



University students' perspectives on mental illness stigma

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ABSTRACT

Mental health issues are increasingly prevalent among North American post-secondary students and often impede academic progress. However, students appear reluctant to seek help and access mental health services due to stigma associated with mental health issues. Our study explored university students' perspectives on and experiences of mental illness stigma on campus with the ultimate aim of working towards building more inclusive communities. Drawing on a participatory action research approach, we recruited 24 Canadian university students and conducted 13 semi-structured interviews, three focus groups, and three Photovoice sessions. Thematic analysis of the transcribed narratives and discussions derived from the data-collection process generated three themes. First, students identified academic pressure, the concealed nature of mental illness, and mistreatment of people with mental illness as sources of stigma. Second, stigma threatened three aspects of student life: being, doing, and belonging. Third, enhancing awareness of students' mental health issues and improving mental health service delivery were indicated as critical to addressing stigma. The university's ability-focused culture appeared to contribute to reinforcing stigma and to students being threatened with losing or damaging their academic competence status. Universities should initiate dialogue with students and faculty to communicate the relationship between students' mental health and academic success.

1. Introduction

Mental health issues among post-secondary students have been receiving increasing attention from researchers in North America, with a mounting body of evidence indicating that depression, anxiety, eating disorders, and panic disorder have been prevalent among university students in the last decade (Eisenberg, Hunt, & Speer, 2013; Hunt & Eisenberg, 2010; Kerr, Santurri, & Peters, 2013; Keyes et al., 2012; Zivin, Eisenberg, Gollust, & Golberstein, 2009). The American College Health Association (2016) reported that, in a defined 12-month period, 65% of students enrolled in post-secondary institutions in Canada had experienced overwhelming anxiety, over 60% had experienced "more than average" or "tremendous" stress, and 44% had felt so depressed that they had difficulty functioning. More than 32% of students reported that anxiety had affected their academic performance, and approximately 21% reported that depression had a similar effect.

Despite growing evidence of the prevalence of mental health issues and their adverse effects on university students' academic progress (Eisenberg et al., 2013; Keyes et al., 2012), relatively few students appear to seek out help or access mental health services (Eisenberg,

Hunt, Speer, & Zivin, 2011; Reavley, McCann, & Jorm, 2012; Zivin et al., 2009). Previous studies revealed that treatment rates were modest among students who had mental health issues: 18% in 2005, 25% in 2007 (Zivin et al., 2009), 35% in 2011 (Walter et al., 2013), and 36% in 2006 and 2008 (Eisenberg et al., 2011). While some students with mental health issues claimed that they did not seek treatment because they considered it to be less of a priority than meeting the immediate, more tangible demands on their time (e.g., coursework) (Eisenberg et al., 2011), there is evidence that other factors exert an equally significant influence on their decision making. Although only 25% of students in Canadian post-secondary institutions reported that they would not seek professional help for mental health problems (American College Health Association, 2016), those who reported that they would seek help may find themselves confronted with the additional problem of not knowing who or what services to approach (Reavley et al., 2012). Research shows that students may feel dissuaded from seeking help when it is not immediately obvious to them where that help may be found (Storrie, Ahern, & Tuckett, 2010). Furthermore, their perception of how mental illness is perceived on campus may reinforce an aversion to seeking help (Chen, Romero, & Karver, 2016).

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The association between students' seeking help for mental illness and both public and personal stigma towards mental illness has been the subject of several studies. Public stigma, a social phenomenon, is defined as the publicly endorsed holding of negative stereotypes about and prejudices against certain groups of people, which hinders those groups' opportunities to achieve their life goals (Corrigan, 2004), while personal stigma refers to an individual's holding of negative stereotypes about and prejudices against a group of people that reflects and (re) produces public stigma (Griffiths, Christensen, Jorm, Evans, & Groves, 2004). Some studies identified the perceived public stigma associated with mental illness as presenting a particular obstacle to students' seeking help or accessing the available services (Boyd et al., 2007; Storrie et al., 2010), while others found that personal stigma was negatively associated with a disposition to seeking help (Corrigan, 2004; Eisenberg, Downs, Golberstein, & Zivin, 2009; Lally, Ó Conghaile, Quigley, Bainbridge, & McDonald, 2013).

