

**SELF-COMPASSION AS A PROTECTIVE FACTOR AGAINST MENTAL ILLNESS
SELF-STIGMA**

WENFENG ZHAO

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ABSTRACT

Self-stigma, the internalization of public stigma, is a significant hindrance to help-seeking and treatment adherence for mental illness. Stigma reduction strategies have thus far focused on mitigating the negative impact of self-stigma by bolstering self-esteem. However, self-esteem is resistant to change and direct attempts to boost self-esteem have been suggested to foster narcissism and unhealthy attachment to positive self-image. Alternatively, self-compassion has been demonstrated to offer similar benefits as self-esteem with fewer downsides. More importantly, self-compassion can be improved with short interventions. Study One is a mixed method study that examined how self-compassion, and the different facets of self-compassion, related to mental health stigma and help-seeking attitude and intentions. Study One compared self-compassion and self-esteem as predictors of self-stigma related to having a mental illness (SSMI) and self-stigma of seeking help for mental illness (SSOSH). Regression analyses showed that self-compassion uniquely predicted both forms of self-stigma and explained more of the variances in both SSMI and SSOSH than self-esteem in a sample of undergraduate students ($N = 185$). Findings also suggest that the *self-kindness* aspect of self-compassion may be more protective against SSMI, whereas *common humanity* is particularly relevant for SSOSH and help-seeking. The qualitative component of Study One revealed both interpersonal and intrapersonal themes in participants' perception and experience of SSOSH. Study Two explored the potential of a brief one-time intervention to improve self-stigma and help-seeking attitude and intentions in a separate sample of undergraduate students ($N = 133$). Study Two also found evidence that self-efficacy and perceived self-competence, two factors positively related to self-compassion, may deter professional help-seeking. Findings of the present set of studies indicate

that self-compassion is a promising target for intervention to reduce both forms of self-stigma identified as barriers to mental health recovery.

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Chapter One: Introduction

Self-stigma is an identified barrier to help-seeking and treatment adherence for mental illness. Self-stigma is conceptualized as the internalization of perceived social stigma such that affected individuals consider negative public attitudes to be self-relevant, resulting in anticipated social rejection and loss of self-esteem and self-worth (Corrigan & Watson, 2002; Corrigan, Watson, & Barr, 2006). Such devaluation of the self as a result of self-stigmatization leads to hopelessness and treatment resistance that further complicates the recovery process (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012; Wade, Post, Cornish, Vogel, & Tucker, 2011; Yanos, Row, Markus, & Lysaker, 2008). A meta-analysis of 45 published studies on internalized stigma of mental illness found high levels of stigma to be strongly associated with symptom severity, hopelessness, poorer self-esteem, lowered empowerment, reduced self-efficacy, decreased quality of life, and weakened social support (Livingston & Boyd, 2010).

Self-stigma commonly manifests in feelings of shame, leading to self-isolation and reluctance to seek employment, social relationships, and other important life opportunities (Kranke, Floersch, Townsend, & Munson, 2010; Watson, Corrigan, Larson, & Sells, 2007). More alarmingly, self-stigma is negatively correlated with attitude towards seeking help, with findings suggesting that individuals high in self-stigma are less likely to seek help due to self-image concerns (Nam, Choi, Lee, Lee, Kim, & Lee, 2013). A recent systematic review revealed that mental health stigma was the fourth most frequently reported barrier to mental health care, with internalized stigma and treatment stigma consistently found to be negatively associated with help-seeking (Clement et al., 2015). A study of barriers to mental healthcare access also found that the top five treatment barriers identified by service users were stigma related, such as concerns about being perceived as weak for having a mental health problem and feeling

embarrassed or ashamed for seeking treatment (Dockery, et al., 2015). These and other studies have identified self-stigma as a hindrance to mental illness treatment, underscoring the need for anti-stigma interventions to reduce the discrepancy between services needed and utilization of available resources (Corrigan, 2004; Jennings et al., 2015; Livingston & Boyd, 2010).

Studies evaluating mental health stigma reduction strategies have focused largely on targeting public stigma, with modest findings of success. A scoping review of interventions addressing self and public stigma in the Canadian context were only able to identify 35 studies meeting selection criteria over a period of 10 years between 2005 to 2015 (Guruge, Wang, Jayasuriya-Illesinghe, & Sidani, 2017). A combination of direct contact and education-based strategies had been found to reduce stigmatizing attitudes in targeted groups in the short term (Guruge et al., 2017). Education programs intended to increase mental health literacy, such as those providing information about mental illness, treatment options, and resources, led to unchanged or increased stigmatizing attitudes towards individuals living with mental illness in both Canada and in the United States (Guruge et al., 2017). Guruge et al., 2017 called attention to the lack of intervention studies addressing mental health related self-stigma in Canada and in the global context. The current set of studies aims to contribute to filling the highlighted gap in research by investigating whether self-compassion is a potential protective factor against the harmful effects of self-stigma, and to explore its applicability for anti-stigma interventions.

Self-stigma of Seeking Help

Past research has not always clearly defined self-stigma, leading to inconsistent findings and confusion in the literature. A related but distinct phenomenon, self-stigma specific to seeking help for mental health difficulties (SSOSH), was previously considered a behavioural component of self-stigma for having a mental illness (Tucker, Hammer, Vogel, Bitman, Wade, & Maier,

2013). Tucker and colleagues (2013) demonstrated that SSOSH and self-stigma of having a mental illness (SSOMI) are conceptually distinct and that the two stigmas relate differently to self-blame and social inadequacy. Specifically, SSOSH was found to be the only significant predictor of self-blame, whereas SSOMI was found to be the only significant predictor of social inadequacy (Tucker et al., 2013). This distinction between SSOSH and SSOMI has important theoretical and practical implications as it suggests that the two stigmas potentially relate differently to perceptions of controllability, blame, hopelessness, social inadequacy, and changes in self-concept. Individuals may struggle with different forms of self-stigma at various points of their illness and recovery. As such, efforts to improve mental health care utilization need to address both forms of self-stigma. Therefore, the current research considered factors related to both SSOMI and SSOSH and examined the meaning and manifestation of self-stigma for seeking help through qualitative methods.

Corrigan's Model of Self-stigma

Not all members of a stigmatized group internalize negative public attitudes into a form of self-stigma (Corrigan & Watson, 2002; Watson et al., 2007). Some reject the perceived stigma and react in righteous anger (i.e. “I was angry that I’d been crazy, but I was even more angry at the inhumane, hurtful, degrading, and judgmental ‘treatment’ I’d been subjected to”), and others appear to be unaffected and indifferent (Corrigan & Watson, 2012). Corrigan & Watson (2012) coined the divergent personal reactions to mental illness stigma as “the self-stigma paradox.” According to Watson et al. (2007), stigma awareness is a necessary but insufficient component of self-stigma. Their theoretical model of self-stigma delineates a hierarchical process of self-stigmatization whereby an individual is exposed to public stereotypes (*stereotype awareness*), endorses the common public stereotypes (*stereotype agreement*), and

applies the internalized beliefs to him or herself (*self-concurrence*), resulting in detriment to self-esteem (Corrigan, Watson, & Barr, 2006). Self-stigma reduction strategies have thus far taken two contrasting approaches: 1) intervening at the level of *stereotype agreement* by challenging stigmatizing beliefs and attitudes and 2) mitigating the negative effects of self-stigmatization by bolstering self-esteem (Knight, Wykes, & Hayward, 2006; Lucksted, Drapalski, Calmes, Forbes, DeForge, & Boyd; 2011; MacInnes, & Lewis, 2008; Mittal et al., 2012). In a critical review by Mittal and colleagues (2012), the latter approach focusing on self-esteem enhancement was described to have gained more traction among stigma experts.

Self-compassion, an Alternative to Self-esteem

Previous research on protective factors against self-stigma related to mental illness has focused primarily on self-esteem (Knight et al., 2006; Livingston & Boyd, 2010; MacInnes & Lewis, 2008). However, self-esteem is highly resistant to change, and many programs designed to raise self-esteem are shown to be ineffective (Baumeister, Campbell, Krueger, & Vohs, 2003; Corker, Brown, & Henderson, 2015; Swann, 1996). Further, direct attempts to boost self-esteem have been demonstrated to lead to poorer academic performance and is suggested to encourage narcissism and antisocial tendencies (Baumeister, Campbell, Krueger, & Vohs, 2003; Baumeister, Smart, & Boden, 1996). Individuals with high self-esteem tend to engage in self-enhancement and focus on increasing self-esteem exclusively may encourage attachment to a maladaptive positive self-view, which can lead to decreased ownership of personal responsibility for actions and hinder potential personal growth (Baumeister, Campbell, Krueger, & Vohs, 2; Sedikies, 1993). Alternatively, self-compassion had been shown to offer similar benefits to those derived from self-esteem with fewer downsides (Neff, 2011). For instance, self-esteem was shown to be positively correlated with narcissism, whereas self-compassion was not (Neff,

2003). Self-compassion is also associated with more stable feelings of self-worth than self-esteem (Neff & Vonk, 2009). More importantly, self-compassion can be improved with brief interventions, yielding benefits such as optimism, self-efficacy and decrease in rumination (Shapira & Mongrain, 2010; Smeets, Neff, Alberts, & Peters, 2014).

Neff's (2011) model of self-compassion is composed of three overlapping components: self-kindness versus self-judgment, feelings of common humanity versus isolation, and mindfulness versus over-identification. *Self-kindness* is characterized as the tendency to treat oneself with care and understanding rather than self-judgment and criticism (Neff, 2011). *Common humanity* refers to the recognition that all people fail and make mistakes and feeling connected during difficult life circumstances with the attitude that imperfection is a part of the shared human condition (Neff, 2011). *Mindfulness* is defined as an awareness of present moment experiences in a balanced manner that neither ignores nor amplifies negative aspects of oneself or one's life, such that one does not exaggerate and fixate on negative self-relevant thoughts and emotions (Neff, 2011). Self-compassion is associated with greater life satisfaction, emotional intelligence, social connectedness, learning goals, wisdom, personal initiative, curiosity, happiness, optimism, positive affect, as well as less self-criticism, depression, anxiety, fear of failure, thought suppression, perfectionism, performance goals, and disordered eating behaviours (see Neff, 2009, for a complete review).

Self-compassion is believed to tap into different psychophysiological systems than self-esteem; self-compassion is thought to be related to wellbeing through feelings of safety and security by activation of the self-soothing and attachment system, whereas self-esteem relates to wellbeing partly because it bolsters self-confidence and feelings of superiority (Gilbert & Irons, 2005; Neff, 2011). Indeed, individuals reported fewer negative emotions when thinking about a

past failure, rejection, or loss after a self-compassion induction compared to those in the self-esteem and control conditions (Leary, Tate, Adams, Allen, & Hancock, 2007). Further, self-compassion was found to be a significant predictor of self-worth stability, and self-compassionate individuals are less likely to engage in social comparisons (Neff, 2011). The current set of studies propose that the components of self-compassion interrupt the self-stigmatization process proposed by Watson et al. (2007), such that self-compassionate individuals are less inclined to apply social stereotypes to him or herself (e.g., I am weak because I have a mental illness). Self-compassion is potentially protective against the detrimental effects of self-stigma for both having mental illness and that of seeking help.

Chapter Two: Study One

Personal stigma regarding mental illness and attitude towards seeking help are highly associated with active help-seeking behaviours (Schnyder, Panczak, Groth, & Schultze-Lutter, 2017). Different forms of mental illness stigma had been demonstrated to exert unique influences on help-seeking (Schnyder et al., 2017). Study One explored the associations among the distinct forms of public and self-stigma related to mental illness, self-compassion, self-esteem, social desirability, as well as attitude, intentions, and willingness towards seeking help. Self-compassion had only recently been examined in the area of mental health stigma (Heath, Brenner, Lannin, & Vogel, 2016). As self-compassion was found to provide similar benefits for psychological resilience as self-esteem (Neff, 2011), Study One evaluated the contributions of self-compassion to mental health self-stigma in comparison to that of self-esteem, a well-researched intervention target for stigma reduction (Mittal et al., 2012). Additionally, the current study investigated whether self-compassion moderates the positive relationship between public and self-stigma for having mental illness. Self-compassionate individuals recognize personal failings and struggles as part of the shared human experience (Neff, 2011). Indeed, self-compassion had been shown to protect against negative self-judgments in a longitudinal study with adolescents (Marshall, Parker, Ciarrochi, Sahdra, Jackson, & Heaven, 2014). Further, self-compassion was demonstrated in a series of studies to moderate an individual's response to a variety of negative, ego-threatening situations (Breines & Chen, 2012). Past research indicates that self-stigma of seeking help is related to self-image concerns (Nam et al., 2013). Given findings that self-compassionate individuals are better able to resist becoming entangled with negative self-concepts, the current study proposed that self-compassion will also moderate the positive relation between public and self-stigma for seeking help.

