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Mental Health Stigma and Communication and Their Intersections with Education

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Roughly one in four Americans will experience a mental health issue during his or her lifetime (National Academy of Sciences, Engineering, and Medicine, 2016). The consequences of mental disorders are profound: people with mental disorders experience higher rates of disability and mortality. People with depression and schizophrenia have a 40–60% greater chance of dying prematurely than the general population (WHO, 2017). One reason is that some physical problems are left unattended (e.g., cardiovascular disease; WHO, 2017), suggesting that people with mental disorders pull away from care. On the other hand, it could be that more people need treatment for mental health symptoms than health systems around the world are ready to provide (WHO, 2017): 35% to 50% of people in high-income countries who need treatment never receive it. A different possibility is that stigma and discrimination create barriers for people with mental disorders to access to treatment, jobs, housing, and relationships; this lack of access compromises their ability to attend to their physical health (WHO, 2017; Corrigan & Fong, 2014). Being stigmatized, by itself, depletes instrumental, social, and economic resources, resulting in many negative outcomes, including disparities in the quality and quantity of education (Hatzenbuehler, Phelan, & Link, 2013).

Adapting previous definitions of stigma in communication research (e.g., Smith, 2007), mental health stigma is defined herein as profoundly negative stereotypes about people living with mental disorders. In stigma research, it is useful to employ the term *public stigma* to refer to the stereotypes that have diffused and normalized through a community (Rüsch, Angermeyer, & Corrigan, 2005; Smith, Zhu, & Quesnell, 2016) and *internalized stigma* to refer to how the person living with the mental disorder absorbs public stigma into his or her identity (Rüsch et al., 2005). A variety of personal and social discriminatory acts arise from mental health stigma, from interpersonal avoidance to human rights violations, including restrictions on rights to education, work, marriage, and reproduction (WHO, 2017). Anticipating and experiencing these acts affect how people function in society as a whole and in education settings specifically. This essay hopes to spark a discussion about the intersections of communication, stigma, mental health, and education.

Communication Theories on Stigma and its Management

Rüsch and colleagues (2005) argue that “the misunderstandings of society about the various mental disorders result in stigma” (p. 529). This claim puts communication and education in a position to create new stigmas, bolster existing ones, or help eliminate them or reduce their power. In the past decade, in communication scholarship, we have advanced our understanding of how content choices in educational messages result (likely unintentionally) in prejudicial thoughts and discriminatory actions against those with the condition (e.g., Smith, 2012, 2014). The model of stigma communication (Smith, 2007) describes how the presence of four types of content in health messaging results in framing the people with the condition as dangerous and feeling threatened by them. The stigma frame includes (1) marks: cues that identify membership in a stigmatized group; (2) labels: terms used to refer to a stigmatized group; (3) etiology: explanations for why someone became part of a stigmatized group; and (4) peril: how stigmatized group threatens group functioning and wellbeing (Smith, 2007; also see Smith, Coffman, & Zhu, in press). Exposure to messages using a stigma frame results in stigma-related outcomes. Experiments and content analyses (see Smith et al., 2016 for a review) have highlighted how we can better craft messages in order to avoid creating stigmas. The theory of stigma management communication (SMC; Meisenbach, 2010) provides insights into the nuanced range of communication behaviors used by stigmatized people in interactions to manage these caustic conversations. We have significantly less insight into the various ways in which people verbally and nonverbally enact stigmatization and the relative impact of these acts.

Mental Health and Higher Education

Mental health issues, such as depression, anxiety, suicidal ideation, and self-injury, are prevalent among college students; in a study of thousands of college students, 32% reported symptoms consistent with at least one of these health issues (Eisenberg, Hunt, & Speer, 2013). They can affect educational outcomes and relationships and can result in death. In a national, longitudinal study, students with mental disorders had lower odds of high school graduation, going to college, and graduating from college (Mojtabai et al., 2015). The American College Health Association (2015) reported that 11.9% of college students felt so depressed that it was difficult to function in the last two weeks; 34.5% reported the same in the last 12 months (2015). The same study found that 8.9% of college students had seriously considered suicide. Among 15–24 year olds, death by suicide increased from 3 per 100,000 in 1999 to 4.6 per 100,000 in 2014 (Curtin, Warner, & Hedegaard, 2016). According to the Centers for Disease Control and Prevention WISQARS reporting system (2015), suicide was the second most common cause of death among 18–22 year olds in the United States in 2013, 2014, and 2015.