Goffman (1963) defined stigma as "an attribute that is deeply discrediting." It diminishes the social status of an individual by reducing them in the eyes of others from being "whole" and "usual" to "tainted" and "discounted" (p. 3). The defining characteristics of a stigma are generally perceived as negative, and contrary to the dominant cultural norms and beliefs in a society, which results in stereotyping and discrimination. However, the conceptualization of stigma was criticized not only for its imprecision and failure to integrate the perceptions and experiences of people who are stigmatized (Schneidre, 1988) but also for its focus on primarily individual and interactional levels, as opposed to social and institutional levels (Fine & Asch, 1988). Addressing the issues of the conceptualization, Link and Phelan (2001) synthesized literature on the conceptual development of stigma, expanded on Goffman's definition of stigma, and posited stigma as a multifaceted concept comprising four phenomena. First, individuals distinguish and label human characteristics/conditions that are significant within a social context and can be categorized as "different." Second, such labelled differences are connected to negative stereotypes based on perceived undesirable characteristics. For example, mental illnesses have long been associated with violence, fear, and danger (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Third, labelling people with characteristics/conditions categorized as "different" leads to their being separated and excluded from and rejected by those who do not present such characteristics/conditions. The stereotypical notion that people with mental illnesses are potentially dangerous, for example, may lead to limited opportunities for social interaction between them and people who are not living with such illnesses (Link et al., 1999). Fourth, individuals who present "different" characteristics/conditions report being devalued, losing status, and being discriminated against. Link, Yang, Phelan, and Collins (2004) contend that the emotional reactions and responses to socially undesirable attributes (e.g., fear and shame) of people who stigmatize, as well as people who are stigmatized, which they see as crucial conceptual components of stigma, are underrepresented in Link and Phelan's conceptualization.

According to Yang et al. (2007), as stigma is increasingly perceived as a social, cultural, and interpretive process, it is equally increasingly perceived as a moral issue, embedded in people's engagement in their everyday lives, "threaten[ing] the loss or diminution of what is most at stake, or actually diminish[ing] or destroy[ing] that lived value" (p. 1530). Thus, people with stigmatized characteristics face the prospect of losing what matters most in their local world, tangible or otherwise. This threat puts extra pressure on them to circumvent the stigma they experience and to preserve their capacity to engage in meaningful activities that are key to their being seen as—and feeling like—a moral person in their social world (Yang et al., 2007). For example, for Chinese immigrants, maintaining the capacity to earn an income represents a fundamental form of engagement in their everyday life that will enable them to attain essential social goals, such as marriage; thus, Chinese immigrants living with mental illnesses experience stigma most acutely and intensely when it obstructs their ability to work

(Yang et al., 2014).

Previous research has shown that stigma surrounding mental health issues is not unusual on college or university campuses. For example, Lally et al. (2013) found that university students not only perceive the general population as accepting and perpetuating negative stereotypes about mental illnesses but also behave in this way themselves, although they believe they attach less stigma to mental illness than the general public does. Pedersen and Paves (2014) investigated discrepancies between perceived public stigma and personal stigma specifically towards seeking mental health treatment among college students. Their findings showed that the students noted more perceived public stigma than personal stigma. Previous studies identified certain characteristics associated with a stigmatizing attitude towards mental illness, including younger age, male, lower education, Asian ethnic background, international (i.e., foreign nationals), strong religious beliefs, lower socio-economic family status (Eisenberg et al., 2009; Reavley et al., 2012), no history or treatment of mental illness, and no personal contact with individuals with mental illness (Lally et al., 2013). In addition, Schwenk, Davis, and Wimsatt (2010) found that depressed students endorsed a stigmatizing attitude more frequently than non-depressed students.

Some efforts have been made to create initiatives to reduce mental illness stigma in a higher education environment. For example, previous research found that mental health first-aid training was effective in improving students' recognition of mental illnesses and reducing stigmatizing attitudes towards mental illnesses (O'Reilly, Bell, Kelly, & Chen, 2011). Providing students with opportunities to interact directly with people with mental illness has been shown to positively influence adults' and adolescents' attitude and behaviour towards people with mental illness (Corrigan, Morris, Michaels, Rafacz, & Rüsche, 2012; Yamaguchi et al., 2013). However, Eisenberg, Downs, and Golberstein (2012) and Mehta et al. (2015) found that the opportunity by itself did not improve attitudes towards people with mental illnesses particularly in a long term, which indicates a need to integrate other strategies, such as new approaches to and techniques for education, as has been suggested by Pinfold, Thornicroft, Huxley, and Farmer (2005). For example, taking a first-person narrative approach (using stories by individuals with mental illnesses) to teaching psychopathology resulted in a significant decrease in mental illness stigma among students compared to taking a traditional diagnostic approach (using diagnostic manuals and materials based on a third-person perspective) (Mann & Himelein, 2008). Mental illness stigma may also be reduced when students recognize and acknowledge their own mental health issues. Eisenberg, Speer, and Hunt (2012) found that 65% of students who screened positive for depression, anxiety, and suicidal ideation and also reported not being treated displayed positive attitudes towards mental illness and optimistic beliefs about the effectiveness of treatment. Yet, in addition to there being no evidence-based agreement on the most effective intervention for reducing mental illness stigma in a post-secondary learning environment, methodological weaknesses (e.g., lack of randomized designs, failure to check pre-intervention equivalence between groups) have also been identified in the previous studies (Mehta et al., 2015).