Vogel and colleagues (2006) developed the Self-Stigma for Seeking Help Scale and operationalized self-stigma of seeking help according to Corrigan's (2004) definition of self-stigma in relation to self-esteem. Given the distinctions found between self-stigma of mental illness (SSOMI) and self-stigma of seeking help (SSOSH), the present study endeavoured to clarify the construct of SSOSH. Qualitative research is considered the most useful approach to understanding the meaning people make of their experiences (Morrow, 2007). Qualitative inquiry was integrated in the current study to facilitate theory building and to examine the meaning of SSOSH in an inductive manner to allow for the emergence of new and unexpected knowledge. A mixed method approach of combining quantitative and qualitative inquiries had been recognized and recommended to enhance understanding of complex psychological phenomena (Nastasi & Schensul, 2005). Study One takes the quantitative dominant mixed methods approach, typically designated QUAN + qual (Johnson, Onwuegbuzie, & Turner, 2007). Participants underwent an experimental procedure wherein quantitative data were collected, followed by three open-ended questions about the meaning and impact of SSOSH. The qualitative analysis in the present study provided convergence and corroboration of the quantitative results and complemented the quantitative findings by illuminating the multifaceted phenomenon of self-stigma for seeking help.

In summary, the main objectives of the current study were to investigate whether self-compassion is a potential protective factor against self-stigma related to mental illness, and to compare the benefits of self-compassion and self-esteem to determine the suitability of self-compassion as a target for self-stigma reduction interventions. Specifically, Study One explored how the different facets of self-compassion relate to self-stigma for having mental illness and that of seeking help. Study One also examined whether self-compassion mitigates the positive

relationship between stigma awareness and mental illness self-stigma. The hypotheses for the quantitative portion of Study One are as follows:

- H1: Self-compassion is negatively correlated with public and self-stigma associated with having mental illness and that of seeking help.
- H2: Self-compassion is positively correlated with attitude, intentions, and willingness to seek psychological help.
- H3: Self-compassion is positively correlated with self-esteem.
- H4: Self-compassion is negatively correlated with psychological distress
- H5: Self-compassion is a unique predictor of SSMI.
- H6: Self-compassion is a unique predictor of SSOSH.
- H7: Self-compassion moderates the positive relationship between public and self-stigma for having mental illness.
- H8: Self-compassion moderates the positive relationship between public and self-stigma of seeking help for mental health difficulties.

A secondary focus of the present study was to broaden our understanding of SSOSH through a qualitative analysis of participants' subjective experience and conceptualization of self-stigma related to professional help-seeking. The qualitative inquiry provided depth of understanding into the nature of SSOSH from the perspective of participants and offered suggestive questions towards theory building rather than specific hypotheses to be tested (Fossey, Harvey, McDermott, & Davidson, 2002; Nastasi & Schensul, 2005). The qualitative questions of the present study were adapted from items on the self-stigma of seeking help measure as follows (Vogel et al., 2006):

- 1) “Some people identify that they would feel ‘inadequate’ or less satisfied with themselves if they were to see a mental health professional for psychological help. Would you feel the same way? Please explain why or why not.”
- 2) “Some people also believe their view of themselves would change if they made the choice to see a mental health professional. Would seeing a mental health professional change how you see yourself? Please explain how your view of yourself might change.”
- 3) “Aside from practical reasons (money, time, access to services), are there any other reasons why you may choose not to seek professional help when experiencing psychological problems?”

Methods

Participants and Procedure

The participants were first-year university students recruited through the undergraduate research participant pool at York University. Participants received research credit towards selected courses for their participation. The sample consisted of 186 students (131 females, 54 males, and 1 person who did not indicate their gender) with a mean age of 19.2 years ($SD = 4.0$). The sample was culturally diverse with 26.3% identifying as Asian/Pacific Islander, 20.4% as Caucasian, 16.7% as Middle Eastern, 10.2% as African Canadian, 2.7% as Hispanic, and 23.1% as Other (participants identified as West Indian, South Asian, European, “mixed” and etc.). The study was administered online through Survey Monkey. After indicating their informed consent, participants completed a battery of questionnaires assessing self-compassion, self-esteem, public and self-stigma for having mental illness, public and self-stigma related to seeking professional help, attitude and intention towards seeking help, willingness to seek help and social desirability. The battery of self-report questionnaires was followed by the three open-ended questions derived from the Vogel et al. (2006) measure.

Instruments

Self-compassion. The Self-Compassion Scale (SCS; Neff, 2003) contains 26 items that assess the positive and negative aspects of the three main components of self-compassion: Self-Kindness (e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need”) versus Self-Judgment (e.g., “I’m disapproving and judgmental about my own flaws and inadequacies”); Common Humanity (e.g., “When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people”) versus Isolation (e.g., “When I fail at something that’s important to me, I tend to feel alone in my failure”); and

Mindfulness (“When something upsets me I try to keep my emotions in balance”) versus Over-Identification (“When I’m feeling down I tend to obsess and fixate on everything that’s wrong”). A single higher order factor has been found to explain the inter-correlation between the six subscales. Items are rated on a five-point Likert scale ranging from 1 (*almost never*) to 5 (*almost always*), with higher mean scores reflecting greater self-compassion. The SCS has a reported internal consistency of $\alpha = .85$ (Smeets et al., 2014).

Self-esteem. The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a well-validated 10-item measure of self-esteem. It includes items such as, “I feel that I have a number of good qualities.” Responses are given on a four-point Likert scale from 1 (*strongly agree*) to 4 (*strongly disagree*). Half of the items are reversed scored such that higher composite scores indicate higher self-esteem. Past studies have reported the internal consistency of the RSES to range from $\alpha = .72$ to $.88$ (Gray-Little, Williams, & Hancock, 1997).

Self-stigma of Mental Illness. Self-stigma for having mental illness was assessed with the modified version of the Self-Stigma of Depression Scale (SSDS; Barney, Griffiths, Christensen, & Jorm, 2010) used to measure dimensions of self-stigma in Tucker et al. (2013). The original SSDS scale is composed of 16 items and contained four factors: Shame, Self-Blame, Social Inadequacy, and Help-Seeking Inhibition. Since self-stigma for help-seeking will be assessed directly with other measures, only the Shame, Self-Blame, and Social Inadequacy subscales were used resulting in a modified 12-item scale. The original scale asks participants to respond to questions beginning with the stem “If I were depressed, I would...” and include items such as “feel inferior to others” (Shame), “think I should be able to cope with things” (Self-Blame), and “feel I couldn’t contribute much socially” (Social Inadequacy). The items are rated on a five-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher

scores indicating greater self-stigma. As in Tucker et al. (2013), references to depression were replaced with the term *mental illness*. The modified SSDS was found to have an internal consistency of .90 (Tucker et al., 2013).

Anticipated Public Stigma. The Devaluation-Discrimination Scale (DDS; Link, 1987) contains 12-items used to ascertain how much an individual believes that the general public devalues and discriminates against those with mental illness. The DDS is composed of items such as “Most people would accept a fully recovered former psychiatric patient as a teacher of young children in a public school.” Items are rated on a six-point Likert scale ranging from 1 (*strongly agree*) to 6 (*strongly disagree*). Half of the items are reversed scored such that higher scores indicate greater public stigma towards mental illness. The DDS has a reported internal consistency of $\alpha = .76$ (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989).

Self-stigma of Help-seeking. The Self-Stigma of Seeking Help Scale (SSOSH; Vogel, Wade, & Haake, 2006) contains ten items used to assess an individual’s self-stigma associated with seeking psychological services. Items are rated on a five-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with half of the items reversed scored such that higher scores reflect a greater concern with loss of self-esteem and self-worth from seeking professional help. A sample item includes: “I would feel inadequate if I went to a therapist for psychological help.” The SSOSH has a reported internal consistency of $\alpha = .91$ and was shown to distinguish between individuals that seek help from those that do not (Vogel et al., 2006).

Public Stigma of Help-seeking. The Social Stigma for Receiving Psychological Help Scale (SSRPH; Komiya, Good, & Sherrod, 2000) assesses an individual's perception of social stigma associated with receiving professional help. The SSRPH consists of five items rated on a four-point Likert scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). The items are

summed such that higher scores indicate greater perception of social stigma. A sample item includes: “People will see a person in a less favourable way if they come to know that he/she has seen a psychologist.” The SSRPH was found to be correlated with attitudes toward seeking profession help and has a reported internal consistency of $\alpha = .73$ (Komiya et al., 2000).

Help-seeking Attitude. The Attitude Towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF; Fischer & Farina, 1995) is a ten-item revision of the original 29-item version of the ATSPPH designed to assess attitude towards seeking professional help for psychological problems in the domain of need, openness, and confidence. Items are rated on a four-point Likert scale ranging from 1 (*disagree*) to 4 (*agree*), with half of the items reverse scored such that higher scores indicate more positive attitudes. Items include: “If I were experiencing a serious emotional crisis at this point in my life. I would be confident that I could find relief in psychotherapy.” The ATSPPH-S has a reported internal consistency of $\alpha = .84$ (Fischer & Farina, 1995).

Help-seeking Intentions. The Intentions to Seek Counselling Inventory (ISCI; Cash, Bagley, McCown, & Weise, 1975) is composed of 17 items relating to issues frequently brought up in counselling and is used to assess an individual’s intentions to seeking counselling in the future. Examples of issues include excessive alcohol use, depression, and speech anxiety. Participants are asked to rate how likely they are to seek counselling for each item on a six-point Likert scale ranging from 1 (*very unlikely*) to 6 (*very likely*). Items are summed such that higher scores reflect a greater likelihood of seeking professional help. The ISCI has a reported internal consistency of $\alpha = .90$ and was found to be related to perceived significance of problems and to general attitude towards seeking help (Kelly & Achter, 1995).

Willingness to Seek Help. The Willingness to Engage in Help-Seeking Behaviour Scale (WHSBS; Hammer & Vogel, 2013) assesses an individual's openness to spontaneously engage in help-seeking behaviour if given the opportunity to do so. The WHSBS is composed of seven items related to four help-seeking scenarios. An example of a scenario is "Suppose you were walking through the Student Services Building sometimes in the next 3 months and you see a National Mental Health Screening Day booth set up in one of the private offices, where psychologists are doing confidential, free on-the-spot mental health screenings. You have two hours before your next class, so you have plenty of time available". Participants rate the likelihood of performing the responses related to the scenario such as "walk over to the booth to learn more about the mental health screening" on a seven-point Likert scale ranging from 1 (*not at all willing*) to 7 (*very willing*). Higher summed scores indicated higher level of willingness. The WHSBS has a reported internal consistency of $\alpha = .90$ and was found to be related to both help-seeking attitude and intentions (Hammer & Vogel, 2013).

Psychological Distress. The General Population-Clinical Outcomes in Routine Evaluation measure (CORE-GP; Evans, Connell, Audin, Sinclair & Barkham, 2005) was used to measure individuals' current level of distress. The CORE-GP contains 14 items that assesses individuals' experience of symptoms in the domains of wellbeing, problems/symptoms and functioning during the past week. Items are rated on a five-point Likert scale ranging from 0 (*Not at all*) to 4 (*Most or all of the time*). Eight of the items are reversed scores with higher composite scores indicative of greater distress. A sample item includes: "I have felt tense, anxious or nervous." The CORE-GP has a reported internal consistency ranging from $\alpha = .82$ to $.90$ and test-retest reliability $r = .91$ (Evans et al., 2005).

Social Desirability. Social desirability was assessed using Ballard's (1992) short version of the well-validated Marlowe-Crowne Social Desirability Scale (SD; Ballard, 1992). It consists of 11 items where participants indicate *True* (0) or *False* (1) in response to statements such as: "I have never deliberately said something that hurt someone's feelings." Higher scores represent a greater tendency to respond in a socially desirable manner. The SD has a reported internal consistency of $\alpha = .65$ (Zhao, Young, Breslow, Michel, Flett, & Goldberg, 2015).

Quantitative Results

Descriptive Statistics

The means, standard deviations and internal consistency of each scale used in the study are reported in Table 1. All the Cronbach's alphas were .71 and above, with the exception of the social desirability scale, which traditionally has a lower reported internal consistency. As expected, gender differences were found in self-compassion and self-esteem with male participants reporting higher scores than female participants. Additionally, female participants reported higher psychological distress and more willingness to seek help than male participants (see Table 1). Given these gender differences, subsequent statistical analyses were conducted controlling for gender.