Vulnerable groups.

Mental health is a result of personal characteristics (e.g., the ability to manage emotions) as well as biological, pharmaceutical, social, economic, and environmental factors (WHO, 2017). People who experience marginalization and/or stigmatization within their society for other reasons, such as minority groups, are at a significantly higher risk of experiencing

mental health problems (WHO, 2017). Mental health issues vary by student demographics. For example, compared with heterosexual students, bisexual and gay/lesbian students had a substantially elevated risk for mental health issues (Eisenberg, Downs, Golberstein, & Zivin, 2013). Minority students and those with current or past financial difficulties were found to have a substantially higher prevalence of depression (Eisenberg et al., 2013). Attention has been paid to lower graduation rates among minority groups (Planty, Kena, & Hannes, 2009), but less attention has been given to differences in students with mental health issues (Eisenberg et al., 2013), although research indicates that depression predicts lack of persistence in college (Eisenberg et al., 2009). To be clear, these vulnerabilities do not only appear in higher education; they may have appeared and affected people long before they reach (if they reach) settings of higher education.

Stigma as a Barrier to Accessing Mental Health Services

For students of all ages, in settings from kindergarten to graduate education, anticipated stigma is a barrier to seeking school-based mental health services. In the K12 setting, adolescents report that fear of being stigmatized was the most significant barrier to accessing mental health services at school (Bowers, Manion, Papadopoulos, & Gauvreau, 2013). This worry is reasonable: adolescents who disclosed their mental health issues report stigmatization from some peers, teachers, and school staff (Moses, 2010). Teachers' reactions matter: a teacher's view of ADHD and how they react to students living with ADHD shape those students' academic achievement, behavior, self-esteem and peer relationships (Kos, Richdale, & Hay, 2006; Sherman, Rasmussen, & Baydala, 2008).

Parents' perspectives.

Parents also report anticipated stigma for their children (e.g., labeled, put in a box, perceived as problematic, troubled, bad, and treated differently by teachers) and themselves as bad parents (Eaton, Ohan, Stritzke, & Corrigan, 2016; Gray, 2002). Furthermore, parents who perceive a stronger public stigma about mental health treatment are less willing to seek services at school, versus other locations (e.g., a private office; Polaha, Williams, Heflinger, & Studts, 2015). School psychologists also expect that parents will want their children to have greater social distance from a child with depression than with diabetes, which has some influence on their decision to provide services (Forman, Fagley, Chu, & Walkup, 2012). In fact, a national study of stigma focused on children found that children with ADHD (33% of the sample) and major depression (81%) were perceived as somewhat or very likely to be dangerous to themselves or others, compared to children with asthma (15%; Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). Over a third of the sample were willing to use legal means to force treatment by a clinician on children with depression. Of note to communication scholars, the label mattered. Participants who labeled a child in one of the vignettes as "mentally ill" (e.g., versus physically ill) were twice as likely to suspect the child of potential violence and five times as likely to support forced treatment.

Accessing services after K12.

What is unclear is how these experiences in K12 shape college students' expectations and use of services available to them on campuses of higher education. An interesting paradox

occurs among people seeking mental health treatment: people with mental disorders often require treatment to function in society, but the simple act of seeking treatment can identify them as a person with a mental disorder, triggering stigma and threatening their employment (Stuart, 2004), ability to maintain health insurance, relationships, and standing in the community (Corrigan & Fong, 2014). Continuing to avoid treatment can result in worsening of symptoms, putting the person in a situation where they suffer with treatment or suffer without it.

College athletes may provide a unique microcosm in which to view the complexities of mental health, stigma, and education (Kaier, Cromer, Johnson, Strunk, & Davis, 2015). Due to the cumulative stresses related to competitive sports, college athletes are at risk for mental health issues, and yet college athletes underutilize psychological services (Watson, 2006). One reason is that people seen at mental health clinics may be labeled as mentally ill and stigmatized; People in the public eye are particularly vulnerable to this possibility (Corrigan, 2004). College athletes often are well known and do not have privacy if they are seen walking into campus counseling (Etzel, Ferrante, & Pinkney, 1991). Minority students, who are disproportionately underrepresented as college students but over represented in athletic teams, report experiencing racism, hostility, and isolation in class and by fans (Beamon, 2014), which carry their own consequences for mental health (McKenzie, 2006). These factors may shed light on why minority college athletes are at risk of not successfully graduating from college (Beamon, 2014).