An increasing number of universities have been making a concerted effort to promote students' mental health in recent years (Conley, Durlak, & Dickson, 2013; O'Reilly et al., 2011; Warwick, Maxwell, Statham, Aggleton, & Simon, 2008), and non-profit organizations have been educating and empowering students to advocate for their mental health (Active Minds, 2019; Jed Foundation, 2019). Research has shown that in post-secondary institutions, having students participate in both skill-oriented interventions (e.g., mindfulness training, cognitive-behavioural techniques) and active supervised hands-on practice is critical if they are to acquire both theoretical knowledge of and practical skills in mental health issues and treatment (Conley et al., 2013). Furthermore, when implementing mental health promotion and prevention programs to post-secondary students, a class format is more

likely than an individual—or small group-based format to yield positive mental health outcomes, such as decrease in emotional distress and heightened self-esteem, and improved social and emotional skills (Conley et al., 2013). Mental health first-aid training can also increase students' mental health literacy (e.g., ability to identify mental illness and to recognize helpful interventions) and mitigate students' stigmatizing attitudes (O'Reilly et al., 2011). Non-profit organizations have been executing campaigns and providing programs to educate and inform about students' mental health issues and resources, change policies and systems, and influence campus culture with the aim of reducing stigma (Active Minds, 2019; Jed Foundation, 2019).

However, given that past efforts to promote awareness of mental health issues and services on college campuses have yet to produce significant changes in students' attitudes towards reaching out for assistance, there is a growing need to explore the role that an awareness of mental illness stigma plays in students' disclosure, or otherwise, of their mental illness and willingness to seek treatment. While previous quantitative research revealed if and to what degree university students perceive social and personal stigma in the context of mental illnesses, little research to date has qualitatively explored how university students directly perceive mental illness stigma that exists, and is socially (re)created, in their everyday academic context. Using participatory action research (PAR), this study explores how students at a Canadian university perceive mental illness stigma in their academic lives in order to gain insight into how to reduce it and build inclusive academic communities that foster students' academic pursuits.

2. Methods

Using a PAR approach, this study encouraged students to engage in the research process from identifying an issue for exploration to investigating it and taking action to address it (Baum, MacDougall, & Smith, 2006; Lee et al., 2018; Whyte, 1991). In contrast with conventional research models, PAR regards community members as experts in the issue of interest because they have direct experience of it, and encourages researchers to share knowledge and power with them and to collaborate with them in the research process (Baum et al., 2006; Horowitz, Robinson, & Seifer, 2009).

Our research team comprised 11 members: seven students enrolled in the university at which the study was conducted, one volunteer—a recent graduate from the university—one postdoctoral fellow, and two faculty members. As active research team members, the students and volunteer engaged in recruitment, data collection and analysis, and knowledge dissemination. The faculty and postdoctoral fellow guided the team in rigorously conducting the research. For example, they provided training in data collection and analysis for the student and volunteer members. The researchers obtained ethical approvals from their university prior to conducting the research.

2.1. Participants

Participants in the study had to be 19 years of age or older; registered for undergraduate or graduate programs at the selected university; and able to attend a project orientation session in autumn 2013. In an attempt to obtain a breadth of perspectives on mental illness stigma, experience of mental health issues was not a requirement. Recruitment strategies included advertisements posted across campus, on university websites, and in social media; and announcements in classes and at campus events. As part of this process, we highlighted the aim of the project as being to explore and address the impact of mental illness stigma on student life.

Twenty-four participants provided written consent to participate in the study. They were predominantly female (88%), heterosexual (92%), single (79%), domestic (92%), and enrolled in the Faculty of Arts (58%), with 50% self-identifying as being of European ethnic origin, 25% as being of East Asian ethnic origin, and 13% as being of Middle

Table 1
Participant characteristics.

