Mental Illness Stigma for Regional Campus Students is More Connected to Previous Exposure, Political Conservatism than Experiential Learning

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In this pilot study, regional college students (n = 24) hosting an on-campus social event for individuals with severe mental illness (SMI) were compared to 135 non-equivalent, college student controls on four stigma measures. Individual differences (political conservatism, previous exposure to people with SMI) predicted college students' SMI stigma. While outgroup contact with community members with severe mental illness (SMI) during the event did not show significant decreases in college students' SMI stigma levels, results were in the hypothesized direction. Given the influential individual difference variables related to stigma that students carry with them, repeated experiential learning may prove more beneficial than one-time events when mental illness stigma reduction is the goal.

The Pedagogical and the Personal: Is College Students' Severe Mental Illness Stigma Related to Experiential Learning or Demographic Factors Like Political Conservatism?

In psychology and sociology, research on stigma dates back to early 1900s. Stigma involves labeling or defining a group of people who are often disgraced, feared, or ostracized based on a particular trait or traits (Adekson, 2014). These traits are evaluated negatively, often impacting the individuals' lives. In 1989, Crocker and Major noted that psychological consequences of stigma can be devastating, not only to those individuals who are subjected to it, but also to those who are close with people who

are stigmatized – otherwise known as secondary stigma (Green, 2003). More recent research demonstrates that mental illness stigma beliefs for college students can be reduced experientially (Feeg et al., 2014). By helping participants perceive and parse their attitudes and assumptions about people who are different from the majority group, stigma beliefs can begin to dissipate. Stigma reduction strategies are important to study in order to help people overcome their false assumptions that represent many minority and disadvantaged groups today. The purpose of the current pilot study was to explore whether psychology and nursing professors at a regional campus might help their students reduce stigmatizing beliefs through class-related exposure to a specific stigmatized group: people with severe mental illness. We also explored a variety of demographic characteristics—particularly previous exposure to people with mental illness and political conservatism—to investigate whether some students are more likely to express mental illness stigma than others.

Severe Mental Illness (SMI) Stigma

While the everyday person might define severe or serious mental illness (SMI) as schizophrenia or bipolar disorder, the Substance Abuse and Mental Health Service Administration (SAMHSA) defines SMI as conditions, for people who are over 18, that meet psychiatric criterion and result in serious impairment in daily functioning (SAMHSA, 2020). Mental illness (MI) stigma, and more specifically SMI stigma, devalues people for their mental health conditions. Stigma typically results because people lack information about mental health and disorders, which leads to fear, avoidance, misconceptions, and social distance (Corrigan et al., 2001; Corrigan & Watson, 2002). MI/SMI stigma has been prevalent for a long time in American culture, as education about mental illness tends to be sparse for most Americans. MI stigma is particularly detrimental to the general public as people self-stigmatize. Henderson et al. (2013) describe how the internalization of MI stigma is often more debilitating than the illness itself because it can lead to refusal to seek psychological or psychiatric help out of fear of judgment or discrimination. The authors note how MI/SMI stigma are linked to damaged relationships, loss of housing or employment, and low self-esteem. Some studies have indicated that the impact of SMI can be even greater than other forms of MI. The typical layperson, for example, may not clearly understand psychosis and might tend to exaggerate its dangerousness, which is exacerbated by sensational media. Indeed,

perceptions of violence for SMI have remained relatively stable in recent times (Pescosolido et al., 2010). Thus, symptomatic behavior related to a SMI like schizophrenia can amplify stigmatization because of psychotic tendencies (Markowitz, 1998), and the relatively higher stigma for SMI compared to lesser forms of MI may negatively impact the quality of life for these individuals. The danger might even be cyclical rather than unidirectional: Stigma can lead individuals with SMI to cease taking their medications, which can increase psychotic and bizarre behaviors, thus increasing stigmatization further.

Stigma, which separates individuals from each other, has several different components: affective (feelings), behavioral, and cognitive (thoughts) (Murman, 2014). Prejudice—defined as an antipathy based upon a faulty and inflexible generalization (Allport, 1954)—tends to capture the affective part of stigma. Stereotypes—or widely held beliefs that oversimplify a particular group down to a few negative traits of individuals in the group, which results in falsely categorizing the entire group—address the cognitive part of stigma. Discrimination, or unjust acts against a person or group, often follows prejudice and stereotypes. Discrimination addresses the behavioral part of stigma. Therefore, the prejudice, stereotypes, and discrimination that make up stigma are distinct by definition but intricately interrelated.

Stigma of many kinds results when people believe or act is if "they" (an outgroup) are somehow different from or more undesirable than "us" (an ingroup). Group culture is based on individuals holding certain views, beliefs, or ideals about the world that are consistent with collective beliefs or worldviews of a particular group (Eidelson & Eidelson, 2003). According to Tajfel (1982), to belong to a group, people must be frequently associated with that group and identify with the group on several different levels: cognitively (aware of membership), evaluatively (the awareness of membership must hold some sort of value), and emotionally (feeling investment or connection in the group). Ingroup/outgroup theory focuses on the behaviors, feelings, and thoughts of ingroup members toward those whom they do not perceive as sharing the same group membership. These views are often based on stereotypes and are perpetrated by a selective worldview that allows people to dismiss events or behaviors that do not reflect their stereotypical views (Link & Phelan, 2001).

Habitual ways of thinking about and perceiving outgroups cause problems when the beliefs that individuals hold are distorted, in part

because these beliefs are self-perpetuated. People's views can be biased when they hold beliefs that they are inherently better than others in important ways (Eidelson & Eidelson, 2003). For example, a belief in superiority can lead to the disregard of societal rules, a lack of empathy or desire to understand others' viewpoints, and feelings of specialness, entitlement, and deservingness. Moreover, biased beliefs are linked with a lower willingness to engage or compromise with others. At a group level, these beliefs can include group superiority, feelings of chosenness and entitlement, and viewing those outside of the group as contemptible, immoral, and/or inferior. In addition, if people feel as though they have experienced injustice on a personal level, they are more likely to join or belong to groups that hold the same belief. In this case, an ingroup can feel justified at having negative views and feelings about an outgroup, which can then be seen in cultural conflicts between the groups. In the context of SMI stigma, if people believe that individuals with mental illness are violating norms and are more dangerous than the general public, they may feel justified in disliking and excluding "those people" from everyday life and restraining the behavior of people with SMI in certain ways (Opotow, 1990).