The Problems with Labels

We have much to learn about the subtle and overt ways that teachers and students stigmatize each other. Importantly, multiple studies in education have documented a strong association between teachers' ratings of students' academic competence and their ratings of students' social skills (for a review see Algozzine, Wang, & Violette, 2011). Teachers who rate students as having more problematic behaviors also provide students lower ratings in academic competence. However, longitudinal studies in which someone other than the teacher completes the ratings find no causal relationship between social skills and academics (Algozzine et al., 2011). A different interpretation, then, is that "teachers are more likely to rate well-behaved students highly on academic competence and to hold higher expectations of these students" (Algozzine et al., 2011, p. 12). Some students with mental disorders, such as those with emotional and behavior disorders, may be prone to the externalizing or internalizing behavior patterns that teachers find problematic (Lane, Jolivette, Conroy, Nelson, & Brenner, 2011). Some problematic behaviors are due to factors that have nothing to do with mental health. Regardless of the source for problematic behavior, the responsibility for the stigma often rests on the person being stigmatized: students are expected to engage in ways that will help them avoid being labeled and categorized into a marginalized group. However, advocates emphasize that stigma is "mostly an injustice perpetrated by one's community" (Corrigan & Fong, 2014, p. 113).

Approaches like the one described above consider mental disorders as problems to be resolved in order to fit into society, instead of broadening our ideas about what is normal, accepted, and admired. The label *mental disorder* used herein was taken from the DSM 5

(American Psychiatric Association, 2013). According to the DSM 5, a mental disorder is “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (p. 20). It goes on to say that mental disorders are “usually associated with significant distress or disability in social, occupational, or other important activities” (p. 20). School is the central context for youth development outside the home, and success in school is associated with mental health and future life opportunities (Roeser & Eccles, 2014). This term “mental disorder” itself carries a stigma that can inhibit help-seeking (Wright, Jorm, & Mackinnon, 2011). In a qualitative study of 473 14-year-old students, researchers found that students used 250 different terms to refer to individuals with mental illness (Rose, Thornicroft, Pinfold, & Kassam, 2007). The students provided no words or phrases with a positive connotation; the vast majority of the list was comprised of derogatory and slang terms.

The label has consequences not only for stigma, but for access to education and accommodations for success. There are notable policy differences at different levels of education. Public elementary, middle, and high schools who receive funding for special education are, as part of the Individuals With Disabilities Education Act (IDEA), required to identify students who have disabilities that affect their learning and to ensure all children with disabilities receive a “free appropriate public education to meet their unique needs and prepare them for further education, employment, and independent living” (American Psychological Association, n.d.). This includes mental health issues. Post-secondary schools, however, are not bound by IDEA (Cohen, 2009). Approximately 25% of U.S. students have mental health issues that interfere with their daily functioning in and out of the classroom, and many never receive care for these issues (Roeser & Eccles, 2014).

The special education system uses labels and categories to determine eligibility for services, even though laws may not necessitate certification by disability category as long as access to services is provided within the law (Cohen, 2009). The labeling process becomes involved in determining a child’s individualized education program (IEP) and what services or affordances the child receives. These labels are also used in qualifying for accommodation on college achievement tests, and then for getting accommodations in college or in a job, qualifying for government benefits, and qualifying for insurance benefits (for a review see Cohen, 2009). In US college settings, students have to disclose their labeled diagnoses, such as dyslexia, to university employees (typically in a disability services office) designated to determine legally required accommodations, if they want to receive accommodations. In addition to this, some students choose to disclose their diagnosis to teachers, as well. A meta-analysis of research conducted internationally (comprised of studies mostly in the UK) suggests that disclosure is not without consequence and does not always lead to accommodations; students report experiences with teachers who say the disclosure is an excuse for special treatment, skepticism of dyslexia’s existence, and prejudice that students with dyslexia are unable to succeed (Pino & Mortari, 2014).