Characteristic	N	%	
Age ^a	19–20	9	38
	21–22	5	21
	23+	10	42
Sex ^a	Male	3	13
	Female	21	88
Ethnic origin	East Asian	6	25
	European	12	50
	Middle Eastern	3	13
	South/South East Asian	2	8
	Mixed	1	4
Faculty	Arts	14	58
	Science	5	21
	Other	5	21
Year of study	1	4	17
	2	5	21
	3	6	25
	4	6	25
	5+	2	8
	Unknown	1	4
Sexual orientation	Heterosexual	22	92
	Gay/Lesbian	1	4
	Other	1	4
Relationship status	Single	19	79
	Partnered	5	21

Note. ^aPercentages sum to 101% due to rounding.

Eastern ethnic origin (Table 1).

2.2. Data collection

In October and November 2013, 13 semi-structured individual interviews, three focus groups, and three Photovoice sessions were conducted to explore how students perceived (a) causes and sources of stigma associated with mental illness, (b) the effects of mental illness stigma on students' lives, and (c) strategies for minimizing stigma on campus. Each method had the same exploration focus. However, the multi-methods approach served as a triangulation strategy to offer us opportunities to find inconsistencies in the findings generated by the different methods, and analyzing those inconsistencies provided us with a deeper insight into and understanding of the phenomenon of interest, mental illness stigma (Patton, 1999). The interviews facilitated a more in-depth exploration of interviewees' specific perspectives and experiences, whereas the focus groups provided breadth of data as they encouraged students to identify both shared and discrete experiences and opinions through discussing their experiences and perspectives with other students. As a complementary method to PAR, Photovoice not only enabled us to co-create knowledge with participants and empower them to transform their learning community through critical and reflective dialogue about stigma and strategies for addressing it (Lal, Jarus, & Suto, 2012; Wang & Burris, 1997; Wang, Yi, Tao, & Carovano, 1998), but also enriched the data elucidating students' perceptions of mental illness stigma because visual images allowed students to capture and present complex meanings associated with it. One photograph, for example, showed a huge lecture room with over 200 chairs and was titled "Just another number," thus illustrating how the university environment could leave students with mental illness feeling isolated and disconnected from their peers and instructors on campus.

The research team developed guides for conducting semi-structured interviews (Appendix) and facilitating focus groups and modified these as required following research team discussion after each interview and focus group as the data collection process progressed. For Photovoice, the team also created a discussion guide with the objective of exploring mental illness stigma through its visual representations and symbolic meanings of stigma. The foundation of this guide was the "SHOWED" method, exploring in each photograph "What is Seen?" "What was

Happening?” “Does this problem happen in Our community?” “Why does this problem happen?” and “What are we going to Do about this problem?” (Shaffer, 1983, p. 25).

Each interview was conducted by one research team member and took approximately 60 min. Each focus group and Photovoice session was facilitated by two to three members and took approximately 120 min. Once the interviews and focus groups were completed, a set of three Photovoice sessions were conducted, drawing on Wang and Burris's (1997) three-stage process: “selecting,” “contextualizing,” and “codifying” (p. 380). Participants who signed up for the Photovoice sessions were instructed to take photographs that represented their perceptions of what mental illness stigma means and, if such stigma was a concern for students in the university, how it affected students' life. The participants took photographs with their smartphones over the course of one week. Each participant selected a maximum of six photographs from those they had taken to illustrate stigma surrounding mental illness on campus (selecting) and gathered in a group to share the stories behind their photographs, which captured what mental illness stigma meant to them and how it affected students' lives, and to voice their individual and collective ideas about how to combat mental illness stigma (contextualizing). By using the SHOWeD discussion questions, the participants reached agreement on common themes in their photographs (codifying). Dialogues from the interviews, focus groups, and Photovoice sessions were audio-taped and transcribed verbatim.

Of 24 participants, 14 provided their perspectives through more than one data collection method. Thirteen participants were interviewed, 20 attended focus groups, and five engaged in Photovoice. One participant engaged with all three methods, nine participated in both an interview and focus group, and four were involved in both a focus group and Photovoice sessions. Each participant was assigned an ID number, which was noted on the transcripts to allow us to identify comments from individual participants who participated in multiple data collection sessions (e.g., focus group and interview) and to avoid identifying those perceptions as dominant and representative. It should also be noted that the objective of this qualitative study was to capture individual students' perceptions of mental illness stigma rather than identifying dominant perceptions.

