time 1)

At the same time, participants described being surprised or taken back when acquiring insights about others' mental health challenges.

> She started getting depressed and did not say anything... We only knew of her depression in later years, when her mother was talking to ours. (Participant 24, Year 1, Time 1)

> No one realized he was struggling in silence. (Participant 12, Year 2, Time 1)

Participants also described emotional reactivity to learning about others' mental health challenges, especially family members or close friends. Specifically, they described experiencing a range of emotions including surprise, hurt, disappointment, and/or anger.

> Hearing all of it (suicide ideation) was a shock to me, and it really hurt that he did not feel like he could confide in me… . (Participant 13, Year 1, Time 1)

> I grew up alongside this person, and could have never imagined that he would be struggling with sadness and depression … He still might be struggling and just not telling me… I am still shocked about how easily mental illnesses go unnoticed. (Participant 5, Year 2, Time 1)

In a few instances, participants spoke about a negative change in their relationship as a function of either their emotionality or the shame associated with disclosure.

I realized how self-centered my point of view was….it involved a lot of my reactions to the situation, instead of what really mattered, his well-being… Course helped make me more understanding of his situation and try and support him… I have reached out to him… and am working towards mending our strained friendship. (Participant 13, Year 1, Time 2)

I would call him a good friend, but I have not spoken to him since this incident happened (five years ago). I could see how ashamed he felt, how nervous he was… We have yet to [re]discuss this day … there were a lot of negative aspects that someone had to reveal about their life. (Participant 16, Year 2, Time 2)

Within their end-of-course narratives, many participants appeared to be more empathetic to the challenges associated with disclosure including feelings of shame and demonstrated increased recognition about stigmatization processes. They spoke about the need to promote a sense of normalization of mental health challenges and promote understandings of wellness as a dynamic state. Especially impressive, some participants felt empowered to disclose their personal mental challenges, or those of their family, without shame or fear of being stigmatized. Participants qualified that individuals should not be defined by their mental health challenges.

I realize that talking about these topics is how we break the stigma and help spread awareness about them … Thanks to this course I no longer feel ashamed to identify myself as someone who has dealt with depression. (Participant 3, Year 2, Time 2)

I have also learned to become more open about my struggles as I understand how important speaking to others can be for myself and other people who are struggling … Furthermore, I now see how important understanding and having discussions about mental health issues are for my classroom as a future teacher. (Participant 30, Year 2, Time 2)

Fear of stigma (self and others) remains one of the greatest barriers to engagement in help-seeking behaviours, both on campus and community (Corrigan et al., 2016; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Marsh & Wilcoxon, 2015; Michaels, Corrigan, Kanodia, Buchholz, & Abelson, 2015). Participation in supportive, peer discussions can promote an overall sense of connectedness and well-being, as well as support positive self-esteem, provide affirmations, and inculcate a sense of self efficacy (Corrigan et al., 2012, 2016; Lannin, Vogel, Brenner, Abraham, & Heath, 2016). Especially important, engagement in such positive experiences presumably supports participants willingness to engage in future help-seeking behaviours and helps sustain their role as advocates for mental health and wellness. Consistent with this perspective, participants in this study expressed a desire for additional learning and ongoing professional development opportunities,

[I would like] to broaden the scope of my knowledge of mental unwellness, both in myself and in others. (Participant 11, Year 1, Time 2)

This course made me realize I still have a lot to learn. (Participant 10, Year 2, Time 2)

Conclusion

Recently there has been increased attention to supporting, sustaining, and enhancing postsecondary students' mental health and wellbeing (Condra et al., 2015). For the most part, these efforts have focused on promoting initiatives to increase students' mental health literacy while simultaneously increasing and promoting access to counselling and other direct support services (MacKean, 2011). While beneficial, these initiatives are largely removed from formal academic study, and thus, are likely to service selective students only. Furthermore, when programs offer courses in mental health, they often provide greater emphasis on screening, assessment, diagnosis, and management of illness versus promoting understanding and empathy, eliminating stigma, and sustaining wellness (PHE Canada, 2014).

The findings here suggest that students' lived narratives can be used successfully to promote their understanding of the dynamic nature of mental health. The sharing of lived narratives provided students in this course with first-hand evidence of the pervasive nature of mental health challenges, with the majority of participants sharing challenging experiences related to themselves, their families, or their friends. By revisiting their narratives through the lens of course content, participants were able to develop a sense of agency for supporting others and promoting their own wellness, replacing, in part, previous perceptions of helplessness. In these ways, students were able to bridge the theory-to-practice gap and view course content as integral to their daily experiences (Davis & Wilcock, 2013).

Developing skills to engage in challenging discussions about mental health and wellness, as well as developing a repertoire of effective coping mechanisms, is especially important for teacher candidates as they prepare to enter the profession (Paterson & Grantham, 2014). Many practicing educators report feeling ill-prepared to identify, support, and advocate for those with mental health challenges. With these concerns come requests ongoing professional development (Armstrong et al., 2015; Soares, Estanislau, Brietzke, Lefevre, & Bressan, 2014). Participants in this study presented themselves as willing to engage in such professional development initiatives within their future roles as educators.

The university environment is increasingly recognized as stressful and demanding (MacKean, 2011; Knowlden, Hackman, & Sharma, 2016), with many institutions coming to view professors as critical persons in supporting students' mental health and social-emotional needs (DiPlacito-DeRango, 2016). We believe that offering highly specialized courses in mental health and wellness that go beyond knowledge dissemination to include a focus on personal experiences is one method of providing such support. We qualify, however, that such courses need to be taught by appropriately trained instructors who possess relevant clinical training or mental health expertise. With appropriate training instructors can shape and support discussions in ways that work to reduce stigma, create a sense of normalcy and foster a non-judgmental community. The findings of this study provide postsecondary instructors with insights about the complexities of student life as well as the pedagogical utility of using narratives to engage students in troubles conversations.

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