Effective Strategies for Reducing Stigma

From news to entertainment, criticism and stigmatization of people with MI/SMI is deeply rooted in the history of Western media (Klin & Lemish, 2008). News stories frequently link deviant behavior to MI/SMI whenever the opportunity presents itself. Movies and television shows often portray people with MI/SMI as terrifying or irrational while dehumanizing them by making them unidimensional characters who are defined solely by their struggles. Combatting this perpetuation of stigma, however, is possible (Corrigan et al., 2012). For example, education on the topic of MI/SMI in the forms of class lectures, workshops, trainings, and volunteerism have been shown to reduce stigma (Couture & Penn, 2003). Advocacy, protest, and social marketing campaigns can be effective (Corrigan, 2011; Corrigan & Penn, 1999). Even a simple discussion can lead to fewer biases against people with MI/SMI (Stylianakis, 2015).

In addition to education about MI/SMI, encountering people with MI/SMI is another very effective way to break stereotypes and reduce stigma. Getting to know and understand people who have MI/SMI may also introduce others to the reality of these conditions instead of the negative stereotypes. Allport's (1954) Contact Hypothesis suggests that negative

views are reduced when people meet and interact with individuals from an outgroup. Allport proposed that the effects predicted by the Contact Hypothesis could only be achieved only under certain conditions such as equal status, cooperation among the groups, common goals, and supportive authorities who regulate the situation. However, recent meta-analyses have shown these conditions to be optimal but not absolutely necessary (Pettigrew, 1998; Pettigrew & Tropp, 2006). Even imagined rather than actual contact, especially with children, shows some evidence of positive impact (e.g., Miles & Crisp, 2013). In terms of MI/SMI stigma, contact between the ingroup (people without MI/SMI) and outgroup (people with MI/SMI) is commonly utilized when working to reduce or reverse negative stereotypes and stigma (Corrigan et al., 2012). It is most effective when the people who are stigmatized do not meet the stereotypical attributes of their outgroup (Corrigan, 2004). Creating a social situation that utilizes the Contact Hypothesis allows people to get to know other people as individuals and thus override previous assumptions. Another potential benefit is the elimination of the ingroup/outgroup distinction. In a setting where the people from the two groups can mingle comfortably, with support from the event coordinators, the differences between individuals may become more easily obscured as participants begin to perceive more similarities between them. However, when people have hesitations about an outgroup, can they realistically be expected to *voluntarily* seek out exposure events? Feeg et al. (2014) found that college students with less familiarity to people with SMI were significantly more likely to fear them. One challenge to testing the potential effectiveness of the Contact Hypothesis, therefore, is that because of self-selection bias, participants with less prejudice towards or fear of the stigmatized group may be more willing and likely to attend such events than people with more prejudice (Callaghan et al., 1997). Multiple studies have found that involving participants in contact situations can reduce their stigma towards people with MI/SMI (e.g., Corrigan et al., 2012; Couture & Penn, 2003; Pettigrew & Tropp, 2006). Interestingly, these events do not tend to study or control for potential individual difference covariates (Couture & Penn, 2003), including gender, previous exposure, religiosity, or political conservatism. It may well be that individuals who hold MI/SMI stigma beliefs, feelings, and behaviors need to be encouraged or required to attend exposure events that, for a variety of reasons, they would not otherwise self-select.

Stigma Reduction Through Experiential Learning

One way that college educators have required exposure events with a stigmatized group is Party with a Purpose (PWAP; Wickline et al., 2016). Originally implemented with community members with developmental disabilities and college students without disabilities, PWAP is a form of experiential learning (Kolb, 1984) that some have argued qualifies as short-term service learning. Experiential learning is a way of learning through doing, an active learning strategy that encourages students to reflect after an experience while developing original thoughts and opinions about the context. Service-learning is a specific type of experiential learning where emphasis is placed on personal development, connections to course material, and reflection while accomplishing tasks that meet identified community needs (Gardner & Baron, 1999). All forms of experiential learning—including service-learning—promote cognitive complexity, social skills, increased awareness, and personal and professional development among students (Batchelder & Root, 1994; Reeb et al., 1999). When service-learning is done in short sessions of 2-4 hours, the effects can still be small but meaningful (Batchelder & Root, 1994; Wickline et al., 2016). Some researchers have indicated that service-learning is best evaluated through a combination of qualitative and quantitative data, as each kind of data has its strengths and limitations: Statistical analyses allow for group comparisons and hypothesis testing, while narrative reflection allow participants to express their opinions freely, adding depth and context (Castellan, 2010).

Personal Factors Predisposing People to Stigma

Given that we have established what MI/SMI stigma is, the psychological processes that make its influence possible, and possible ways to reduce it, we also wondered what predisposes some people to MI/SMI stigma more than others. The degree to which people adhere to MI/SMI stigma beliefs or attitudes is likely to be influenced by or related to demographic factors such as education, gender, socioeconomic status, religion, and political orientation. In U.S. society, where independence is highly valued, people with MI can find challenges in overcoming stigma if they are not fully independent. This particular cultural value might shape beliefs about MI by contributing to stereotypes. As each kind of stigma is unique, there is no conclusive evidence that any one demographic factor affects various kinds of stigma universally. Generally, people with certain demographic characteristics are not necessarily predisposed to hold more

prejudices, but demographic variables may be associated with more or less bias under specific conditions. Several demographic factors consistently predict prejudicial attitudes, one of which is education. Studies suggest that those with a secondary education or higher intelligence scores are typically more tolerant of outgroups than those without (Allport, 1979; Hodson & Busseri, 2012). Education could be important for several reasons, including increased exposure to different groups, knowledge about specific groups, or willingness to accept others. Another important demographic factor could be religion. Some studies report religious individuals might hold fewer prejudices about mental health than non-religious individuals (Batson & Stocks, 2005). Paradoxically, religion can teach principles in theory of compassion and inclusion yet simultaneously promote exclusion of outgroups in practice. In some cases, individuals who are more religious tend to exclude outgroups more so than less religious people (e.g., Johnson et al., 2012). Thus, we wanted to explore a host of demographic factors to determine their potential connections with MI/SMI stigma.