Table 1

Gender Differences in All Variables of Interest

Variable	Self_Com	SSMI	SSOSH	DDS	SSRPH	ATSPPH	ISCI	WTSH	Self_Est	CORE-G	Social
<i>Alphas</i>	.9	.86	.87	.85	.71	.79	.86	.92	.89	.85	.63
Female <i>M(SD)</i>	2.8(.59)	2.9(.83)	2.5(.71)	3.8(.91)	2.3(.52)	2.8(.56)	40.7(9.6)	30.8(10.9)	2.7(.54)	2.8(.66)	5.3(2.3)
Male <i>M(SD)</i>	3.1(.52)	3.2(.71)	2.6(.68)	3.7(.71)	2.4(.47)	2.6(.48)	39.4(10.1)	26.4(9.8)	3(.55)	2.5(.59)	5.9(2.5)
Total	2.9(.58)	3(.8)	2.5(.7)	3.7(.86)	2.3(.5)	2.7(.54)	40.3(9.8)	29.5(10.7)	2.7(.56)	2.7(.65)	5.5(2.4)
F	5.7*	3.1	.84	.21	.9	3.4	.65	6.6*	11**	8.6**	2.5

Note. $N = 185$. Self_Com refers to self-compassion, SSMI refers to self-stigma of mental illness, SSOSH refers to self-stigma of seeking help, DDS refers to stigma awareness, SSRPH refers to social stigma for receiving help, ATSPPH refers to attitude towards seeking professional help, ISCI refers to intentions to seek help, WTSH refers to willingness to seek help, Self_Est refers to self-esteem, CORE-G refers to psychological distress, Social refers to social desirability.

* $p < .05$. ** $p < .01$.

Correlational Analyses

Table 2 displays the partial correlations among the variables of interests controlling for gender. The separate components of self-compassion were examined to explore how self-kindness, common humanity, and mindfulness related to self-stigma as well as attitude and intentions for seeking help. Consistent with Hypothesis One, all three components of self-

compassion were significantly inversely related to self-stigma for having a mental illness as well as that of seeking help. Self-kindness in particular was significantly negatively correlated with public stigma *for having mental illness* whereas common humanity and mindfulness were not. Both self-kindness and mindfulness were significantly inversely related to public stigma *for receiving help* whereas common humanity was not. As expected, public and self-stigma related to having mental illness and for seeking help were positively correlated amongst each other. Hypothesis Two predicted that self-compassion would be positively associated with attitude, intentions, and willingness to seeking help. However, we did not find support for this in the current study. All three components of self-compassion were positively related to self-esteem and negatively correlated with psychological distress, supporting Hypothesis Three and Four.

Table 2

Partial Correlations Among All Variables of Interest Controlling for Gender

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Self_Kind	-											
2. Co_Hum	.61**	-										
3. Mindful	.69**	.61**	-									
4. SSMI	-.47**	-.34**	-.38**	-								
5. SSOSH	-.28**	-.34**	-.26**	.41**	-							
6. DDS	-.15*	-.08	-.08	.28**	.25**	-						
7. SSRPH	-.16*	-.13	-.15*	.3**	.38**	.54**	-					
8. ATSPPH	.04	.03	.01	-.21**	-.52**	-.16*	-.26**	-				
9. ISCI	-.02	-.07	-.09	.1	-.22**	-.13	-.01	.45**	-			
10. WTSH	.06	.09	.03	-.14	-.4**	-.2**	-.21**	.46**	.46**	-		
11. Self_Est	.66**	.55**	.59**	-.45**	-.29**	-.12	-.2**	-.06	-.12	-.05	-	
12. CORE-G	-.57**	-.56**	-.53**	.4**	.29**	.05	.19*	-.08	.08	-.001	-.7**	-

Note. $N = 185$. Self_Kind refers to the self-kindness subscale of the Self-compassion questionnaire, Co_Hum refers to the common humanity sub-scale of the Self-compassion questionnaire, Mindful refers to the mindfulness subscale of the Self-compassion questionnaire, SSMI refers to self-stigma of mental illness, SSOSH refers to self-stigma of seeking help, DDS refers to stigma awareness, SSRPH refers to social stigma for receiving help, ATSPPH refers to attitude towards seeking professional help, ISCI refers to intentions to seek help, WTSH refers to willingness to seek help, Self_Est refers to self-esteem, CORE-G refers to psychological distress.

* $p < .05$. ** $p < .01$.

Regression Analyses

Hierarchical multiple regression analyses were conducted to determine whether self-compassion is a unique predictor of mental health related self-stigma as predicted in Hypothesis Five and Six. Self-esteem and the components of self-compassion found to be related to self-stigma for having mental health difficulties and that of seeking help were examined respectively, after controlling for gender and social desirability. The predictor variables were considered simultaneously to test their relative unique ability to predict self-stigma in relation to mental health difficulties. Gender and social desirability were entered into the first predictor block. Self-esteem and the three components of self-compassion were entered into the second predictor block. As presented in Table 3, the overall model predicted 26.5% of the variance in SSMI, $F(6, 178) = 10.7, p < .001$. Self-kindness and self-esteem were found to be significant negative predictors of SSMI. Gender was positively associated with SSMI, indicating that male participants are more likely to endorse self-stigma for having mental health difficulties.

Table 3

Hierarchical Multiple Regression Analyses Predicting Self-Stigma of Mental Illness

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	ΔR^2	R^2	<i>F</i>
Model 1					.05	.05	4.8**
Gender	.26	.13	.15	2.06*			
Social Desirability	-.06	.02	-.18	-2.5*			
Model 2					.22*	.27	10.7**
Gender	.38	.12	.22	3.2**			
Social Desirability	-.01	.02	-.03	-.48			
Self Kindness	-.3	.19	-.21	-2.7**			

Common Humanity	-.007	.11	-.006	-.07
Mindfulness	-.06	.13	-.04	-.43
Self-esteem	-.32	.13	-.23	-2.5*

Note. $N = 185$. * $p < .05$. ** $p < .01$.

With regards to self-stigma of seeking help, the overall model predicted 13.5% of the variances in SSOSH (see Table 4). Among the predictors, common humanity was the only unique contributing variable to SSOSH, indicating that individuals who endorse this component of self-compassion are less likely to experience self-stigma when it comes to seeking professional help.

Table 4

Hierarchical Multiple Regression Analyses Predicting Self-Stigma of Seeking Help

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	ΔR^2	R^2	<i>F</i>
Model 1					.03	.03	2.6
Gender	.13	.11	.09	1.2			
Social Desirability	-.05	.02	-.15	-2.1*			
Model 2					.11*	.14	4.6**
Gender	.21	.12	.14	1.8			
Social Desirability	-.007	.02	-.02	-.29			
Self Kindness	-.06	.11	-.06	-.5			
Common Humanity	-.24	.11	-.22	-2.3*			
Mindfulness	-.009	.12	-.008	-.07			
Self-esteem	-.16	.13	-.13	-1.3			

Note. $N = 185$. * $p < .05$.

Moderation Analyses

Self-compassion

Separate linear regression models were tested using R Version 3.3.3 software to examine whether self-compassion moderates the relationship between public and self-stigma related to having mental illness, as predicted in Hypothesis Seven, and that of seeking help, in accordance with Hypothesis Eight. All variables were mean centred prior to analyses to reduce multicollinearity in the moderated multiple regression. The model predicting self-stigma for having mental illness from public stigma of mental illness and self-compassion was significant, $F(3, 182) = 17.18, p < .001$, and accounted for 20.79% of the variability in SSMI. Both public stigma of mental illness ($\beta = .22, SE B = .06, p = .001$) and self-compassion ($\beta = -.39, SE B = .09, p < .001$) significantly predicted SSMI. The interaction between self-compassion and public stigma of mental illness was not statistically significant ($\beta = .02, SE B = .09, p = .73$), suggesting that self-compassion did not moderate the relationship between anticipated public stigma and self-stigma for having mental illness in our sample.

The overall model predicting self-stigma for seeking help from public stigma of mental illness and self-compassion was also significant, $F(3, 182) = 10.5, p < .001$, and accounted for 13.34% of the variability in SSOSH. Again, public stigma of mental illness ($\beta = .23, SE B = .06, p = .001$) and self-compassion ($\beta = -.27, SE B = .09, p < .001$) significantly predicted SSOSH. However, the interaction between public stigma and self-compassion was not significant ($\beta = -.07, SE B = .08, p = .31$), suggesting self-compassion did not moderate the relationship between anticipated public stigma and self-stigma for seeking help in our sample.

Self-esteem

A comparison analysis was conducted for self-esteem. The model predicting self-stigma for having mental illness from public stigma of mental illness and self-esteem was significant, $F(3, 182) = 15.99, p < .001$, and accounted for 19.56% of the variability in SSMI. Both public stigma of mental illness ($\beta = .22, SE B = .06, p = .001$) and self-esteem ($\beta = -.37, SE B = .1, p < .001$) were significant predictors of SSMI. However, the interaction between self-esteem and public stigma of mental illness was not significant ($\beta = -.02, SE B = .1, p = .82$), suggesting that self-esteem also did not moderate the relationship between anticipated public stigma and self-stigma for having mental illness.

The overall model predicting self-stigma of seeking help from public stigma of mental illness and self-esteem was again significant, $F(3, 182) = 8.64, p < .001$, and accounted for 11.02% of the variability in SSOSH. Public stigma of mental illness ($\beta = .23, SE B = .06, p = .001$) and self-esteem ($\beta = -.23, SE B = .09, p = .001$) both significantly predicted SSOSH. Once again, the interaction between public stigma and self-esteem was not significant ($\beta = -.06, SE B = .09, p = .39$), suggesting self-esteem again did not moderate the relationship between anticipated public stigma and self-stigma for seeking help in our sample.

Qualitative Analysis

Beyond differences in methodology, qualitative and quantitative research is based on distinct paradigms consisting of discrete ontological (view of the nature of reality) and epistemological (how reality is known) assumptions (Morrow, 2007). Whereas *quantitative* methods follow a deductive process in gathering data to test predefined theories or hypotheses, *qualitative* work is inductive in nature and moves from observations to the formulation of theories and hypotheses (Morrow, 2007; Pope & Mays, 1995). The strength of taking a quantitative approach to studying a phenomenon is the ability to generalize the findings found; the inclusion of qualitative observations provides insight and clarity as to what participants meant when they indicated their experiences, attitudes, and behaviours related to SSOSH. As opposed to the aspiration of objectivity held by quantitative research methods, judicious use of subjectivity is embraced in qualitative research, from the very nature of the data to the analytic process (Morrow, 2005). As such, the researcher is the instrument of investigation and co-creator of meaning (the inclusion of additional readers is not to be treated as validation or verification, but rather considered additional data) (Morrow, 2005).

A theoretical thematic analysis was conducted following the procedures outlined by Braun and Clarke (2006) to identify and analyze patterns found in participants' responses to the open-ended questions related to SSOSH. In contrast to the practice of random sampling for the purpose of generalizability in quantitative methodologies, participant selection in qualitative studies is guided by the research question and typically focus on one (in the instance of a case study) or a very few select individuals considered to have experience relevant to the phenomenon of interest (Marshall, 1996; Morrow, 2005; Nastasi & Schensul, 2005). Qualitative sampling is always purposeful (participants are deliberately selected) and criterion based to allow for the

most information-rich data possible (Marshall, 1996; Morrow, 2005; Pope & Mays, 1995). The current study considered the conventional selection criteria of appropriateness and adequacy in addressing the research questions to guide the selection of participants (Fossey et al., 2002). Extreme case sampling was used to identify adequate exemplars of the experience of self-stigma for seeking help. Self-stigmatizing individuals in the current study were identified using a cut-off score of 34 (1 SD above the mean in the Vogel et al. [2006] validation study) on the Self-Stigma of Seeking Help Scale, based on recommendations in Hartman et al., 2013. With regards to the broader consideration of help-seeking interventions, these participants likely represent the high-risk and vulnerable population that stigma reduction strategies may wish to target. A total of 27 identified participants (15% of the sample) were included in the qualitative analysis, 20 participants of which were female and seven were male.

The responses of the selected participants were pooled and analyzed, without regard to which participant the responses came from, in order to reduce bias and to allow patterns in the data corpus to emerge more naturally. The primary investigator read through the responses multiple times to become familiar with the data and initial ideas were recorded. Participant responses were broken down into ‘meaning units’ (Giorgi, 2009), and assigned a code that represented loss of satisfaction with oneself related to help-seeking for mental health issues, such as “inferior to others.” Basic themes were abstracted from the coded text segments at the semantic level since the responses were not rich enough to warrant deeper, more meaningful level of interpretation (Braun & Clarke, 2006). The identified themes were further refined and those that were not adequately endorsed by the data corpus were discarded. Similar themes were then grouped into organizational themes and broader categories based on content and theoretical relatedness (Attride-Stirling, 2001). If a meaning unit did not fit appropriately within an existing

category, a new category was created. The writer consulted with research supervisory committee members when reviewing and refining the themes as well as the generation of clear definitions and names for each theme. A thematic map was created to organize and denote the relationship between categories and themes.