Welcoming Difference and Neurodiversity

As an alternative to problematic labels and the barriers that come with them, fields are emerging to attempt to remove stigma and normalize variations in the human brain for students and teachers. In the past two decades, emerging movements in neurodiversity for autism spectrum disorders (Harmon, 2004) and mad studies/mad pride (Lewis, 2006) seek to move away from medical models that seek to treat a disease and enforce psychological conformity; rather, they encourage acceptance of a spectrum of neurological differences that may need accommodation. Indeed, “everyone can be placed on a range of spectrums” (Pollack, 2009, p. 4). These movements also seek to ensure that people affected by these neurological differences are the ones leading conversations about the best ways to support them (e.g., “Nothing about us without us,” Charlton, 1998). It is outside the scope of this essay to discuss the merits and drawbacks of these movements; we note their presence as evidence, however, that individuals with mental disorders feel the need to organize in order to combat stigma and acquire reasonable accommodations.

Mental health versus mental illness.

Keyes’ (2002) model conceptualizes mental health and mental issues on two separate continua, instead of as the two ends of a single continuum. In the dual-continua model, one continuum spans from no mental health to abundant mental health, and the second continuum spans from no mental health issues, to many issues. This conceptualization allows for ways to consider *flourishing* as high levels of mental health and low levels of mental issues, but *languishing* as having low levels of both mental health and mental issues. This dual-continua model has been empirically tested in numerous studies, including national representative samples of U.S. adolescents (for a review see Keyes, 2014).

This conceptualization also instantiates the World Health Organization’s idea that the absence of mental symptoms does not imply the presence of mental well-being. According to the World Health Organization (WHO; 2017), mental health is a “state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 6). Mental health also includes the ability “to build social relationships, and the ability to learn and to acquire an education, ultimately enabling their full active participation in society” (p. 6).

The dual continuum also provides a better picture of the complexities of mental health. For example, in studies of the American adult population (aged 25 to 74), although 75% of adults did not experience symptoms of major depressive episodes, panic attacks, or generalized anxiety disorder, only 20% reported positive indicators of mental well-being; only 20% were flourishing. In contrast, about 70% of the adults with symptoms had moderate to high levels of positive mental well-being. We put attention onto symptoms, yet adults and adolescents with moderate or low positive mental well-being, with or without mental symptoms, have worse physical health outcomes, health care utilization, missed days of work, and psychosocial functioning (for a review see, Keyes, 2014).

In education scholarship, this resonates with a turn toward understanding educational resilience—school success in the face of personal, family, or environmental risks, in which students who had exposure to opportunities (even out of school) that created social relationships and bonds to community-based schools outperform those who do not (for a review see Roeser & Eccles, 2014). A longitudinal study of middle school students showed that, controlling for initial levels of academic skills, those with higher subjective wellbeing had better academic skills in future years (Suldo, Thalji, & Ferron, 2011). This dual-continua model has implications for creating policy that promotes positive mental well-being, protects against its loss, and facilitates management of symptoms.

The question for the communication scholars, including those focused on instructional design and academic policies, is how can we better understand and promote emotional, psychological, and social well-being in our research and classrooms? Simultaneously, we need to consider how we can effectively help people to manage symptoms that challenge their ability to communicate well and create social bonds. A related topic is how we might use communication to remove existing stigmas, which we review next.

What Have We Learned about Reducing Existing Stigmas?

There have been multiple efforts to eliminate existing stigmas, and more than one meta-analysis of their effects have been published (e.g., Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Unfortunately, the results show that there is not a reliable, consistent means by which to do so. In the most recent meta-analysis, Corrigan and colleagues (2012) grouped existing reduction efforts into three categories: protest, education, and contact.

Protest efforts highlight instances of stigmatization and their injustice, and then attempt to shame those responsible for the stigmatizing behaviors. In anti-stigma campaigns, these efforts have not studied actual protests (see National Academy of Sciences, Engineering, and Medicine, 2016 for benefits of such vocal advocacy); the term is used to refer largely to training programs in which the audience is shown “egregious images from the media (Headline: “Psycho Killer Released from Jail!”) and instructed to stop thinking that way” (Corrigan & Fong, 2014, p. 112). Protest efforts do not reduce stigma-related beliefs or acts; in fact, sometimes they increase them (Corrigan, et al., 2001; Penn & Corrigan, 2002). Ironically, this may resonate with people’s experiences in sensitivity training programs and help to explain their negative results. In social psychology, this is typically seen as thought-suppression rebounding (e.g., Wegner, 2009; Wegner, Erber, & Zanakos, 1993), but it can also be reactance to freedom threatened (e.g., Dillard & Shen, 2005) and a defensive reaction against shame (Carrera, Munoz, & Caballero, 2010). It can be a recipe for disaster.