Stigma and Political Conservatism

One particular demographic characteristic that has not received a lot of attention in stigma research is political conservatism, sometimes captured as Right-Wing Authoritarianism (DeLuca & Yanos, 2016). Brandt et al. (2014) suggest that, across political parties, people seek to maintain a worldview consistent with their own. To do so requires selective filtering, or what they refer to as motivated information processing, meaning that people often selectively attend to, ignore, or distort information that does not conform to their own existing beliefs. In addition, research suggests that people who identify as politically conservative often display personality traits (a higher need for closure, lower openness to experience, and higher authoritarianism) and cognitive styles (e.g., cognitive rigidity) that make them more likely to selectively process information than less conservative individuals (Crowson et al., 2005). This selective worldview could lead to intolerance towards groups that conflict with one's values and outgroup prejudice towards other, often stigmatized groups (Brandt et. al, 2013; Hodson & Busseri, 2012). In contrast, low adherence to conservatism and its principles, along with a minimal degree of dogmatism, tend to indicate more positive mental health ideology (Baker & Schulberg, 1969).

While political conservatism appears to influence beliefs, social psychologists have also argued that political conservatism can sometimes be

linked to discriminatory behaviors. For example, Wetherell et al. (2013) suggest that discrimination by persons who identify as more politically conservative can be due to guiding values of traditionalism (defined as wanting to uphold traditional family structures or other pervading societal norms) and self-reliance (e.g., the opposition of public aid, such as welfare, public health care, mortgage relief, etc.). Conservative values might support discrimination against outgroups if others violate those values (for example, one might perceive gay marriage as violating "traditional" marriage and family structures). However, Wetherell et al. note that there is a significant lack of research on discrimination by people who identify as politically liberal, whose guiding values tend to be those of egalitarianism (valuing the welfare of others) and universalism (valuing peace and tolerance). Wetherell and colleagues found that, across the board, both partisan groups supported discrimination against those that violated their group values, supporting the ingroup/outgroup theory of discrimination, though they noted that other research has still shown that conservatism is linked to ideologies of ethnocentrism and intolerance of outgroups.

Goals of the Current Research

Given the literature on the impacts of stigma for people with MI/SMI, we were interested in 1) finding potentially effective pedagogical ways to decrease said stigma for college students and 2) understanding which students are more likely to stigmatize people with MI/SMI in our regional campus teaching context. Using the robust Contact Hypothesis (Allport, 1954) as a theoretical base, we designed and implemented a short-term experiential learning event for regional campus students involving community members with SMI. In this applied rather than experimental setting, we utilized an interdisciplinary, mixed-methods research approach, incorporating both qualitative and quantitative analyses. Thus, we proposed both general research questions more typical of qualitative work and specific research hypotheses more common in quantitative approaches.

First, we explored two primary research questions in this small pilot study. First, could a brief social experience decrease college students' stigma for MI/SMI? Second, would demographic characteristics and individual differences relate to college students' self-reported MI/SMI stigma beliefs? Then, we made the following three predictions for quantitative analyses. First, based on the Contact Hypothesis and related studies (e.g., Allport, 1954; Pettigrew & Tropp, 2006; Wickline et al., 2016),

we hypothesized that those who attended a structured experiential learning event would report lower stigma beliefs than those who did not attend. Second, also based on the Contact Hypothesis, we predicted that people with previous exposure to individuals with SMI would hold lower stigma beliefs than those with less exposure. Lastly, based on the seminal work by Baker and Schulberg (1969) and more recent studies (e.g., DeLuca & Yanos, 2016), we hypothesized that political orientation would be linked to stigma, such that individuals who reported less political conservatism would also report lower MI stigma beliefs.

The purpose of our initial research is admittedly exploratory rather than confirmatory. Instructors who read this article can consider and refine the experiential learning exercise we describe. Researchers could use our findings to explore the potential benefits of our approach under more well-controlled conditions with larger samples and more rigorous methods.

Method

Participants

After approval by the Institutional Review Board, the research took place on a university regional campus in the U.S. American Midwest, a commuter campus with a higher proportion of students with more non-traditional characteristics than a typical residential campus. Being a "non-traditional" student is not a binary option (i.e., someone is not traditional or non-traditional) but a matter of degree. Common defining characteristics of being more non-traditional include: being age 24 years and older; having a GED instead of a high school diploma; having taken time off between high school and college; having families to take care of; working full-time; living off campus; being international students; or a combination of said factors (National Center for Education Statistics, n.d.).

Utilizing an applied, interdisciplinary setting with a quasi-experimental rather than experimental design, participants were not randomly assigned to classes; they had already signed up for the particular sections of the nursing and psychology courses involved in the study. They were informed on the syllabi that a social event with people with SMI would be part of their required educational experiences. Thus, while they could not opt out of the experience, they could decline having their data included in the research. The exposure group included participants who were enrolled in either a psychology class (n = 18) or one of two nursing classes (n

= 8 and *n* = 7) that were taught by the first and fourth authors, respectively, or a third instructor. Of the 33 possible participants, 24 undergraduate students in the exposure group participated in the study; the students who declined did not indicate their reasons for not participating. Of these 24 participants, only 16 provided identification codes necessary to match up their post-event data with their pre-event data. However, this subsample was too small to compare matched (dependent samples) data with sufficient power. Thus, we conducted independent samples analyses for the post-event (experimental) versus end-of-semester (control) data.

The exposure group attending the social event (nine were from nursing classes; 15 were from psychology classes) included 7 males and 17 females with a mean age of 21.8 (range 13-31, 17% were 24-years-old or older). This group identified as Asian/Asian American (1), Biracial/Other (1) or White/Caucasian American (15), with seven who did not respond. There were five first-year students, six sophomores, 11 juniors, and one senior. Two participants identified themselves as conservative, 10 as moderate, and six as liberal (4 non-responders).