Self-stigma of seeking help is theorized as the “reduction of an individual’s self-esteem or self-worth caused by the individual self-labeling as someone who is socially unacceptable” as a result of seeking and engaging in mental health treatment (Vogel et al., 2006). Self-stigma of seeking help has traditionally been subsumed under internalized stigma of mental illness and has only in recent years been considered as a separate construct (Tucker et al., 2014). Given the findings of the nuanced differences between SSMI and SSOSH, it is important for stigma reduction research to explicitly define and distinguish these two constructs to improve clarity and consistency in findings. This is particularly important given that SSOSH has not been clearly conceptualized in the literature, and investigations of its impact on help-seeking and treatment engagement are still in nascent stages (Clement et al., 2015; Guruge et al., 2017). A richer understanding of the meaning and experience of SSOSH would not only inform stigma reduction interventions, but also provide insight into how health providers can better approach and support individuals to engage with professional services. The analysis in the current study yielded a four-tier hierarchical model wherein higher-order global characteristics and organizing themes were formed from basic themes extracted from coded text in an inductive manner (see *Figure 1*). The emergent themes can be organized as constructs experienced in relation to oneself (intrapersonal) and as experienced in relation to others (interpersonal). Category labels are italicized when introduced in the analysis below.

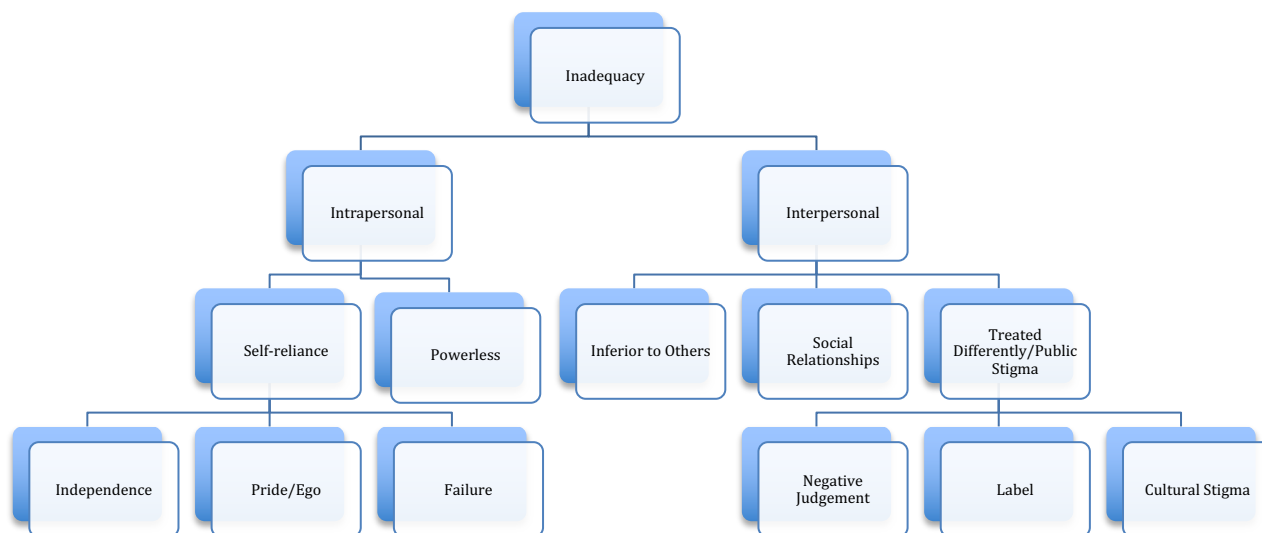


Figure 1. Thematic network model of self-stigma for help-seeking among high stigmatizers

Intrapersonal Themes

From the responses of participants identified as high-stigmatizers, the overarching intrapersonal themes that emerged were prizing of *self-reliance* and avoidance of feeling helpless and “*powerless*.” Within the category of self-reliance, participants expressed a sense of inadequacy for seeking help as it reflects a lack of *independence*. One participant stated: “I would feel embarrassed with myself that I wasn’t able to solve my own issue on my own,” and that, “I feel like there’s a good possibility of me changing the way I view myself if I were to see a mental health professional because I might think of myself as less able to deal with things on my own.” Another participant echoed that: “I would choose not to seek professional help when experiencing psychological problems because I don’t like depending on people.” It appeared that the act of seeking help may be perceived as a threat to self-competence and personal

autonomy for some individuals prone to self-stigmatization. One participant's response illustrated that the desire to cope independently can out-weight the perceived acceptance of professional help-seeking: "I think that seeking professional help is incredibly courageous and should not be seen as inadequate. However, as I am very self-critical and a perfectionist, I would have the desire to resolve any problem I would be going through on my own."

Participants also identified that their "*pride/ego*" would prevent them from seeking help. One participant responded: "Any reason I would not seek professional help, other than practical reasons, would probably be me being stubborn and assuming that I can handle the situation on my own or just not wanting to admit it or even bother talking about it." Other participants responded that their view of themselves would change from seeking professional help such that: "I'm not as strong as I think I am", and another: "I would definitely feel bad about myself, I would feel ashamed." These responses reflect that the act of seeking help may be experienced as a threat to one's self-image and self-worth. One participant's response: "I'm not the person to seek help" illustrated that for some high-stigmatizers, seeking help may be so incongruent with their self-concept that they are unlikely to seek help from any external sources.

Other responses from participants indicated that seeking help from a professional may be experienced as a *failure*: "I know they [mental health professionals] are there to help people but I feel that I would be a failure to myself." More than a desire for independence and the need to maintain a certain self-image, responses from some participants convey a sense of self-blame for not meeting standards and expectations one holds for oneself. One participant stated: "I have been placed in a strong society and have no excuse to let troubles get the better of me." Such responses reflect a self-critical voice that may be evoked in high-stigmatizers when confronted with the realities of their mental health struggles.

The wish to avoid feeling *powerless* and weak was another prevalent theme named by participants who endorsed high self-stigma for seeking help. One participant responded: “I would choose not to seek a professional for help specifically because it makes me feel weak and incapable.” Other participants also endorsed anticipating feeling “weak”, “useless”, “powerless” and not being in control of their lives. Human beings have an innate psychosocial and biological need for control; the absence of the perception of control and ability to produce desired effects in one’s life is highly aversive (Leotti, Iyengar, & Ochsner, 2011). Certainly, if high-stigmatizers associate seeking help with loss of control and self-efficacy, it would be more challenging for such individuals to elicit and accept assistance from an external source. Several other factors associated with self-stigma make it difficult for individuals to seek help, one of which is self-concealment. For example, one participant stated: “I don’t want to share my problems with anybody even if I think it would be a relief.” In these responses we observe the powerful impact self-stigma and other associated factors have on help-seeking, which in turn underscores the difficult intrapersonal barriers individuals must overcome to ask for and accept help, even in times of recognized need.

Interpersonal Themes

In addition to the intrapersonal constructs with which individuals struggle in the process of seeking help, several interpersonal themes emerged from the data corpus. One of the most prevalent themes is the belief that seeking help is an indication of *inferiority* relative to others. Responses that reflected this theme included, “seeking psychological help would make me feel both mentally and socially inferior to other people” and, “if I need extra help...it means there must be something lacking there.” Individuals struggling with their mental health in concert with self-stigma tended to regard themselves as being less than their peers. More so, requiring

professional intervention seems to connote a level of severity of maladjustment and a deviance from the norm that further reduces the individual's sense of self-worth. It is not surprising that the quantitative results indicated that common humanity, the recognition that everyone struggles and feels inadequate in some way, is the particular aspect of self-compassion that is protective against self-stigma for help-seeking.

Some participants voiced concerns about the negative impact of their engaging in psychological services on *social relationships* with family and peers. One participant stated: "Well, I don't want to feel like I have a problem. It makes me feel sad just thinking about that. I feel like I would have let my mum down or something." Still others feared that engaging in professional services may jeopardize their social relationships, stating: "There are many jokes about it, and why would anyone be friends with someone like you if they could be friends with someone normal and healthy." These responses are exemplars of the anticipation of social rejection that is integral to the experience of self-stigma (Corrigan & Watson, 2002).

Additionally, participants were concerned that seeking professional help for mental health difficulties would result in being *treated differently* by others. Participants described fear of *negative judgment* and potential consequences for seeking mental health services with responses such as: "I feel embarrassed and believe that other people would negatively judge me because of my psychological problems." Others alluded to a fear of being judged for seemingly unjustly utilizing professional services, responding, "others may not understand why I am getting the help because I seem to live a great life which would discourage me to go." It is curious to find that though most high-stigmatizers were concerned with being perceived as severely broken or flawed, there is a subset of individuals who fear that seeking help from a professional would somehow be considered undeserved and unjustified, like a type of imposter syndrome (Clance &

Imes, 1978). One participant responded: “I don’t feel my problems are severe enough to [seek] a professional.” This concern is important to note as treating professionals may overlook the guilt that some high-stigmatizers may experience for receiving help, which further underscores the need to normalize the utilization of mental health services.

Lastly, participants explicitly named social stigma, particularly the fear of being *labeled*, as deterrents for seeking help. One participant stated, “...there’s a stigma around the whole thing. People tend to treat you differently when they find out you’re seeking help. They think you’re crazy.” Another expressed, “we look at the person differently, because we know that they are going through something that requires outside intervention. People put labels on one another.” Link and colleagues (1987) demonstrated the impact of labeling in a series of studies which showed that a person labeled mentally ill are likely to be stigmatized by a member of the general public regardless of their behaviour. The studies by Link and others validated that the fear of being labeled is not without basis (Link, Cullen, Frank, & Wozniak, 1987; Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011; Page & Day, 1990), and the responses of participants in the present study illustrated the ways in which labeling hinders professional help-seeking. One participant responded: “I think the people around me (friends, family, etc.) would think different/negatively about me,” despite their stated belief in the benefits of professional help: “I personally think that getting help will make me feel more satisfied and happier with myself.”

Some participants identified that mental illness is particularly stigmatized in their *culture*, and that seeing a professional for mental health difficulties is not accepted in the community that they belong. One participant highlighted the mental illness stigma in Middle Eastern communities. Another self-identified South Asian participant stated, “[seeking psychological help] would make me feel like a failure because in my community mental health is not even

spoken of.” It is not surprising to see participants in our diverse sample endorse culturally specific stigma associated with having mental illness and for seeking help. Many studies have examined cross-cultural differences in attitude toward help-seeking for mental illness, particularly focused on the contrast between Eastern and Western cultures (Atkutsu & Chu, 2006; Chentsova-Dutton, Tsai, & Gotlib, 2010; Fogel & Ford, 2005; Masuda & Boone, 2011; Ryder, Yang, Zhu, Yao, Yi, & Heine, 2008). The responses obtained in the current study speak to the strength of influence culture has on help-seeking for mental illness in the present day, even in our sample of educated young adults attending a large multicultural university in North America. Taken together, the qualitative analysis provided us a detailed snap-shot of how self-stigma for seeking help is expressed, enriching our understanding of the psychological and social barriers individuals are confronted with when considering professional help.

Discussion

Study One examined the relationships between self-compassion and self-stigma associated with both having mental illness and that of seeking help. Self-compassion has only very recently been considered in mental health stigma reduction research (Heath et al, 2016; Heath, Brenner, Vogel, Lannin, & Strass, 2017; Wasylikiw & Clairo, 2016). Heath and colleagues (2016) were the first to demonstrate the buffering effects of self-compassion on the relationship between anticipated public stigma and self-stigma for seeking help. The present study endeavoured to replicate the novel findings and to extend these findings by exploring how the three distinct facets of self-compassion uniquely contribute to self-stigma. Study One also investigated whether self-compassion would moderate the relationship between perceived public stigma and anticipated self-stigma for having mental illness. Further, Study One compared the benefits of self-compassion and self-esteem with regards to mental illness related self-stigma to determine whether self-compassion may be a more accessible target for stigma reduction interventions. Lastly, qualitative analysis was performed to broaden our understanding of the complexity in meaning and expression of self-stigma for seeking professional help.

Factors of Self-compassion Related to Self-stigma

As predicted, all three components of self-compassion were significantly negatively correlated with self-stigma related to having a mental illness and that of seeking help, with noted distinctions. Firstly, only self-kindness and mindfulness were significantly negatively correlated with social stigma of receiving help, whereas common humanity was not. This was surprising given common humanity is the recognition that all people have aspects of themselves that makes them feel inadequate in some way and feeling connected rather than isolated during times of failure (Neff, 2011). Self-kindness, treating oneself with care and understanding, and

mindfulness, considering one's own experiences from a broader perspective, are arguably more self-directed components of self-compassion. It is possible that although common humanity is important when it comes to combatting negative self-judgment for seeking help, self-kindness and mindfulness are more protective against anticipated stigma from other people. Consistent with past studies (Leary et al., 2007, Neff, 2011, Neff, Pisitsungkagarn, & Hsieh, 2008), all three factors of self-compassion were positively related to self-esteem and negatively correlated with psychological distress. Lastly, self-kindness was the only component of self-compassion that was significantly negatively correlated with anticipated public stigma for having mental illness. It makes sense that if one tends to respond to one's own failings with understanding rather than criticism that one may expect others to respond in kind.