Education and contact efforts have some promise. Education efforts focus on correcting inaccurate stereotypes about people living with mental disorders and working to change them by providing factual, disconfirming information (Corrigan et al., 2012). They align with the claims that misunderstanding contributes to the presence of mental health stigmas (Rüsch et al., 2005). For example, to counter the myth that people living with mental disorders are profoundly dangerous, people are shown facts about the very small difference in the rates of homicides by people with serious mental disorders versus the general public

(Corrigan et al., 2012). These efforts directly address incorrect ideas. Contact efforts rely on interpersonal contact between the general public and members of a stigmatized group.

Although education and contact intervention showed positive results, meeting people with serious mental disorders, especially face to face, provided significantly greater effects on reducing stigma-related behaviors, but the results may be short-lived (Corrigan, Michaels, & Morris, 2015). Importantly, face-to-face contact interventions were the most powerful. Of note, the contact interventions are not simply about spending time with others (e.g., inclusive classrooms or mainstreaming in K12 settings); but, interventions in which someone discloses their experiences of living with mental health issues. The authors of the meta-analysis noted the significant concerns about contact interventions in peer networks. In contact interventions, brave people living with mental disorders are asked to be the vehicle by which the public changes. After disclosing their stories, these people may face profound stigmatization and discrimination (Corrigan, Kosyluk, et al., 2015). In a different area, HIV diagnosis, a meta-analysis of studies showed that disclosing one's positive diagnosis sometimes resulted in receiving social support, but reliably resulted in experiencing stigmatization (Smith, Rossetto, & Peterson, 2008). Contact efforts, while having the potential to reduce stigmas and to improve the mental well-being of the interactants, need to be carefully designed and implemented in order to protect everyone involved.

Concluding Comments

The opportunity to write an essay to stimulate conversation about mental health stigma, communication, and education is a weighty responsibility. Communication and stigma are dynamically connected (for a review see Smith, Zhu, & Quesnell, 2016). Stigmas are socially constructed: through mediated and interpersonal communication, personal prejudices become social entities (e.g., social facts, Durkheim, 1982; collective norms, Rimal & Lapinski, 2015) that can influence people's actions. People perform stigmatization (devaluation and ostracism) through communication, and those experiencing stigmatization use communication to avoid or cope with future caustic experiences. Communication campaigns are also a potential vehicle for eliminating existing stigmas, but existing strategies have yielded limited success and sometimes unintended, negative consequences (Corrigan & Fong, 2014).

Furthermore, communication is implicitly needed to achieve mental health—to build social relationships and be an active participant in the world and its many publics. And yet stigmas, in general, compromise building social relationships. As stigmatized people attempt to avoid the painful experience of stigmatization and as non-stigmatized people attempt to avoid interactions with stigmatized people, stigmatized people's social networks shrink in size and quality (e.g., Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Lennon, Link, Marbach, & Dohrenwend, 1989; Strauss & Pollack, 2003).

The question, then, is what to do as students, instructors, and administrators? We can avoid creating new stigmas through word choice (e.g., using the model of stigma communication; Smith, 2007), and we can avoid enacting stigmatization. We could embrace neurodiversity in our instructional design and institutional policies. The communication discipline has an

opportunity to conduct the scholarship needed to have more reliable, validated, theory and evidence-based recommendations for how to use communication in and out of education settings to achieve, promote, and protect mental health. In this essay, we focused mostly on psychiatric diagnoses such as depression and bipolar disorder; stigma also exists for individuals with other diagnoses from the DSM-5, such as intellectual disabilities, eating disorders, substance use disorders, and attention deficit/hyperactivity disorder. Emerging trends in communication and education, such as participation in an increasingly technology stimulating environment, also need attention for how they shape academic achievement by promoting mental health or exacerbating mental health issues. It is important that researchers in mental health, stigma, communication, and higher education come together to help answer this question: How do we promote inclusive teaching and learning for a diverse population with different abilities and insights and thoughtfully consider evaluation of academic competency, achievement, and success?

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