Comparison groups came from students in other Introduction to Psychology (*n* = 46) or Nursing classes (*n* = 89) during the same semester. These courses were selected because they were entry-level courses in the same fields, so students in the comparison groups would not yet have taken Abnormal Psychology or Psychiatric Mental Health Nursing. These students, who did not participate in the social event, completed the survey only once. A total of 135 students in these comparison groups agreed to submit their responses to the study. This group included 16 males and 119 females, with an average age of 23.6 (range 17-53, 31% were 24-years-old or older). Participants identified as African American/Black (2), Asian/Asian American (1), or White/Caucasian American (61), with 44 participants identifying themselves as conservative, 38 as moderate, and 22 as liberal (21 did not respond). There were 20 first-year students, 58 sophomores, 43 juniors, and 10 seniors (with 3 “others”). Given the size of our campus, it is possible but unlikely that students from the exposure group communicated with those in the comparison groups about their experience.

Research Design

We utilized a mixed-methods approach for analyses. First, we had a primary survey of both closed-ended and open-ended items, so our qualitative and quantitative results came from the same participants. For

the exposure group, the survey was distributed immediately before the event. The post-test survey was provided the next time the respective classes met, which was immediately after the event (nursing students) or two days later (psychology students). To insure anonymity, we linked pre-post surveys with a self-selected code. However, relatively few students provided a code to link their surveys, and for the comparison groups, the primary survey was administered only once, toward the end of the semester. Thus, we only use between-groups statistical analyses rather than within-groups analyses.

Exposure group students also completed a secondary, anonymous satisfaction survey after the experiential learning event (see Appendix). Even though no deception was utilized, all groups were debriefed.

Procedure (Including Party with a Purpose Experiential Event)

Three sections of students, one group enrolled in Abnormal Psychology and two in Psychiatric Mental Health Nursing, had signed up for classes designated with an experiential learning component. All students in these two courses were required to attend the Party with a Purpose (PWAP), a two-hour, fully catered social gathering with stations that included opportunities for dancing, karaoke, crafts, glitter tattoos, table-top and party games, and conversation with community members with SMI. As a semi-structured event, community members could move from station to station at their leisure, and all activities and interaction opportunities were available for the duration of the overall event. Community members with SMI were recruited by the nursing students through several community agencies including a local community mental health drop-in center and a local treatment facility for persons with mental illness and substance abuse issues. While the PWAP provided a much-needed social opportunity for the community members with SMI, the teaching goals the PWAP event for college students were to educate students about people with SMI, expose them to the pedagogy of experiential learning, and have them consider biases and stereotypes they may have for this often stigmatized group. In designing the event, we utilized many principles of best practice for contact suggested by Allport (1954): equal status (both students and community members with SMI were party attendees), cooperation among the groups (games, crafts, karaoke), and supportive authorities who regulate the situation (nursing and psychology professors attended the event alongside students). One might argue, however, that as students were getting course

credit for attending, they might have had different or additional goals (completing a course requirement and pleasing their professors) than did the community members with SMI (getting acquainted and having a good time).

Quantitative Measures

Community Attitudes Toward the Mentally Ill scale (CAMI; Taylor & Dear, 1981)

The CAMI was originally designed to measure community attitude towards people with mental illness by (1) discerning between those who accept and reject individuals with mental illness, and (2) predict and explain reactions to local facilities for the people with mental illness in the community. The CAMI measure was composed of four scales: authoritarianism (α = .68), benevolence (α = .76), social restrictiveness (α = .80), and community mental health ideology (CMHI). These scales were then shortened and revised by Taylor and Dear (1961) to be used towards the general population, with some questions being excluded due to the length of the survey. Each of the four scales were composed of ten questions (40 items overall). For each of the four CAMI subscales, five questions are positively worded and five are negatively worded. Items are on a Likert Scale, where 1 = strongly agree and 5 = strongly disagree. The five negatively worded questions are reverse scored so that higher scores (averaged, rather than summed) indicate more positive attitudes.

For the current research, the *Authoritarianism* subscale was excluded because its internal consistency was poor (α = .44). Questions about *Benevolence* identify opinions of the responsibility of society towards people with MI, the necessity for sympathetic and kind attitudes towards people with MI, a person's willingness to become personally involved, and anti-custodial feelings. Questions about *Social Restrictiveness* indicate opinions on the dangerousness of people with MI, maintaining social distance, lack of responsibility of people with MI, and the normality of people with MI. The *CMHI Subscale* includes opinions on the therapeutic value of the community, the impact of mental health facilities in the neighborhood, the danger that people with MI pose to residents of the neighborhood, and social acceptance of deinstitutionalized care. The remaining three CAMI subscales were sufficiently reliable for the current

sample (benevolence: α = .72; social restrictiveness: α = .73; community mental health ideology: α = .85).

Stigma Differential Scales (Nordt, Rössler, & Lauber, 2006)

The Stigma Differential Scales measure how people evaluate those with SMI as compared to the general public. These 10 questions asked opinions about the degree to which people see those with SMI as: dangerous, unpredictable, stupid, bedraggled, abnormal, unreliable, weird, reasonable, self-controlled, and/or healthy. Students indicated whether they believed people with SMI were more or less likely to have that trait, with -2 = more likely to have that trait, 0 = no different from the general public, and +2 = less likely to have that trait. Thus, a negative number indicated more stigma. With α = .60 in the current study, this measure was only moderately reliable.

Demographic and Previous Experience Questions

These questions addressed participants' gender, age, year in college, college majors and minors, ethnicity, and annual family income. Given the small sample size, political orientation was recoded from five groups on the original survey (very liberal, liberal, moderate, conservative, and very conservative) to three groups for data analysis (liberal, moderate, conservative). This resulted in a loss of variance but improved sample size in these categories to more acceptable levels for statistical analyses. Two questions regarding students' personal experience with people with MI asked "How many people with some kind of mental illness/disorder do you know?" and "How many people with severe mental illness (like schizophrenia) do you know?" Additionally, yes/no questions were asked regarding whether the participant: 1) had friends or family members with some kind of MI, and 2) had friends or family with SMI (like schizophrenia). For hypothesis testing, we used the latter, dichotomous questions about whether or not people had friends/family members with MI or SMI.