To further assess the unique contributions of self-compassion to variability in self-stigma associated with having mental illness and self-stigma of seeking help, separate regression analyses were conducted with the two forms of self-stigma. *Self-kindness* was the only component of self-compassion that significantly contributed to variability in self-stigma for having mental illness whereas *common humanity* was the only significant predictor of self-stigma for seeking help. This is interesting to note as it suggests that different aspects of self-compassion may be more relevant for different forms of self-stigma and further validates that the two forms of self-stigma are indeed conceptually distinct. Past research has shown that individuals who self-stigmatize have difficulty accepting a mental illness diagnosis (Corrigan, 2004; Corrigan, & Kleinlein; 2005), and tend to attribute personal responsibility to the cause of illness (Mak and Wu, 2006). Self-kindness, treating oneself with warmth and understanding, is particularly important when confronted with the reality of one's imperfection and suffering. Though it is important for anti-stigma interventions to target both forms of stigma, individuals

who wish to help those struggling with the day to day realities of living with mental illness may wish to highlight the value of treating oneself with the care and understanding one would offer a loved one. In contrast, for those struggling to engage in services and advocating for themselves, it may be particularly important to encourage a broader perspective that personal inadequacy is part of the shared human experience, and to normalize seeking and receiving help from others. Indeed, the literature shows that alienation and social withdrawal are endorsed even more highly than stereotype agreement among self-stigmatizing individuals with mental illness (Brohan, Elgie, Sartorius, Thornicroft, & Grp, 2010; Corker, Brown, & Henderson, 2016). Cultivating a sense of connectedness during moments of suffering is not only important for overcoming shame and isolation that hinders help-seeking and recovery, it may also interrupt the process whereby perceived stigma is internalized.

Corrigan and Watson (2012) observed the divergent personal reactions to mental health stigma and described empowerment and self-stigma as opposing ends on a continuum. Watson and colleagues (2007) subsequently proposed a theoretical model delineating a hierarchical process of self-stigmatization and asserted that there are factors that may influence the extent to which individuals agree with public stereotypes and apply the perceived stigma to themselves. Components of self-compassion were found in the current study to contribute to low self-stigma and it may be that such factors impact *stereotype agreement* and *self-concurrence* in the self-stigma model proposed by Watson et al. (2007). Future studies may wish to explore this by examining whether aspects of self-compassion mediate the relationships between stereotype awareness and stereotype agreement and self-concurrence. The qualitative components of the present study suggest that such exploration may be promising.

Common humanity significantly predicted self-stigma of seeking help (SSOSH), and of the 27 participants who scored higher than average (1 SD above the mean) on the common humanity scale, only four (14% of all respondents) responded that they would feel inadequate for seeking professional help for mental health difficulties. Of the other responders, four participants indicated that they would anticipate experiencing SSOSH depending on circumstances, and 19 (71% of all respondents) stated that they would not feel inadequate for seeking help. Participants provided responses that reflected normalization of seeking help for mental illness, with one participant responding: “It is like attending physiotherapy for your body, paying for a service for the benefit of yourself.” Another participant equated physical illness and mental illness stating: “No I would not feel inadequate because seeking mental care is the same as seeking medical care if not more important.” Other responses reflected the sense of common humanity, such as: “NO, because no one is perfect, people always need help sometimes...people will be more powerful with others’ help” and another, “...I’m human like everyone else.” These responses illustrate how common humanity may protect against SSOSH and are consistent with Corrigan’s “self-stigma paradox” of divergent personal reactions reflecting a rejection of public stigma (Corrigan & Watson, 2012). The qualitative responses obtained presently is not rich enough for further analysis. More in depth qualitative interviews may be able to provide greater insight into the experience of SSOSH and ways to build an individual’s internal resistance to social stigma.

Self-compassion vs. Self-esteem

One of the unique contributions of the present study is the direct comparison of the effects of self-compassion and self-esteem on the two forms of self-stigma related to mental illness. Self-compassion contributed to just as much variance in self-stigma of mental illness as self-esteem, and in the case of seeking help specifically, predicted more of the variability in self-

stigma than self-esteem. Past studies have shown self-compassion to reduce feelings of shame and negative affect in shame-prone individuals when processing shame-inducing episodes (Johnson & O'Brien, 2013). It is not surprising that self-compassion predicted levels of self-stigma for having mental illness and that of seeking help. Tucker et al. (2013) demonstrated that self-stigma of mental illness is closely related to social inadequacy, such that individuals experiencing mental health difficulties view themselves as less valuable than others (Link & Phelan, 2001). It is consistent that self-esteem, the appraisal of one's own value and belief that one is valued by others (Rosenberg, 1965), significantly predicted mental health stigma. However, the protective effect of self-esteem does not appear to extend to seeking help, which carries its own stigma and is shown to be more closely related to self-blame (Tucker et al., 2013).

A body of literature has demonstrated self-compassion to be particularly important when confronted with challenging situations, performing a crucial role in self-regulation and coping with stress (Allen & Leary, 2010). Further, self-compassion was demonstrated to buffer the effect of perceived stress on negative affect, whereas self-esteem did not (Krieger, Hermann, Zimmermann, & Holtforth, 2015). Self-compassion is consistently found to be associated with lower levels of maladaptive coping, such as avoidance and rumination (Krieger, Holtforth, Altenstein, Baettig, & Doerig, 2013; Neff, Kirkpatrick, & Rude, 2007). It stands to reason that taking an understanding, accepting and compassionate attitude towards one's difficulties would be more conducive to help-seeking than would an attachment to a positive self-image. Indeed, common humanity, feeling connected with others in the shared human condition of being imperfect, was precisely the component of self-compassion that predicted lower levels of help-seeking self-stigma. For many, the act of seeking help evokes a sense of inadequacy in personal strength and lack of internal resources to cope independently. Even for individuals who are able

to maintain positive self-appraisal for having mental illness, seeking professional services may be experienced as a failure to rise above mental health difficulties. The acknowledgment that every person struggles and feels inadequate in some way normalizes the experience of suffering, reduces self-blame and increases safety in asking for and accepting help.

Gender and Self-stigma

It is also important to note that gender significantly predicted SSMI. Despite self-reports of higher self-compassion and self-esteem by male participants in our sample, being male contributed to greater experience of self-stigma related to mental health. This is congruent with existing theory that men who adhere to a more traditional prescription of masculinity are more likely to view mental health difficulties as signs of weakness and subsequently deny psychological issues (Magovcevic & Addis, 2005; Pederson & Vogel, 2007). Further, it has been proposed that men's experience of gender role conflict (i.e., disclosing distress and intimate emotions violates societal expectations of men to be independent, stoic, and controlled) is related to decreased willingness to seek help (Good & Wood, 1995; Pederson & Vogel, 2007). Though not the focus of the present study, the aforementioned gender effects were reproduced in our sample. Although gender was not found to be a significant predictor of SSOSH, male participants in our study did report significantly lower willingness to seek help than females. This suggests that when experiencing equal amounts of self-stigma, females are still more willing to engage in help-seeking behaviours than males.

Self-compassion Moderating Public and Self-stigma

Self-compassion was not found in our study to significantly moderate the relationship between stigma awareness and self-stigma for having mental health difficulties, nor was it a significant moderator of the relationship between stigma awareness and self-stigma of seeking

professional help as found in the study by Heath and colleagues (2016). There are several differences between the study by Heath et al. and the current study that may have contributed to our failure to replicate findings. Firstly, the sample size (369 participants), and therefore the power in the aforementioned study were much higher than that of the present study. Further, the present study employed a more diverse sample than the study by Heath and colleagues, resulting in more variability in our data. The participants in the study by Heath et al. were predominately European American (81.0%), whereas the participants recruited in the present study were much more culturally diverse. Indeed, the standardized errors of the regressions in the present study were much higher than those in the study by Heath et al. Lastly, Heath and colleagues noted that all of the variables were standardized before their regression analysis probing for moderation effects, whereas the variables were mean centered prior to analysis in the present study.

We believe that the smaller sample size, greater sample variability, and ultimately larger standard errors in our study may have contributed to the lack of statistical significance reached in the proposed moderation relationships examined. It is also common for studies to fail to replicate findings of previous research as a result of sampling variability, measurement error, and other artifacts (Stanley & Spence, 2014). Simulations of ideal replications have shown that study results can differ substantially due to measurement error alone (Stanley & Spence, 2014). It is of interest to note that self-esteem also did not significantly moderate the relationship between public and self-stigmas in the comparison analyses in the present study. Self-stigma intervention research is still in its early stages and none of the published intervention studies have been replicated (Mittal et al., 2012). The existing self-stigma interventions are few and varied in approach (Yanos et al., 2014). Replication studies are vital to determine which strategies can effectively and reliably address the different manifestations of self-stigma. Future studies may

wish to specifically examine mediating variables and diversity factors such as cultural and personality differences to build on, and further refine, our understanding of how self-compassion and self-esteem influence public and self-stigma associated with mental illness.

Qualitative Findings

The complementary qualitative findings provided a glimpse of the different ways self-stigma of seeking help is expressed in our sample of young adults. Among those identified as “high stigmatizers”, the identified feelings of inadequacy were experienced as both intrapersonal and interpersonal phenomena. The intrapersonal manifestation of self-stigma centered around anticipated loss of self-efficacy and autonomy as a result of seeking help. The interpersonal themes extracted were related to unfavourable social comparisons, anticipation of rejection and negative impact on relationships with family and peers. Notably, participants remarked that they would refrain from seeking professional help even when they believed that it would alleviate their suffering. Collectively, the qualitative data speak to the diverse expressions of self-stigma of seeking help and the ways in which it prevents individuals in need from utilizing mental health services. Certainly, self-stigma of seeking help entails more than the loss of self-esteem and has a wide range of impact on an individual’s complex system of self-understanding.

As is the nature of qualitative analysis, the results are both descriptive and embedded with the authors’ interpretations and subjectivity (Fossey et al., 2002). Therefore, the qualitative findings are suggestive rather than definitive and cannot be generalized to the larger population. What the qualitative analysis does provide is a degree of insight into targeted individuals’ subjective experience of self-stigma for seeking psychological help that helped to enrich our understanding of the construct of interest. The qualitative findings lent support to the quantitative results of the present study and contributed to the development of research questions that are

addressed in Study Two. Specifically, it has been suggested that individuals who feel connected to others judge themselves less harshly for perceived flaws and weakness when they recognize that being imperfect is part of the human condition (Barnard & Curry, 2011). Common humanity was precisely the aspect of self-compassion that was found to predict lower self-stigma of seeking professional help. In fact, when common humanity was entered simultaneously in a regression with self-esteem, self-esteem was not a significant predictor of self-stigma of seeking help. This finding suggests that although self-esteem has long been associated with self-stigma of seeking help, once the role of self-compassion is partialled out, self-esteem no longer accounted for self-stigma of seeking help. With respect to the qualitative analysis, responses of high-stigmatizers indicated that in addition to self-worth, seeking professional help also threatens one's sense of self-efficacy and perceived competence to cope independently. Despite the strong relationships between self-compassion and mental health related self-stigma, self-compassion was not correlated with attitudes, intentions and willingness to seek professional help. Study Two examined whether other identified barriers to seeking help, namely self-efficacy and perceived self-competence, explained the lack of predicted relationship between self-compassion and help-seeking attitudes, intentions, and willingness.

Chapter Three: Study Two

Self-efficacy and Perceived Self-competence as Intervening Variables

Study Two investigated potential intervening variables exerting influence on self-compassion and help-seeking attitudes and behaviours. Significant relationships were found between self-compassion and self-stigma associated with both having mental illness and that of seeking help as predicted in Study One, however, self-compassion was not significantly correlated with *attitude* and *intentions* toward seeking help as hypothesized. This was surprising given the strong relationships between the self-stigma measures and measures of attitude and intentions toward professional help-seeking. The qualitative findings in Study One revealed that individuals high on self-stigma may perceive seeking help as a threat to perceived self-efficacy and self-competence. Surprisingly, little is known about the impact of self-efficacy and self-competency on help-seeking for mental illness (Anderson, Dea Moore, Hensing, Krantz, & Staland-Nyman, 2014; Jackson et al., 2007). Study Two examined the role self-efficacy and perceived self-competence plays in the relationship between self-compassion and individuals' attitude and intent to seek professional help to better understand the complex psychological forces keeping those in need from participating in mental health services.