2.3. Data analysis

Data analysis, informed by Braun and Clarke's (2006, 2012) thematic analysis techniques, was conducted by two sets of team members, with one set analyzing the interview and focus group data and another analyzing the Photovoice data, which required a distinct approach to identifying common themes across photographs and discussions based on them (codifying). For each data set, analysis began with reading the transcripts repeatedly to become intimately familiar with the content and actively seeking out patterns within them. Initial codes were inductively generated for respective sets to describe the semantic content of the data and then collated into categories for each set. Each transcript was coded by two research team members to cross-check if the participants' meanings had been interpreted accurately and if the codes generated initially captured the intended meanings. Clustering the categories created overarching themes that informed and addressed the study objective (Braun & Clarke, 2012). The research team met every two weeks to discuss the analysis process to ensure that data within categories and themes were coherent and internally consistent (Braun & Clarke, 2006). The categories and themes developed from each data set were merged through a process of comparing them, identifying and discussing inconsistencies between them, and negotiating and agreeing on the categories and themes that accurately captured the meanings of both sets of data. The preliminary findings were presented in a session to which all participants were invited to discuss the findings and provide feedback, following which the categories and themes were modified, refined, and finalized. Each category and theme were then defined

in a way that accurately captured and reflected participants' perceptions of mental illness stigma.

3. Results

The thematic analysis generated three themes: (1) Sources of mental illness stigma: Academic pressure and lack of understanding of illness; (2) A triple threat: Consequences of mental illness stigma for being, doing, and belonging; and (3) Reducing mental illness stigma through enhanced awareness and service delivery. The findings were informed by two types of perspectives on interactions and the overall campus milieu: first-person experience and observation of mental illness stigma. Participants' names have been changed to ensure confidentiality.

3.1. Sources of mental illness stigma: academic pressure and lack of understanding of illness

Participants identified two main factors that contributed to mental illness stigma on campus: immense pressure to thrive academically as well as mentally, and the opaque nature of mental illness. Participants indicated that the university was such a competitive environment that students felt immense pressure to accomplish more—an indication of “success” in that environment. “The climate and the expectations of the university itself [have] a stigma against people who are not the top 5% or whatever” (Caroline, Interview). The combination of expectations and a competitive environment resulted in excessive workloads for students who felt pressured to exceed expectations and to beat their peers by achieving more—all of which was reflected in participants' comments about feeling overwhelmed and stressed. Diana summed up some of the repercussions of this competitive academic culture:

[I]t sometimes stresses me out to think about how other people are doing better than me and I always tend to view things as a competition—whether it's an assignment or a job or physical.... So I strive to out-win people, but obviously sometimes that doesn't work and if I admit to the public that I'm having mental health issues because I'm stressed about all the competition surrounding my work, then it would be admitting to a weakness and I don't want to do that. I think that's a part of mental health stigma because you want to seem independent and want to see a person who's all happy and all doing so good. ... from my experience I think the fear comes from wanting to achieve more and more and try[ing] to be better than others. That's why I'm driven to keep doing better and do more and more things, but as I do more and more I get more stressed so it's an ongoing cycle. (Interview)

Like Diana, many participants appeared to be reluctant to slow down or take any type of break from the pursuit of excellence because of a fear of missing opportunities their friends were taking advantage of to get ahead. An academic culture such as this—one that pressures students to achieve more and better—was linked, in the minds of participants, to creating and reinforcing a belief that having mental health issues and concerns is an indication of ‘failure’ to excel in academia.

Mental health issues were described as “not very tangible” or “an unseen disability” and thus difficult to understand. Participants described how hard it often was to recognize symptoms of a mental illness, and especially to distinguish between normal levels of mental responses (e.g., feelings of anxiety during exam periods) and those that would be categorized as disorders. For example, Melissa commented:

Before I had kind of identified my depression ... I thought I was just lazy and not resourceful and I just thought I just need to control myself, get motivated, get disciplined. ... it really came from me thinking I was not good enough and it was my fault. (Interview)

The comment above indicates that students with mental health issues may see themselves as responsible for their situation because the signs of their mental illnesses or distress are often obscure or ambiguous. This

self-blame was cited as one of the reasons for postponing efforts to seek help and potential treatment.

Participants noted that people also tend not to learn or talk about mental illness in part because it is non-visible and intangible. From the students' perspective, a lack of knowledge and awareness of mental illness among members in the university contributed to and perpetuated stigma. Participants indicated that the university failed to initiate dialogue about mental health and illness: "[T]here's a lack of education on campus and I think that's where stigma comes from" (Becky, Focus group). Such a culture—that is, one that does not advocate for people with mental health issues and promote awareness of mental illness—was perceived as aggravating mental illness stigma.