Qualitative Analyses

We had student narratives available for the experimental group from several sources, all of which captured students' perspectives on the exposure event and people with SMI. The students filled out anonymous post-test surveys during their next class session, which was immediately after the event (nursing students) or the following day (psychology). These

brief surveys included both quantitative and qualitative data. Five open-ended questions tended to yield short answer responses of 1-2 sentences (see Appendix, questions #5-8). These same students wrote reflection papers or journals about the experience as a course assignment, which encouraged them to describe their experiences during as well as thoughts and feelings after the exposure event. Online discussion boards on the classes' Learning Management System (LMS) also provided the same students an opportunity to share perspectives about the event, where student-to-student conversation allowed the participants to guide the specific direction of the discussion.

For the purposes of this study, we systematically reviewed only the open-ended responses on the satisfaction surveys. We first used categorical aggregation (Creswell, 2007) to initiate review, where two independent reviewers (the third author and another research assistant) began with inductive procedures. In other words, we started with no assumptions and allowed the students' responses to drive the themes that were derived from their narratives about the event's impact. When each reviewer was finished, the research team (four reviewers) met to agree upon the most prominent inductive themes through consensus, thus establishing inter-rater reliability qualitatively rather than quantitatively. Second, given our teaching goal was to reduce stigma, we used the domains in stigma proposed by Murman et al. (2014)—affective (A - feelings), behavioral (B - skills), and cognitive (C - thoughts)—as overarching categories (deductive) by which to arrange the themes from our inductive review (Felner et al., 1990). In other words, we took the themes that derived from students' narratives and encapsulated them within the domains of stigma. To capture student responses that referred to a combination of the components, we merged the primary categories to form blends: AB, AC, BC, and ABC.

Results – Quantitative

Hypothesis Testing

Hypothesis 1: Individuals who attended a structured exposure event for people with SMI (Party with a Purpose) would report lower stigma beliefs than those who did not attend.

This hypothesis was not supported. The MANOVA (Wilks Lambda) predicting four distinct stigma measures (end-of-semester scores) from

event attendance (yes/no) revealed no significant effect, $F(4, 153) = 1.63$, $p = .17$, $\eta_p^2 = .04$. For a series of follow-up independent samples *t*-tests, all results were in the predicted direction, but none were significant (please see Table 1).

Table 1: Means, Standard Deviations, and Independent t-Tests for Stigma Measures by Various Demographic Predictors

	Stigma Differentials *M (SD)*	CAMI-BENEV *M (SD)*	CAMI-RESTRICT *M (SD)*	CAMI-CHMI *M (SD)*
Attended PWAP				
Yes (*n* = 24)	-0.14 (0.36)	4.21 (.43)	1.95 (.45)	4.01 (.44)
No (*n* = 135)	-.29 (.38)	4.04 (.43)	2.13 (.45)	3.80 (.54)
Comparison	*t*(156) = -1.76 *p* = .08 *d* = .40	*t*(157) = -1.77 *p* = .08 *d* = .39	*t*(157) = 1.83 *p* = .07 *d* = .40	*t*(157) = -1.75 *p* = .08 *d* = .41
Gender				
Male (*n* = 22)	-0.18 (.41)	3.90 (.43)	2.22 (.43)	3.83 (.51)
Female (*n* = 136)	-0.28 (.38)	4.09 (.43)	2.09 (.45)	3.84 (.53)
Comparison	*t*(156) = 1.17 *p* = .24 *d* = .26	*t*(157) = -1.94 *p* = .05* *d* = .47	*t*(157) = 1.31 *p* = .06 *d* = .30	*t*(157) = -0.09 *p* = .93 *d* = .02
Year in School				
First/Second years (*n* = 89)	-0.29 (.40)	4.02 (.47)	2.16 (.45)	3.77 (.56)
Juniors/Seniors (*n* = 65)	-0.24 (.37)	4.14 (.37)	1.99 (.41)	3.94 (.48)

Comparison	*t*(151) = -0.78 *p* = .44 *d* = .13	*t*(152) = -1.73 *p* = .09 *d* = .29	*t*(152) = 2.51 *p* = .01** *d* = .41	*t*(152) = -1.99 *p* = .05* *d* = .33
Age				
Under 23 (*n* = 100)	-0.31 (.46)	4.04 (.42)	2.15 (.45)	3.80 (.51)
23+ (*n* = 55)	-0.19 (.41)	4.12 (.46)	1.99 (.43)	3.92 (.54)
Comparison	*t*(152) = -1.85 *p* = .07 *d* = .30	*t*(153) = -1.22 *p* = .22 *d* = .20	*t*(153) = 2.13 *p* = .04* *d* = .36	*t*(153) = -1.28 *p* = .20 *d* = .21

Notes. CAMI = Community Attitudes Toward the Mentally Ill. BENEV = Benevolence. RESTICT = Restrictiveness. CMHI = Community Mental Health Ideology. PWAP = Party with a Purpose. *$p \leq .05$. **$p \leq .01$.

Hypothesis 2: People with more exposure to individuals with MI or SMI would hold lower stigma beliefs than those with less exposure.

This hypothesis was partially supported. The first MANOVA (Wilks Lambda) predicting four distinct stigma measures (end-of-semester scores) from having a close friend or family member with any kind of MI (yes/no) revealed no significant effect, $F(4, 152) = 0.34$, $p = .85$, $\eta_p^2 = .01$. By self-report, having a friend or family member with MI did not predict stigma scores. The second MANOVA (Wilks Lambda) predicting four distinct stigma measures (end-of-semester scores) from having a close friend or family member with SMI (yes/no) approached significance, $F(4, 151) = 2.37$, $p = .06$, $\eta_p^2 = .06$. Thus, a series of follow-up independent samples *t*-tests were conducted. Taken together, when individuals said they knew a friend or family member with SMI (compared to when they did not), they reported less stigma on two of the four stigma measures: Differentials Scales: $t(154) = -2.14$, $p = .04$, $d = .36$; Benevolence: $t(154) = -2.24$, $p = .03$, $d = .38$; Restrictiveness: $t(154) = 1.41$, $p = .16$, $d = .25$; and Ideology: $t(154) = -1.67$, $p = .10$, $d = .29$. Thus, results for two of the measures were significant. The results of the other two stigma measures were in the hypothesized direction but were non-significant.