Self-efficacy was defined by Bandura (1994) as "...people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave." Self-efficacy is purported to explain why people may or may not be motivated to perform health-related behaviours and is associated with a number of predictors of psychological wellbeing, including self-compassion (Anderson et al., 2014; de Souza & Hutz, 2016; Williams & Rhodes, 2016). Intriguingly, the qualitative findings from Study One seem to suggest that self-

efficacy may also prevent individuals from enlisting others in efforts to improve their psychological health when in need. Indeed, individuals with high self-efficacy were found to be less likely to seek help and are more likely to believe that their mental illness will pass by itself (Anderson et al., 2014; Judd et al., 2006). The qualitative findings of Study One suggest that self-efficacy may partially explain the lack of expected relationship between self-compassion and attitudes as well as intentions toward help-seeking.

Participants from Study One also alluded to perceived self-competence being threatened by the idea of seeking professional help. Arising from self-determination theory, self-competence is conceptualized as the overall sense of oneself as capable and in control (Rodgers, Markland, Selzler, Murray, & Wilson, 2014; Tafarodi & Swann, Jr., 1995). Perceived self-competence is internally calibrated and autonomously defined by whether one's intentions are congruent with the outcomes of events (Tafarodi & Swann Jr., 1995). Self-competence plays an important role in motivating purposeful behaviour and coping with stress (Bandura, 1977; Seligman, 1975), and is also positively correlated with self-compassion (Barnard & Curry, 2011; Neff, Hsieh, & Dejitterat, 2005). Though closely related, self-competency is thought to be separate from self-efficacy in that self-efficacy is theorized as situation-specific self-confidence whereas perceived self-competence extends beyond the ability to perform a task and includes consideration of the personal importance of the task (Rodgers et al., 2014). Indeed, self-efficacy and self-competency have been demonstrated to be statistically distinct in the context of physical exercise (Rodgers et al., 2014). Given the associations of self-compassion with both self-efficacy and perceived self-competence, and their respective importance to motivation and behavioural engagement, Study Two examined whether one or both constructs intervene in the relationship

between self-compassion and attitude towards professional help-seeking, as well as the relationship between self-compassion and intentions to seek help.

Self-compassion Interventions

Study One examined the relationships between self-compassion and mental health stigmas and found support that self-compassion is as good of a predictor of self-stigma as self-esteem, and in the case of seeking help specifically, self-compassion accounted for more of the variances than self-esteem. Study Two endeavoured to extend the findings of Study One by investigating whether a brief self-compassion intervention could lead to less self-stigma and more favourable attitude and intention towards seeking help for mental health difficulties. Leading theories on the self propose that self-relevant information is organized by well-formed self-concepts that are relatively stable over an individual's lifespan (Kelly, 1955). However, the parts of the self that guide behaviour, the working self-concept, are acutely sensitive to cues in the environment (Markus & Wurf, 1987). The field of social psychology has produced numerous studies examining the effects of associative priming on a wide range of behaviours from pro-sociality to voting decisions (Berger, Meredith, & Wheeler, 2008; Macrae & Johnston, 1998; Payne, Brown-Iannuzzi, & Loersch). A recent publication by Payne and colleagues (2016) provided evidence that primes can reliably affect behaviour with a series of six studies demonstrating prime influenced responses in a gambling scenario. The present study attempted to prime self-compassion with a letter-writing task commonly used in the therapeutic context (Neff, 2016), and examined whether the exercise led to changes in participants' endorsement of mental health related self-stigmas and help-seeking attitude and intentions.

It has been theorized that there is a self-regulatory function to writing about one's experiences and writing about one's best possible self (BPS) has demonstrated long-term health

benefits, increase in life satisfaction, optimism, and overall-wellbeing (King, 2001; Layous, Nelson, & Lyubomirsky, 2012). A BPS condition, as well as a control condition (CL), was included to check that the effects obtained from the self-compassion (SC) induction are indeed due to self-compassion rather than the positive effects of writing about oneself alone. Our specific hypotheses for Study Two were as follows:

- H1: Participants in the SC condition will report lower self-stigma of seeking help, as well as more positive attitude and greater intentions toward seeking help, than those in the BPS and CL conditions.
- H2: Self-efficacy and perceived self-competence are positively related to self-compassion and inversely related to psychological distress.
- H3: Self-efficacy and perceived self-competence are negatively correlated with attitudes and intentions toward seek help for mental illness.
- H4: Self-efficacy is an intervening variable of the relationship between self-compassion and attitude towards seeking professional help.
- H5: Self-efficacy is an intervening variable of the relationship between self-compassion and intentions to seek professional help.
- H6: Self-competency is an intervening variable of the relationship between self-compassion and attitude towards seeking professional help.
- H7: Self-competency is an intervening variable of the relationship between self-compassion and intentions to seek professional help.

In summary, results of Study One supports the assertion that self-compassion is a protective factor against the deleterious effects of self-stigma associated with mental illness, and Study Two extends the findings of Study One by exploring the ease with which self-compassion

may be manipulated to inform the development of future interventions. Specifically, Study Two examined whether individual's self-compassion can be boosted by a brief intervention exercise. Additionally, Study Two examined the extent to which self-efficacy and perceived self-competence, two important constructs related to self-compassion and behavioural motivation and activation, explain the relationship between self-compassion and attitude and intentions toward professional help-seeking. Given the promising findings of the benefits of self-compassion for self-stigma reduction, it is prudent to investigate the means of delivering self-compassion as well as potential hindrances to its efficacy in improving mental health service use. To the best of our knowledge, this is the first empirical study to examine the relationships among self-compassion, self-efficacy, perceived self-competence, and help-seeking attitude and intentions in the context of mental health.

Methods

Participants and Procedures

The sample consisted of 134 university students recruited through the undergraduate research participant pool (74 females, 59 males and one person who did not indicate their gender) with a mean age of 20.0 year ($SD = 3.8$). Individuals that participated in Study One were excluded from participating in the current study. The sample was again culturally diverse with 20.9% identifying as Middle Eastern, 20.1% as Caucasian, 19.4% as Asian/Pacific Islander, 12.7% as African American, 3.7% as Hispanic, and 23.1% as Other (participants identified as Caribbean, South Asian, “mixed” and etc.) Participants received research credit towards their respective psychology courses.

The present study took place in a university computer lab. Prior to participants' arrival, alternating computers were assigned to administer the self-compassion (SC), best positive self (BPS), or control (CL) condition, such that participants would not be seated next to someone else in the same condition. Participants were randomly assigned to a computer station when they arrived. On average, six participants were in the lab completing the study at the same time. The current study followed a similar self-compassion induction procedure that was used in Shapira & Mongrain (2010). Those assigned to the SC condition were asked to think about a recent experience of failure, rejection, or loss that had left them feeling upset, and directed to write a letter to themselves in the first person about the situation with the following instructions adapted from Shapira & Mongrain (2010):

To start writing your own letter, try to feel that part of you that can be kind and understanding to others. Think about what you would say to a good friend in your position, or what a friend would say to you in this situation. Try to have understanding

for your distress and realize your distress makes sense. Try to be good to yourself. We would like you to write whatever comes to you, but make sure this letter provides you with what you think you need to hear in order to feel comforted and soothed about your situation or event. This letter may take about 15 -20 minutes to write, and there is no “right” of “wrong” way of doing it.

Shapira & Mongrain (2010) found that individuals who completed the self-compassion exercise daily for seven days were less depressed than those in the control condition at three months follow-up, which indicated the efficacy of their self-compassion intervention. The BPS is a widely used script to boost subjective wellbeing and positive affect and reads as follows (Layous, et al., 2012):

Think about your life in the future. Imagine that everything has gone as well as it possibly could. You have worked hard and succeeded at accomplishing all of your life goals. Think of this as the realization of all of your life dreams. Now, for the next 15-20 minutes, write about what you imagined in detail.

Participants in the CL condition were asked to write about their activities in the past 24-hours (Austefeld & Stanton, 2008; Maddalena et al., 2014):

Take 15-20 minutes to objectively describe the past 24-hour activities in as much detail as possible. Where were you? What were you doing? (If you cannot remember some details, that is OK. Just type down what you can remember).

Following the writing exercises, participants completed a battery of self-report questionnaires consisting of self-compassion, public and self-stigma related to having mental illness and that of seeking professional help, attitudes and intentions toward seeking help, self-efficacy, perceived self-competence, and psychological distress.

Instruments

Self-compassion. For brevity, the short form of the Self-Compassion Scale was used in the current study (SCS-SF; Raes, Pommier, Neff & Van Gucht, 2011). The SCS-SF is composed of 12 items and has a reported near perfect correlation of 0.97 with the long form Self-Compassion scale (SCS) when examining total scores (Raes et al., 2011). Similarly to the long form SCS (Neff, 2003), the SCS-SF measures the positive and negative aspects of the three components of self-compassion: Self-Kindness (e.g. “I try to be understanding and patient towards aspects of my personality I don’t like.”) versus Self-Judgement (e.g. “I’m disapproving and judgemental about my own flaws and inadequacies.”); Common Humanity (e.g. “I try to see my failings as part of the human condition.”) versus Isolation (e. g. “When I’m feeling down, I tend to feel like most other people are probably happier than I am.”; and Mindfulness (e.g. “When something painful happens I try to take a balanced view of the situation.”) versus Over-Identification (e.g. “When I fail at something important to me I become consumed by feelings of inadequacy.”) Items are rated on a five-point Likert scale ranging from 1 (*Almost never*) to 5 (*Almost always*). Half of the items are reversed scored such that higher composite scores indicate greater self-compassion. The SCS-SF has reported internal consistency of .86 or higher and is described as a reliable and valid alternative to the long-form SCS (Raes et al., 2011).

Self-efficacy. The General Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995) is comprised of ten items assessing individuals’ perception of their self-efficacy. Items are rated on a four-point Likert scale ranging from 1 (*Not at all true*) to 4 (*Exactly true*), with higher scores indicating greater self-efficacy. A sample item includes: “I can always manage to solve difficult problems if I try hard enough.” The GSE has a reported internal consistency ranging from of $\alpha =$

.76 to .90 (Schwarzer & Jerusalem, 1995). The GSE is related to optimism, work satisfaction, depression, stress and anxiety (Schwarzer & Jerusalem, 1995).

Self-competence. The Self-Liking/Self-Competence Scale (SLCS; Tarfarodi & Swann, Jr., 1995) was designed as a self-report measure of global self-esteem. The SLCS is comprised of a self-liking and self-competence dimension; only the ten items from the self-competence subscale was used in the current research. Half of the ten items are reversed scored such that higher scores reflect higher perceived self-competence. Participants are asked to rate their agreement to first-person statements using a five-point Likert scale ranging from 0 (*strongly disagree*) to 5 (*strongly agree*). A sample item includes: “Owing to my capabilities, I have much potential.” The self-competence subscale has a reported internal consistency ranging from .85 to .89 (Tarfarodi & Swann, Jr., 1995).

Other Measures. Self-stigma for having mental illness was again assessed with the Tucker et al. (2013) modified 12-item version of the Self-Stigma of Depression Scale (SSDS; Barney et al., 2010). Participants’ perception of how much mental illness is stigmatized by the general public was ascertained with the 12-item Devaluation-Discrimination Scale (DDS; Link, 1987). Self-stigma of seeking psychological services was measured using the ten-item Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). Participants’ perception of the social stigma for receiving professional help was assessed with the five-item Social Stigma for Receiving Psychological Help Scale (SSRPH; Komiya et al., 2000). Help-seeking attitudes was measured using the ten-item Attitude towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF; Fischer & Farina, 1995). Intention to seek help was assessed with the 17-item Intentions to Seek Counselling Inventory (ISCI; Cash et al., 1975). Participants’ psychological distress was measured using the 14-item General Population-Clinical Outcomes in

Routine Evaluation measure (CORE-GP; Evans et al., 2005). A detailed description of instruments above can be found in the Methods section of Study One.

Results

Descriptive and Correlational Analyses

The mean, standard deviation, and Cronbach's alpha statistics of the measures used are reported in Table 5. The means for self-compassion, psychological distress, public and self-stigma related to having mental illness and that of seeking help, as well as attitude and intentions to seek professional help in the current sample was comparable to those obtained in Study One. The internal consistencies of the measures used were also similar to those obtained with the sample in Study One; all alphas were .81 and above, with the exception of the social stigma for receiving help scale, which had an alpha of .67. All analyses were done controlling for gender due to gender differences in the variables of interest found in Study One.