3.2. A triple threat: consequences of mental illness stigma for being, doing, and belonging

Participants identified that mental illness stigma had a significant impact on three aspects of student life: *being themselves*, *doing academic and social activities*, and *belonging to social circles*. In this competitive environment, students with mental health issues seemed to be seen as "weak," "inadequate," and ill-equipped to cope with academia. To be seen as competent and academically strong, students with mental health issues often felt reluctant to disclose that they had such issues, and instead presented their able self to people around them.

I mean self-stigma for me would only really happen at [the university] because it's where I try and portray this image that I am confident and able to meet demands. With my family or friends, it's okay if I show weakness, but at [the university] where I'm being judged on my capabilities, I kind of want to hide that. (Jennifer, Photovoice)

In such an ability-focused culture, students were hesitant to seek help because they feared that would mean admitting that they lacked ability.

Participants discussed how mental illness stigma negatively affected students' academic performance, as well as their everyday lives—students were unlikely to disclose their mental health issues, and were subsequently unlikely to sustain any level of social engagement or reach out for help. This social isolation and reluctance to seek help could negatively affect their academic pursuits. Zoe stated:

It [mental illness stigma] would probably affect them [students with mental health issues] academically as well as socially because they probably would feel pretty down and wouldn't want to socialize with people and that could affect their school work and it would be a downward spiral. (Interview)

There was consensus among participants that mental illness stigma could restrict the social engagement of students with mental health issues because they feared being judged and treated differently from "normal" students.

I've seen some people who had [a] fear of meeting other people because they felt like they might be a bit different from the others. ...they were always hoping that they could just stay indoors. They felt alienated. (Emma, Interview)

In general, mental illness stigma was described as a barrier to building friendships and advancing friendships beyond a "surface-level," leading students to feel isolated, disconnected, alienated, and excluded. Consequently, there was no place for students with mental illness to belong because they were unable to be authentic. Furthermore, students' sense of being disconnected discouraged them from sharing their mental health issues, which in turn aggravates the stigma. The caption of Olivia's photo "Blur" (Fig. 1) encapsulated this: "Lack of meaningful connection between those with and without mental illness leads to a lack of knowledge and prevents us from seeing things as they truly are. Resulting fear and confusion lead to stigma" (Photovoice). When students who had mental health issues and concerns withdrew abruptly

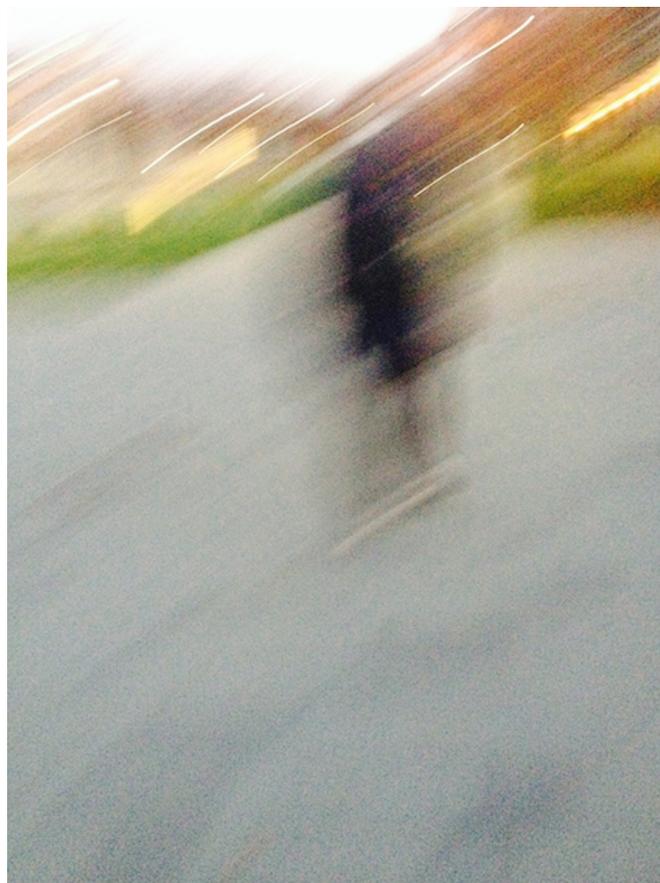


Fig. 1. Blur.

from their social circle, their friends who did not have mental health issues had only limited opportunities to understand that mental illness was the main contributing factor behind their change in behaviour. Furthermore, the distance between them that subsequently arose contributed to a sense of uncertainty and mistrust between the two groups, thus further reinforcing the stigma.