Hypothesis 3: Political orientation would be linked to stigma, such that individuals who reported less political conservatism would also report lower MI stigma beliefs across stigma measures.

This hypothesis was partially supported. The MANOVA (Wilks Lambda) predicting four distinct stigma measures (end-of-semester scores) from political conservatism (liberal, moderate, conservative) was significant, $F(8, 232) = 2.77$, $p < .01$, $\eta_p^2 = .09$. Thus, a series of follow-up one-way ANOVAs with Scheffé post-hoc tests for unequal sample sizes were conducted for each stigma measure. The first ANOVA indicated that differences between political orientation groups on the Stigma Differentials Scale were non-significant, though in the direction we hypothesized, $F(2, 119) = 2.37$, $p = .10$, $\eta_p^2 = .04$. The ANOVAs regarding political conservatism and the CAMI measures yielded significant results for all categories. Regarding benevolence, $F(2, 119) = 7.63$, $p = .001$, $\eta_p^2 = .11$, those who identified as liberal/very liberal ($M = 4.30$, $SD = .43$) had more significantly positive opinions regarding benevolence toward people with SMI than those who identified as moderate ($M = 4.07$, SD = .39) or very conservative/conservative ($M = 3.94$, $SD = .35$), who did not differ significantly from each other. Regarding restrictiveness, $F(2, 119) = 23.91$, $p = .02$, $\eta_p^2 = .06$, those who identified as liberal/very liberal ($M = 1.92$, $SD = .40$) had significantly less restrictive attitudes toward people with SMI than those who identified as very conservative/conservative ($M = 2.20$, $SD = .36$) but not those who identified as moderate ($M = 2.12$, $SD = .50$), who did not differ significantly from each other. The same holds true for ideology, $F(2, 119) = 5.89$, $p < .01$, $\eta_p^2 = .09$: Those who identify as liberal/very liberal ($M = 4.04$, $SD = .65$) differed significantly from those who identified as conservative/very conservative ($M = 3.64$, $SD = .45$), but neither those who identified as conservative/very conservative or liberal/very liberal differed significantly from those who identified as moderate ($M = 3.88$, $SD = .46$). Taken together, those who identified as liberal generally reported less stigmatizing attitudes than those who identified as conservative.

Exploratory Analyses

Although the potential impacts of other demographic factors (i.e., gender, age, and year in school) were not specifically hypothesized, we explored their connections to stigma as well (see Table 1). Females believed people should be more kind to those with mental illness than males. The results by gender for restrictiveness, ideology, and stigma differentials were

not significant. No differences existed by year in school (first years/sophomores versus juniors/seniors) on the Stigma Differentials scale. When comparing more advanced versus less advanced students on the CAMI measures, more advanced students reported significantly more benevolence and positive ideology than less advanced students and lower scores for restrictiveness, though only the differences in restrictiveness and ideology were significant. The correlations between the stigma measures and age were non-significant. When age was recoded for 22 and below, and 23 and above, the Stigma Differentials Scale showed a non-significant trend, with those 23 and above attaching less stigma to those with mental illness than those 22 and below. Lastly, we ran the dependent samples *t*-tests for the 16 individuals who had attended PWAP and provided identification numbers so we could match data from pre-event to post-event (see Table 2). None of these outcomes were significantly different, although all were in the expected direction (lower stigma scores after the event).

Table 2: Means, Standard Deviations, and Dependent t-Tests for Stigma Measures Before and After the Party With a Purpose (PWAP)

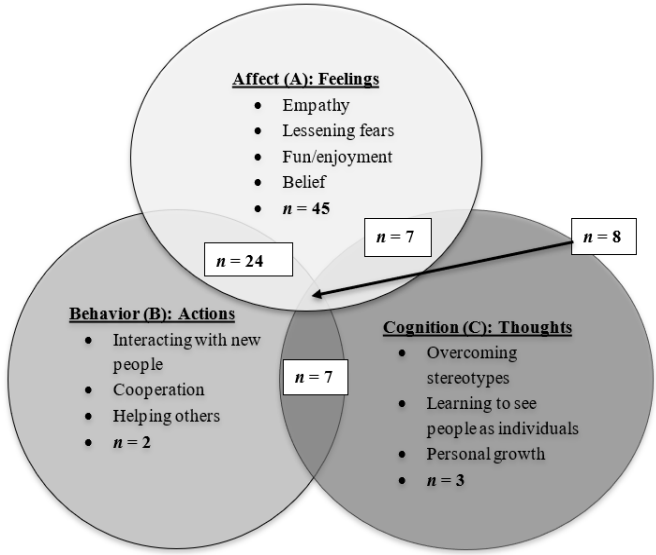
	Stigma Differentials *M (SD)*	CAMI-BENEV *M (SD)*	CAMI-RESTRICT *M (SD)*	CAMI-CHMI *M (SD)*
Before PWAP	-.23 (.24)	4.22 (.32)	1.85 (.33)	4.05 (.34)
After PWAP	-.13 (.27)	4.30 (.35)	1.78 (.40)	4.17 (.37)
Comparison	$t(15) = -1.83$ $p = .09$ $d = .39$	$t(15) = -1.06$ $p = .31$ $d = .24$	$t(15) = 0.76$ $p = .46$ $d = .20$	$t(15) = -1.18$ $p = .26$ $d = .33$

Notes. CAMI = Community Attitudes Toward the Mentally Ill. BENEV = Benevolence. RESTICT = Restrictiveness. CMHI = Community Mental Health Ideology. PWAP = Party with a *Purpose (PWAP)*

Results – Qualitative

From the categorical analysis, four primary themes were inductively derived from the qualitative data. These included: personal enjoyment, more respect for people with SMI, reduced anxiety in working with people with SMI, and reduced stereotypes about people with SMI. Then, using a deductive framework with our three stigma components as overarching categories, we captured the primary themes derived from students narratives as affective (A - feelings), behavioral (B - skills), cognitive (C - thoughts), or some combination. In other words, we used these three overarching categories to encompass the written clusters of responses of the students. Please note that we counted the number of responses in each category, not the number of students who had a response in each category. Therefore, if a student left a survey or question blank, we were not assuming the event had no impact; we only analyzed responses that were provided. Please see Figure 1 for a tally of the number of student responses we saw in each stigma category or combination. Examples will be provided below; for a complete list of student responses, please contact the first author.