The partial correlations among the variables of interest are also reported in Table 5 below. Consistent with the previous study, self-compassion was significantly negatively correlated with self-stigma related to having a mental illness and that for seeking help, social stigma for receiving help, and psychological distress. As with Study One, self-compassion was not significantly correlated with attitude and intentions toward seeking professional help. Both self-efficacy and perceived self-competence were significantly positively associated with self-compassion and inversely related to psychological distress, in support of Hypothesis Two. With regards to the self-stigma measures, self-stigma of *mental illness* was positively related to anticipated public stigma for having mental illness, public and self-stigma related to help-seeking, and psychological distress as expected. Self-stigma for having mental illness was also negatively correlated with perceived self-competence but was unrelated to self-efficacy. Self-stigma of *seeking help* was inversely related to attitude and intentions toward seeking professional help, and positively related to anticipated public stigma for having mental illness

and for receiving help as expected. Additionally, attitude towards seeking professional help was negatively correlated with anticipated public stigma for having mental illness and for receiving help. Attitude and intentions towards professional help-seeking were positively correlated with each other. As hypothesized, self-efficacy was significantly negatively correlated with both attitude and intentions toward professional help-seeking. Self-competency however, was significantly negatively correlated with intentions to seek help but not attitude towards professional help-seeking, providing partial support for Hypothesis Three. As expected, a significant positive correlation was found between self-efficacy and perceived self-competence.

Table 5

Partial Correlations Among Variables of Interest Controlling for Gender

Variable	1	2	3	4	5	6	7	8	9	10
1. Self_CM	-									
2. DDS	-.08	-								
3. SSMI	-.4**	.18*	-							
4. SSOSH	-.28**	.26**	.38**	-						
5. SSRPH	-.2*	.45**	.25**	.51**	-					
6. ATSSPH	.03	-.23**	-.11	-.61**	-.35**	-				
7. ISCI	-.08	-.11	.07	-.22*	-.07	.48**	-			
8. GSE	.41**	.13	-.1	.13	.08	-.29**	-.33**	-		
9. SLCS	.43**	.05	-.29**	-.1	-.1	-.08	-.31**	.62**	-	
10. CORE	-.6**	.03	.38**	.15	.12	.04	.16	-.45**	-.61**	-
<i>Mean (SD)</i>	2.8(.63)	3.9(.87)	3.2(.77)	2.7(.79)	2.3(.5)	2.6(.58)	40.3(10.2)	3(.42)	3.7(.66)	2.8(.69)
<i>Alphas</i>	.82	.86	.86	.89	.67	.81	.86	.83	.86	.84

Note. $N = 133$. Self_CM refers to self-compassion, DDS refers to stigma awareness, SSMI refers to self-stigma of mental illness, SSOSH refers to self-stigma of seeking help, SSRPH refers to social stigma for receiving help, ATSPPH refers to attitude towards seeking professional help, ISCI refers to intentions to seek help, GSE refers to general self-efficacy, SLCS refers to perceived self-competence, CORE refers to psychological distress.

* $p < .05$. ** $p < .01$.

Analyses of Group Differences

To determine whether the experimental manipulation of self-compassion was successful, Analysis of Covariance (ANCOVA) was performed to assess whether self-compassion was different between the experimental groups, along with self-stigma, attitude and intentions toward professional help-seeking, as well as self-efficacy and perceived self-competence. The one-time administered self-compassion letter writing exercise did not appear to significantly increase participants' self-compassion. Hypothesis One was unsupported as no significant differences were found between the experimental groups in any of the variables of interest (see Table 6). It is important to note that the power and effect sizes in the current study are very low [for reference, effect size of 0.2 is considered small, 0.5 medium, and 0.8 large (Cohen, 1969)].

Table 6

Group Differences in Variables of Interest Controlling for Gender

Variables	SC Condition Mean (SD)	BPS Condition Mean (SD)	Control Means (SD)	F	Effect Size	Power
Self-CM	2.8 (.57)	2.7 (.64)	2.8 (.69)	.06	.001	.06
SSMI	3.3 (.76)	3.2 (.91)	3.2 (.94)	.15	.002	.07
SSOSH	2.8 (.82)	2.8 (.8)	2.7 (.76)	.05	.001	.06
ATSPPH	2.6 (.56)	2.6 (.56)	2.6 (.61)	.14	.002	.07
ISCI	39.5 (10.1)	40.6 (10.6)	40.7 (10.1)	.21	.003	.08
GSE	3 (.35)	3 (.45)	3 (.47)	.1	.002	.07
SLCS	3.8 (.57)	3.6 (.69)	3.7 (.71)	1.35	.02	.29
CORE	2.7 (.7)	2.9 (.7)	2.8 (.7)	1	.02	.22

Note. $N = 133$. Self_CM refers to self-compassion, SSMI refers to self-stigma of mental illness, SSOSH refers to self-stigma of seeking help, ATSPPH refers to attitude towards seeking professional help, ISCI refers to intentions to seek help, GSE refers to General Self-efficacy, SLCS refers to perceived self-competence, CORE refers to psychological distress.

* $p < .05$. ** $p < .01$.

Analysis of Intervening Variables

Self-efficacy

Structural equation modeling, using R software version 3.3.2, was conducted to investigate whether self-efficacy was a significant intervening variable in the relationship between self-compassion and attitude towards seeking professional help. A suppression relationship was found, as suggested when the coefficient relating the independent to the dependent variable adjusted for the effects of the third variable (the direct effect), is larger than the overall relationship between the independent and dependent variable (MacKinnon, Krull, & Lockwood, 2000; Tzelgov & Henik, 1991). In situations in which the sign of the indirect effects is opposite to that of the direct effect, which is the case presently, the indirect effect is an estimate of the suppressor effect (MacKinnon et al., 2000). In the present case, self-efficacy significantly suppressed, or falsely obscured, the relationship between self-compassion and attitude towards seeking professional help, supporting Hypothesis Four.

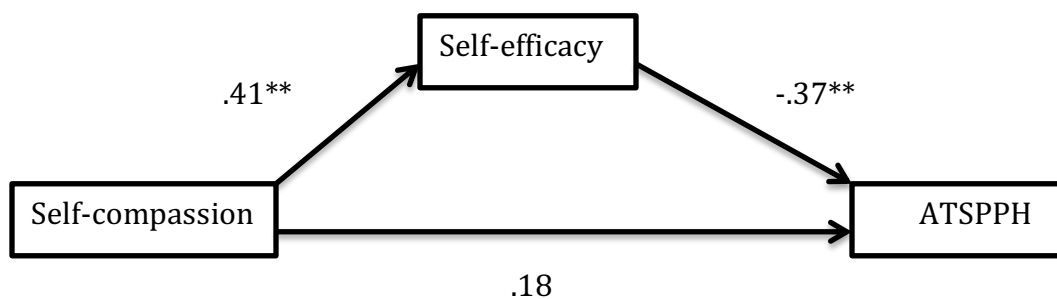


Figure 2. Standardized regression coefficients for the relationship between self-compassion and attitude towards seeking help as mediated by self-efficacy.

$p < .05$. ** $p < .01$.

As Figure 2 illustrates, the standardized partial regression coefficient between self-compassion and self-efficacy after removing the effect of gender was statistically significant ($\beta = .41$, $p <$

.001), as was the standardized regression coefficient between self-efficacy and attitude towards help-seeking ($\beta = -.37, p < .001$). As expected, the standardized regression coefficient between self-compassion and attitude towards seeking help was not significant ($\beta = .18, p = .08$). The standardized indirect effect of self-compassion on attitude towards professional help-seeking, however, was significant ($\beta = -.15, p = .002$). The standardized indirect effects were calculated using bootstrapped standard errors from 1000 samples. The standardized regression coefficient of gender on ATSPH was $-.12$ ($p = .16$) and $.16$ ($p = .04$) on self-efficacy.

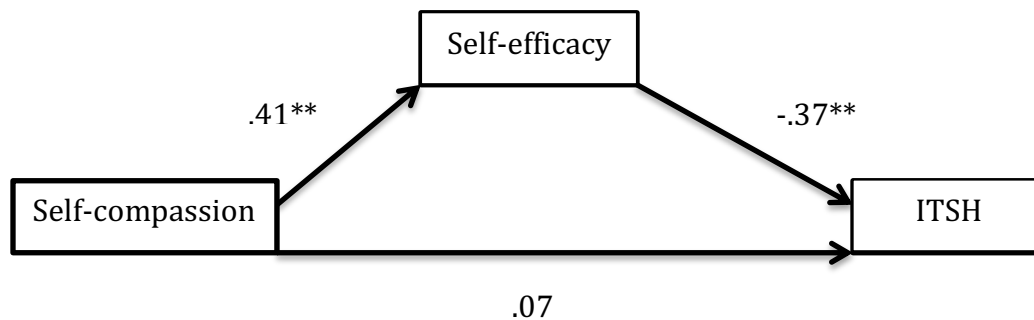


Figure 3. Standardized regression coefficients for the relationship between self-compassion and intentions towards seeking help as mediated by self-efficacy.

* $p < .05$. ** $p < .01$.

Self-efficacy also significantly suppressed the relationship between self-compassion and intentions to seek help as predicted in Hypothesis Five (see Figure 3). The standardized partial regression coefficient between self-compassion and self-efficacy after removing the effect of gender was again statistically significant ($\beta = .41, p < .001$), as was the standardized regression coefficient between self-efficacy and intentions to seek help ($\beta = -.37, p < .001$). As expected, the standardized regression coefficient between self-compassion and intentions to seek help was not significant ($\beta = .07, p = .54$), whereas the standardized indirect effect of self-compassion on

intentions to seek help was significant ($\beta = -.15, p = .001$). Again, the sign of the indirect effects is opposite to that of the direct effect, therefore the indirect effect is taken as an estimate of the suppressor effect. Lastly, the standardized regression coefficient of gender on intentions to seek help was $.06$ ($p = .47$) and $.16$ ($p = .03$) on self-efficacy.

Self-competency

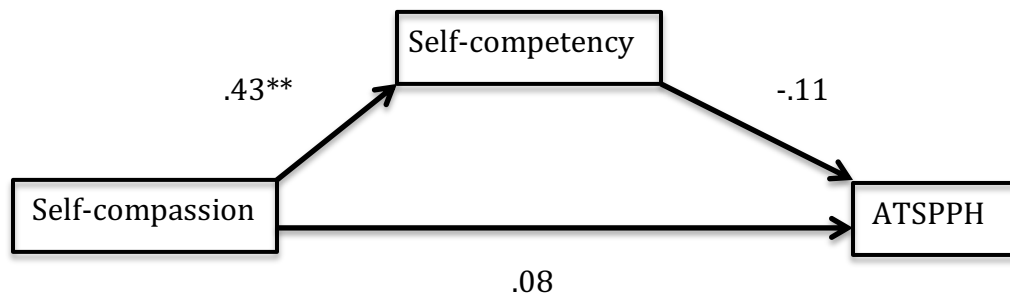


Figure 4. Standardized regression coefficients for the relationship between self-compassion and attitude towards seeking professional help as mediated by self-competency.

Structural equation modeling was conducted to examine whether perceived self-competence was also a suppressor of the relationship between self-compassion and attitude towards professional help-seeking. As shown in Figure 4, perceived self-competence is not a significant intervening variable of the relationship between self-compassion and attitude towards seeking help. Therefore, Hypothesis Six was unsupported. The standardized partial regression coefficient between self-compassion and perceived self-competence after removing the effect of gender was statistically significant ($\beta = .43, p < .001$); however, the standardized regression coefficient between self-competency and attitude towards professional help-seeking was not ($\beta = -.11, p = .25$). As expected, the standardized regression coefficient between self-compassion and attitude towards seeking help was not significant ($\beta = .08, p = .48$). The standardized indirect

effect of self-compassion on attitude towards help-seeking was also not significant ($\beta = .08, p = .48$). The standardized regression coefficient of gender on attitude towards seeking help was $-.17$ ($p = .07$) and $.08$ ($p = .28$) on perceived self-competence.

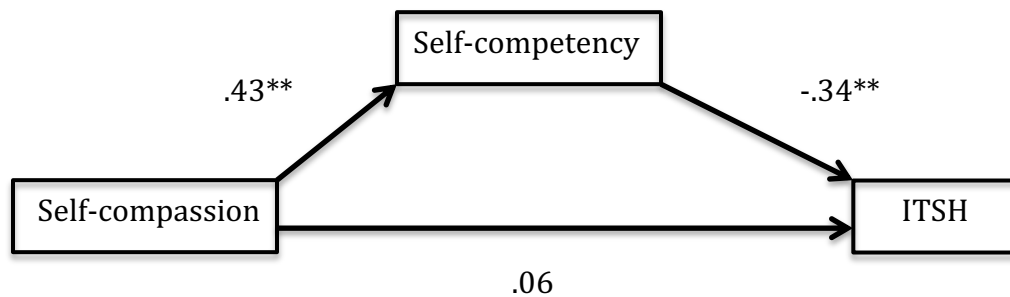


Figure 5. Standardized regression coefficients for the relationship between self-compassion and intentions to seek help as mediated by self-competency.