3.3. Reducing mental illness stigma through enhanced awareness and service delivery

Participants suggested various strategies for combating mental illness stigma on campus, and singled out two in particular: raising awareness about mental health as well as services and resources available on campus, and providing education and training for faculty and staff. For example, Isaac said:

If...we wanted to sort of tackle mental health stigma, it'll be a good way to sort of show examples of how common [mental illness] can be and how normal people or happy people...can actually go through these tough times and how people should deal with them. (Focus group)

Raising awareness among students about the prevalence of mental illness—and how a student can be an academic high-achiever despite having a mental illness—would normalize it in a learning environment. Participants emphasized that the normalization of mental illnesses would alleviate, to some extent, students' feelings of being alone in their experiences and encourage them to seek help for mental health issues.

Promoting the existing resources and services was identified as even more critical for reducing stigma because many students were unaware of the services and support available to them on campus that could help

them to optimize and sustain their mental health. Participants identified teaching staff as playing an important role in raising awareness of services.

[P]eople in the faculty ... knowing that ...most students are gonna be stressed during midterm season or finals ... it would be good if they ... [maybe] say “if you're too stressed out ... go to this place” ... make it known so that if they do feel stressed out they have options. (Kate, Focus group)

Participants noted that if faculty and staff are to successfully direct students towards the resources and supports that could help them to address their mental health concerns and issues, they need to be able to recognize the indicators that a student is struggling with mental health concerns and issues and to be fully aware of what mental health resources are available on campus, as well as how to assist the students in meeting their learning needs and achieving their educational goals. Other suggestions for promoting and enhancing service delivery included creating a package of mental health resources available on campus for prospective students, developing one-stop services on campus, and hiring more counsellors and offering online services. Promoting a culture of self-care on campus (e.g., legitimizing mental health days) was also identified as key to reducing mental illness stigma.

4. Discussion

This study explored how university students perceived mental illness stigma. Students' perception of mental illness stigma portrayed mental health and academic competence as inextricably intertwined. From a student perspective, the competitive and ability-oriented university culture constructs and exacerbates mental illness stigma. Students perceived the university as expecting students to survive and thrive academically and felt that they had to be mentally robust to meet this expectation. An optimal state of mental health was viewed as an indication of academic survival as well as a precursor of academic excellence, while having mental health issues was viewed as a sign of an inability to cope with the significant workload imposed by the university. This view reflects the ability-focused values of the educational institution. Kleinman (2006) contended that life experience is bounded by locally shared values and influenced by what matters most to an individual. Stigma essentially creates a context that threatens the loss or diminution of what matters most to individuals who possess what are perceived to be discrediting attributes (e.g., mental illness) (Yang et al., 2007, 2014). Therefore, in an educational institution that values academic excellence, mental illness stigma can endanger a student's status as academically competent, which is presumably what they value most as a student. The stigma associated with mental illness is reinforced by a culture that elevates the status of academically successful students.

In addition, our analysis identified the covert nature of mental illness as a factor that can encourage students who have mental health issues not to disclose them. As individuals “incorporate and exemplify the officially accredited values of the society” (Goffman, 1959, p. 35), in the ability-focused university culture, students may likely present only their able self to others and otherwise conceal their ill self. The fear of being labelled and discredited may lead them to conceal mental illness in order to differentiate themselves from negative stereotypes that could affect their self-esteem and self-efficacy (Corrigan, 2004; Corrigan, Watson, & Barr, 2006). This could in turn lead them to avoid accessing mental health services for help (Eisenberg et al., 2009; Martin, 2010; Schwenk et al., 2010).

Our findings suggest that students with mental illness often isolate themselves as a form of protection from their perceived threat of being rejected and discriminated against, which reflects findings from previous studies (Abdullah & Brown, 2011; Goffman, 1963; Link, Struening, Dohrenwend, Cullen, & Shrout, 1989). Students seem to withdraw socially, disconnect, and alienate themselves from their social

circles because of a fear of being judged as ‘abnormal,’ especially as mental illness begins to affect their ability to continue to present only their able self to others. While participants in this study seldom observed behaviours that stigmatized students with mental illness on campus, this might be a result of students' efforts to look ‘normal’ and pre-empt the possibility of being stigmatized (Whitley & Denise Campbell, 2014).