Figure 1: Narrative Responses from Party with a Purpose by Theme



Notes. Ven diagram showing number of student narrative responses about the Party With a Purpose whose content reflected one of the three primary themes (affect, behavior, or cognition) or some combination of the three.

Affective

Positive affective responses were demonstrated in participants' responses when they discuss empathy, fear reduction, or increasing their comfort zones. Feeling overwhelmed (a negative affect) was reported by five students; as one student stated, "There were way too many students, in my opinion. It might be better if more people with mental illness were invited and less students. It was too overwhelming." Of the students who commented on the length of the party, all of them reported it was too short. The majority of student responses were categorized as affective (*n* = 45). Examples of improved affect towards people with SMI came in responses such as "I liked being able to have fun with the people [with SMI]" and "...not to fear others that have a severe mental illness". Some students reported on the impact of the atmosphere: "I liked it being a close environment; small and cozy" and "I enjoyed the dancing and found the social and positive atmosphere helpful." No negative reactions during the course of the event were reported. Additionally, nearly all of the students commented that they would be glad to help with an event like this again. Seven students had mentioned that not enough people with SMI were present, such as in the statement, "[I] wished there was more people to interact with." Other negative post-event feedback tended to be logistical, such as the length of the event (too short) and activity participation (wanted more variety).

Behavioral

A behavioral influence is linked to those participants who talked about their interactions with and exposure to people with SMI. Very few student responses were categorized as solely behavioral (*n* = 2). An exclusively behavioral response was, "Maybe a game to make people participate would be good."

Cognitive

A cognitive response is one where students indicated that they learned something new about people with SMI. The number of responses coded solely as cognitive (*n* = 3) was in between the few behavioral and many affective responses students indicated. Cognition is directly related to ideology and exhibited through students in responses that mention breaking stereotypes, becoming more open-minded, and gaining knowledge

on the subject. In the realm of cognition, one participant's positive response stated that he or she had a "better understanding of people who have [mental illness]."

Combined responses

Quite often, students' responses did not neatly fall within one category of affective (A), behavioral (B), or cognitive (C); instead, their responses contained elements of more than one category: AB, BC, AC, or ABC. For example, one participant reported, "[Party with a Purpose] really helped me come out of my shell when interacting with people who have disabilities." Thirty-eight responses incorporated a combination of two of the three components of stigma reduction. Behavioral-cognitive reflections focused on engagement while learning about people with SMI. One participant wrote, "[I liked] to meet people who have [SMI] and to better understand them." Affective-behavioral responses reflected enjoyment while learning, exemplified in this participant's response: "it's a great way to have fun and learn at the same time." A total of 8 responses incorporated all three aspects of stigma into a single response. For example, "…it all functions to battle stigmas and comfort levels with those that function differently than someone with a mental illness" and "I like that I was given an opportunity that I may have never had a chance to participate in and meet individuals with disorders. It helped me learn more about myself and others."

Taken together, the qualitative data from this study indicate that all three components of stigma (affect, behavior, cognition) held by students could be influenced by an experiential learning event. The primary point of impact upon students attitudes toward people with SMI was affective (emotional), and the vast majority of the comments indicated positive student reactions and attitudes towards the event.

Discussion

Taken together, the findings showed partial support for some of our hypotheses and research questions. Beginning with the qualitative analyses, students who attended the experiential learning event typically indicated enjoyable experiences, favorable perspectives, and small changes in their attitudes. Soon after the event, their feelings about people with SMI were positively influenced, although they did not tend to indicate many influences on their beliefs or behaviors towards individuals from this group.

Based on the quantitative analyses, personal factors were more important than the pedagogical strategy implemented in the current study. Results from this pilot study were non-significant (although in the hypothesized direction) when comparing those who participated in a stigma-reduction event versus those that did not. While our results are not conclusive, they suggest potential to reduce stigma from a well-planned experiential learning event like PWAP that is part of a college course requirement. Consistent with the Contact Hypothesis (Allport, 1979) and previous literature on MI stigma (e.g., Couture & Penn, 2003), students' previous self-reported exposure to friends or family members with SMI (but not MI) typically indicated lower MI stigma beliefs across measures. It is encouraging to consider that people's exposure to variety in human behaviors and characteristics through interactions with their own friends and family might also have some trickle-down influence on their beliefs and interactions with others outside their ingroup. Given the robustness of the Contact Hypothesis (e.g., Allport, 1979; Miles & Crisp, 2013; Pettigrew, 1998; Pettigrew & Tropp, 2006), it seems students' prior personal contact with people with SMI could understandably be more impactful than a one-time, semi-structured event. Lastly, similar to previous literature (DeLuca & Yanos, 2016; Hodson & Busseri, 2012), individuals who espoused more conservative political ideations tended to endorse more MI stigma on a variety of measures.

Limitations

Logistical factors and confounds, contributing to low power, are likely to have inhibited the potential impact of the PWAP for reducing stigma. For example, while many community members with SMI were invited to the event by the nursing students, only 12 attended. Thus, the ratio of college students to community members with SMI was about 3:1. Several students reported anecdotally that this made it difficult to interact with the guests, for they did not want to barrage or overwhelm them. Many students were relegated to watching from a distance, rather than directly talking with guests with SMI. Also, a fully factorial, within-subjects design (e.g., where the non-experimental controls also filled out the survey twice) with a larger, random sample instead of convenience sample would have been extremely beneficial. However, we were in an applied teaching setting rather than an experimental setting; thus, we were only able to secure the comparison group data at one point in time.

Several other methodological and situational limitations give important pause in considering the outcomes. The pre-post surveys for the experimental groups were collected very shortly before (within minutes) and after (within 48 hours) the planned social event. However, given when classes were scheduled, the post-tests were collected at slightly different times. One professor (nursing) provided post-test surveys minutes after the event, as that is when their class was scheduled, and the other (psychology) distributed them during their next class session (two days later), leading to a potential methodological confound. Also, we admittedly do not know whether or not the Party with a Purpose had any long-term impact on students. Given this was an applied research setting, the first and fourth authors—the principal investigators on the project—were also the teachers for the experimental group. Although we had research assistants collect the data and run the original coding on the qualitative data, it was not a fully blind or double-blind study. The potential exists that students may have been trying to please their professors by suggesting the structured social event was more meaningful for them than it actually was. The fact that satisfaction surveys were anonymous helps to mitigate that concern, but the responses could still be susceptible to self-presentation bias or social desirability. As the surveys were anonymous, we also do not have any way to compare the individuals who chose to complete the survey instruments versus those who did not. The study included a very small sample with an overwhelming majority of female participants (not uncommon for nursing majors and psychology classes) with a higher proportion of males in the exposure group than the comparison groups. The small sample prohibited us from doing more complicated analyses (e.g., multifactorial MANOVA or MANCOVA) to look at personal factors and pedagogical influences simultaneously or the influence of other potential confounding variables. Lastly, many people (over half) left the ethnicity question in the survey blank. Although the campus has primarily White/Caucasian individuals, and our sample is representative of typical campus demographics, either people were especially sensitive about answering this question, or (we believe) its position on the form led people to miss answering this question. All of these factors potentially limit generalizability to other college students.

Regarding methodological concerns, our questions about people's familiarity with friends and family who had MI or SMI were minimal. We do not know, for example, what people considered "severe" mental illness, as we only listed schizophrenia as one example. Thus, one person could

consider depression to be SMI, while the next person does not. Future studies would benefit both from defining this concept for respondents and asking a more in-depth series of questions to achieve more precision. We also did not ask whether students themselves had been diagnosed with MI or SMI. Our political conservatism measure (one ordinal scale with 5 choices) was also narrow; future studies would do better to use a more standardized measure (e.g., DeLuca & Yanos, 2016). The stigma differentials scale had moderate (some statisticians would say questionable) reliability in the current sample. Also, while our research focused on political conservatism, religiosity could also be an important variable to consider in MI stigma (Batson & Stocks, 2005; Johnson et al., 2005). Lastly, it would be very beneficial to survey the community members with SMI and the community partner staff that brought them in order to determine their satisfaction and the impact of the structured social event for them, not just the regional campus students.

Conclusions, Next Steps, and Teaching Suggestions

Given the qualitative outcomes, the Party with a Purpose experiential learning event was very positively received by students overall. The quantitative data showed some promise in the possibility of reducing college students' stigma for mental illness. However, these potential impacts appear minimal after one two-hour event, especially given the values, beliefs, and previous experiences students already bring with them. Thus, while change in stigma appears possible from positive contact with a stigmatized group like people with SMI, it is not likely to happen instantaneously. Faculty who connect to the idea of creating and encouraging interactions between students and people with mental illness or disabilities may consider that events with more "depth," more time to interact, a better ratio between ingroup (college students) and outgroup (community members with SMI), or more repetition would likely be more beneficial for changing students' attitudes. This could be done in one college course or a series of courses across students' time at their respective institutions (Barney et al., 2017; Chinsky & Rappaport, 1970). Faculty might also consider that voluntary/optional interactions, as opposed to required, sometimes tend to influence a greater degree of attitudinal change (Couture & Penn, 2003).

Another possibility is that the partnership with individuals with SMI could have more impact if events were conducted off-campus instead of on-

campus: in the community partners' gathering spaces, group homes, churches, etc. Then, students could get a more organic experience and see individuals with SMI in a community context, which could allow them to see individuals with SMI as part of the community and everyday fabric of life.

We know that the pilot data reported here are far from precise or conclusive. However, they can generate new research questions and programs. They intimate that faculty should continue to be creative and persistent in finding ways to help students decrease their MI stigma. Given how resistant SMI stigma is (Pescosolido et al., 2010), decreases in stigma would be important for those who hold stigmatizing views of others and for stigmatized people themselves (e.g., Corrigan, 2001, 2004; Corrigan & Watson, 2002; Corrigan et al., 2012). Changes in stigma attitudes might even influence public policy, increasing people's willingness to have more governmental support of individuals who struggle with mental health concerns (McSween, 2002).

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Appendix

Feedback Regarding "Party with a Purpose"

1.) Which "Party with a Purpose" experience did you attend this semester?

- ❑ People with Disabilities
- ❑ People with Severe and Persistent Mental Illness
- ❑ Neither (if you check this box, please discontinue survey)

2.) Please rate your overall satisfaction with your "Party with a Purpose" experience.

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied

3.) Please rate the impact of the "Party with a Purpose" experience on your:

	1 Negative Impact	2	3 No Impact	4	5 Great Impact
Awareness/understanding of mental illness and disabilities					
Ability to interact with people with mental illness or disabilities					
Comfort when interacting with people with mental illness or disabilities					

Fear of people with mental illness or disabilities					
Understanding of Service-Learning as a teaching strategy					
Personal development					
Professional development					
Critical thinking skills (looking at complex issues from various perspectives)					
Other (please describe):					

4.) What did you learn from the Party with a Purpose experience(s)?

5.) What did you like and/or find helpful about the Party with a Purpose experience(s)?

6.) What did you dislike and/or find unhelpful about the Party with a Purpose experience(s)? How could it/they be improved?

7.) Would you consider doing an event like this again? Why and/or why not?

8.) Please feel free to provide more feedback about the experience on back.