This study revealed a reciprocal relationship between mental illness stigma and students' compromised sense of belonging to the campus community. Participants indicated that mental illness stigma diminished students' sense of belonging. Due to stigma, students with mental health issues seemed likely to conceal their illness from their university and peers, withdraw from social circles, and hesitate to seek help for their mental health issues. In addition, the university's ability-focused culture encouraged students to compete with each other, thereby limiting access to peer support networks and lessening the sense of belonging to the university. Their feeling of being disconnected in turn discouraged students with mental health issues from disclosing not only the health issues but also the academic and social challenges associated with those health issues. This can reduce opportunities to initiate conversations about mental illness that could begin to normalize its occurrence and thus reduce stigma. Belonging refers to connecting to others and environment as well as contributing to other people's lives (Hammell, 2014), and a sense of not belonging has been indicated as aggravating depression (Choenarom, Williams, & Hagerty, 2005). Previous research revealed that it is important for people with mental illness to have a place in which they feel safe in order to promote their recovery, meet their need to belong, and foster their participation in activities (Rebeiro, 2001; Rebeiro, Day, Semeniuk, O'Brien, & Wilson, 2001; Sutton, Hocking, & Smythe, 2012).

This study has implications for stigma reduction in post-secondary learning environments. Universities need to enact a multilevel strategic approach (Jed Foundation and Education Development Center, 2011). At an institutional level, they need to be aware that if they over-emphasize and exclusively value students' academic excellence, they could solidify the link between mental and academic abilities, which in turn reinforces and perpetuates mental illness stigma and ableism. Thus, universities should initiate dialogue with students, teaching faculty, and staff for changes in teaching practices and evaluation criteria (an interpersonal level), and offer workshops to help students who need learning assistance (an individual level). In addition, developing an environment that encourages students to support each other in both an academic (that is, in terms of learning) and self-care (that is, in terms of fostering their health and well-being) sense could nurture a sense of belonging, which may in turn make it easier for students to disclose mental health issues. As our study showed, on-campus mental health services are available to students, but their existence must be promoted to help students address their mental health needs and subsequently pursue academic success. Universities might share evidence of effective outcomes of students' use of the services with students, faculty, and staff to encourage students with mental health issues to seek help and fully participate in treatment (Corrigan, 2004).

This study has limitations and strengths. Due to the small sample size, homogeneous characteristics, and context of the specific university, the findings may not be transferable to other settings. The small sample size and homogeneity of the participants' characteristics also precluded comparison among sub-groups. Because female, domestic, and heterosexual students accounted for the majority of the sample, future research needs to explore perspectives of students with other characteristics—for example, male, non-binary, from a variety of cultural backgrounds. Female students have been shown to be more likely than their male counterparts to seek help to address mental health issues (Leong & Zachar, 1999; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011), so male students may have more negative views about mental illness. Future research should examine international and first-generation immigrant students, because the influence exerted by those

students' home culture may have more impact on their perceptions of mental illness stigma and help-seeking behaviour than their new culture does. This may suggest a need for a different approach to minimizing stigma for those populations and to encouraging them to seek help. In addition, as most of the participants were likely to be interested in or concerned about mental health, the findings might not represent students who were not interested or concerned. Including students in the research process helped us generate the findings and identify implications that reflect their perspectives and needs; the use of interviews, focus groups, and Photovoice enabled us to triangulate the data and enriched our understanding of students' perspectives on mental illness stigma.

5. Conclusions

This study explored how post-secondary students perceive mental illness stigma in their university lives and revealed that the university's ability-focused culture channelled the consequence of having mental health issues towards a threat of losing or damaging academic status among students. Educational institutions must revisit their expectations of students, evaluation criteria and methods, and teaching practices and assess how the culture created by those expectations (re)produces stigma towards students with mental illness as well as negative meanings attributed to it in terms of students' academic competence.

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Declarations of interest

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Appendix

Mental Health Needs Assessment—Interview Questions

- 1 As a student at [University] what are some of your goals, aspirations and dreams, including academic-related, career-oriented or other?
- 2 What does mental health stigma mean to you?
- 3 Do you think mental health stigma is a concern for [University] students? If so, how does mental health stigma affect student life?
- 4 What do you think are the causes or sources of mental health stigma for [University] students?
- 5 What are some of the current strategies that address mental health stigma on campus?
- 6 What are some new strategies or changes to existing strategies to address mental health stigma on campus?
- 7 How can [University] implement these strategies to create a stigma-free campus?
- 8 Is there anything else you would like to add or talk about?

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