On the other hand, perceived self-competence was a significant suppressor of the relationship between self-compassion and intentions to seek help, supporting Hypothesis Seven (see Figure 5). The standardized partial regression coefficient between self-compassion and self-competency after removing the effect of gender was again statistically significant ($\beta = .43, p < .001$), as was the standardized regression coefficient between self-competency and intentions to seek help ($\beta = -.34, p = .001$). As expected, the standardized regression coefficient between self-compassion and intentions to seek help was not significant ($\beta = .06, p = .55$). However, the standardized indirect effect of self-compassion on intentions to seek help was significant ($\beta = -.15, p = .001$), and is an estimator of the suppression effect. The standardized regression coefficient of gender on intentions to seek help was $.03$ ($p = .73$) and $.08$ ($p = .27$) on perceived self-competence.

Discussion

Study Two examined the role of self-efficacy and perceived self-competence in the relationships between self-compassion and help-seeking attitude and intentions. The present study also explored whether a brief one-time self-compassion induction would lead to reduced self-stigma and more favourable attitude and intentions toward seeking help for mental health concerns. The current study was able to replicate the correlations found in Study One, which provided confidence in our findings that self-compassion is at odds with both self-stigma for having mental illness and that of seeking help. It was also affirming to find once again that self-compassion was not significantly related to attitude and intentions toward seeking help in another sample group.

As hypothesized, both self-efficacy and perceived self-competence were positively related to self-compassion and inversely related to psychological distress. There are very few studies that have examined the relationship between self-compassion and self-efficacy, and none in the context of seeking help for mental health difficulties. As predicted, self-efficacy was found in this study to be inversely related to both attitude and intentions toward seeking help. Interestingly, perceived self-competence was negatively correlated with intentions to seek help, however it was not significantly correlated with attitude towards seeking help. This could be an artifact of the present study or an indication of conceptual differences between attitudes and intentions regarding behaviour. Intention to enact on behaviour is theorized to be predicted by attitudes as well as perceived social norms (Albrecht & Carpenter, 1976; Leone, Perugini, & Ercolani, 1999). The measure of attitude towards seeking professional psychological help assesses a person's perception of need, openness, as well as confidence in professional help, whereas the measure of intentions to seek help inquires how likely an individual is to seek help

for a range of psychological difficulties, which is influenced by more than need and confidence in professional services and include other factors such as social norms and perceived acceptability of seeking help for specified issues.

Intervening Variables

One of the main goals of Study Two was to investigate whether self-efficacy and perceived self-competence obfuscate the relationship between self-compassion and attitude towards seeking help, as well as the relationship between self-compassion and intentions to seek help. As hypothesized, self-efficacy was a significant suppressor of the observed relationships. The structural equation modeling provided an explanation as to why self-compassion, despite being strongly correlated with self-stigma measures, appeared to be unrelated to attitude and intentions toward seeking professional help. The model obtained exemplified a special case where the population direct effect and the population third variable effect are of similar magnitude and opposite signs, resulting in a near complete suppression (MacKinnon et al., 2000), with self-compassion falsely appearing to have no relationship with attitude and intentions toward professional help-seeking. The structural equation modeling provided insight into the unexpected findings of Study One and understanding of the suppression relationships contribute to theoretical thinking and may potentially inform efforts to increase access to mental health care for undertreated populations.

Specifically, the findings of the present study suggest that self-compassionate individuals tend to have higher perceived self-efficacy, which is associated with lower intent and less favourable attitude towards seeking professional help. Self-efficacy may be expressed as confidence that one does not need psychological services to overcome one's difficulties, and thus affects both attitudes and intentions toward seeking professional assistance. Indeed, self-efficacy

was found to be positively related to self-report of not wanting help with changing health habits (smoking, alcohol, eating, and physical activity) in a workplace health promotion study, leading the authors to conclude that high self-efficacy fosters feelings of self-reliance that may act as an “individual barrier and hindrance to receiving help” (Persson, Cleal, Jakobsen, Villadsen, & Andersen, 2014). Additionally, perceived self-competence was found in our study to significantly suppress the relation between self-compassion and intentions to seek help. Intention is theorized to be determined by belief-based constructs such as attitudes, as well as subjective norms, such that individuals have greater intent to seek help if they have positive attitudes toward seeking help *and* perceive that important others approve of their doing so (Hammer & Vogel, 2013). Self-competency, in contrast to self-efficacy, is regarded as the general perception of one’s ability to function in different domains and considers expected consequence of behaviours with regards to motivation to act (Rodgers et al., 2014). Findings of Study Two suggest that perceived self-competence may be more closely related to intentions to seek help, and that individuals with high self-competency could endorse low intentions to seek help for psychological concerns regardless of their attitude towards professional services.

Despite the well-researched roles self-efficacy and self-competency play in health promoting behaviours (Boman & Walker, 2010; Hevey, Smith, & McGee, 1998; Rodgers et al., 2014; Yeom, 2014), the impact of self-efficacy and perceived self-competence on help-seeking in the context of mental health is understudied. To date, only a few studies have examined self-efficacy and help-seeking for mental health difficulties, with results suggesting that high self-efficacy is associated with decreased self-report of mental illness and lower lifetime help-seeking for mental health issues (Andersson et al., 2014; Judd et al., 2006). Paradoxically, self-efficacy is also associated with several indicators of psychological wellbeing including optimism, self-

compassion, self-regulation, self-esteem, and life satisfaction (de Souza & Claudio, 2016; Luszczynska, Gutierrez-Dona, & Schwarzer, 2005). To the best of our knowledge, there are no published studies on the relation between perceived self-competence and psychological help-seeking. Results of the current study strongly suggest that high self-efficacy and perceived self-competence negatively impact attitude and intentions toward professional help-seeking for mental illness. Further, though self-compassionate individuals likely experience lower mental health related self-stigmas, the benefits of self-compassion may not carry forward to influence attitude and intentions toward seeking professional help when self-efficacy and self-competency are held in high regard. Follow-up and replications studies are crucial to clarify how self-efficacy and perceived self-competence impact the solicitation and acceptance of professional assistance for mental health difficulties, which carries distinct stigmas and risk of disclosure compared to physiological ailments. The findings of the current line of research highlight the need to examine underlying mechanisms of factors that facilitate or hinder help-seeking, and the particular circumstances under which stigma reduction strategies are efficacious in reducing the gap between services needed and utilized.

Self-compassion Intervention

The current study also examined the impact of a brief self-compassion intervention on mental health related self-stigmas, as well as attitude and intentions towards seeking help. Unfortunately, the current study did not find any significant differences in the variables of interest between conditions. With regards to the self-compassion manipulation, most participants did not spend the 15 to 20 minutes allotted time on the letter writing exercise as instructed. However, it is promising to note that all participants were able to engage in the self-compassion

writing exercise, and many produced letters that contained the essential elements of self-kindness, common humanity, and mindfulness. Please see sample letters in Appendix A.

It was encouraging to see young adults in our study actively engaged in the self-compassion exercise with minimal instructions and no prior training. The depth of content in the letters obtained lends further support that self-compassion is an accessible construct that young adults can easily tap into. Nonetheless, the short in-lab exercise did not produce the intended effects on self-stigma and help-seeking attitudes and intentions. It may be necessary to implement a psychoeducational or training component that teaches participants the core aspects of self-compassion that they are then encouraged to evoke during the exercise. Further, studies that have successfully and reliably increased participants' self-compassion implemented more intensive and lengthier interventions, including self-compassion journaling, workbooks, and directed loving-kindness meditation (Held & Owens, 2015; Shapira et al., 2010; Smeets et al., 2014; Talbot, Theriault, & French; 2016). For instance, a six-week mindful self-compassion program for adolescents was shown to effectively increase participants' self-compassion, which in turn predicted increase in life satisfaction and decrease in depression and perceived stress (Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2015). The amount of time participants spent practicing self-compassion is also important for post-intervention gains (Krieger, Martig, Brink, & Berger, 2016), however, it is yet unclear as to the threshold of time spent and level of engagement that is adequate to effect meaningful and lasting change. The current study examined whether a brief one-time intervention was a sufficient "test dose" to influence participants' self-compassion and self-stigma regarding mental illness. Future studies may wish to explore this question further to create accessible and efficient anti-stigma interventions that

may be implemented well before individuals encounter the need to seek professional help, such as through health education curriculums in schools and community programs.

It is of significance to note that the current study did not employ manipulation checks such as assessing participant's baseline self-compassion before the manipulation or asking participants to guess the purpose of the study. Owing to the sensitivity of priming effects, manipulation checks were omitted due to concerns that its inclusion may inadvertently prime self-compassion in all treatment conditions, direct attention to the research goals and potentially influence participants' responses. Though it is within the tradition of experimental research, some scholars have argued that measures of manipulations are not necessary and not useful (Fayant, Sigall, Lemonnier, Retsin, & Alexopoulos, 2017; Sigall & Mills, 1998). Sigall & Mills (1998) argued that manipulation checks (MC) do not "rule out" or "rule in" alternative explanations of causal effects. Specifically, in the condition where no alternative explanation exists, the author reasoned that a successful MC does not provide definitive proof of construct validity and that a failed MC does not invalidate the theoretically expected result (Sigall & Mills, 1998). On the other hand, when other explanations do exist, a successful MC does not eliminate said alternatives and a failed MC does not bolster the favoured explanation (Sigall & Mills, 1998). Though some believe MCs are useful when treatment conditions do not produce the intended effects, as in the present study, others argue that MCs should not be relied on to determine successful manipulation as a positive MC could actually be due to covariates of the independent variable (Fayant, et al., 2017). Further, adding an additional MC measure to an already lengthy self-report battery run the risk of increasing participant fatigue. The addition of multiple tests also increases Type 1 error rate and decrease the power to observe statistically significant effects on all variables of interest (Cohen, 1990).

To determine whether self-compassion can be induced to produce favourable effects on mental health related self-stigma and attitude and intentions towards professional help-seeking, sophisticated and systematic replication studies are necessary. The specific research questions regarding the efficacy and feasibility of self-compassion-based interventions for stigma reduction would be better addressed with a community sample of individuals with mental health challenges that are likely experiencing high levels of mental health related self-stigmas. Utilizing a community or clinical sample would improve the ecological validity, as well as allow studies to tailor the self-compassion exercises to focus specifically on mental health self-stigmas. Self-compassion interventions have been successfully adapted to address a number of issues, including trauma, eating disorders, psychosis, shame and self-criticism (Albertson, Neff, & Dill-Shackleford, 2014; Beaumont, Galpin, & Jenkins, 2012; Braehler, Gumley, Harper, Wallace, Norrie, & Gilbert, 2013; Gilbert & Procter, 2006; Kelly & Carter, 2015). One of such studies demonstrated that practice of guided meditations consisting of compassionate body scan, affectionate breathing, and loving-kindness over a period of three weeks significantly increased self-compassion and led to significant reduction in body dissatisfaction, body shame, and contingent self-worth based on appearance (Albertson, et al., 2014). As such, future studies may wish to create or modify existing self-compassion exercises to directly target mental health related self-stigma.

A growing number of studies are showing self-compassion-based interventions, and the integration of self-compassion with traditional treatments, to benefit a number of mental and physical illnesses (Beaumont, et al., 2012; Braehler, et al., 2013; Friis, Johnson, Cutfield, & Consedine, 2016; Held & Owens, 2015; Kelly & Carter, 2015; Mantzios & Wilson, 2014). The findings of the present study, though limited, are encouraging of further exploration of online

approaches to self-compassion intervention for individuals struggling with self-stigma related to mental health. The anonymity associated with online formats of intervention may be particularly attractive to individuals who are experiencing a high degree of shame, as well as those in the contemplative and preparation stages of change (Prochaska, DiClemente, & Norcross, 1992). A proof of concept study found that a self-compassion program administered entirely over the Internet was able to significantly increase participants' self-compassion and satisfaction with life, as well as decrease their self-criticism and fear of self-compassion (Krieger, et al., 2016). Notably, one third of participants (35%) stated that they would have only completed the self-compassion program in an online setting (Krieger, et al., 2016). It is conceivable that these are the individuals likely to self-conceal and experience difficulty engaging in psychological services in traditional settings. Participating in an online intervention program that cultivates self-compassion and normalizes seeking help for mental health struggles is potentially impactful for individuals ambivalent about engaging in in-person treatments.

Chapter Four: Summary and Conclusion

Self-stigma is a major barrier to mental health recovery, contributing not only to symptom severity and poorer quality of life, but also to delays in treatment (Livingston & Boyd, 2010; Kohn, Saxena, Levav, & Saraceno, 2004). Delays to treatment and duration of untreated illness are associated with worse outcomes across psychological disorders including psychosis, bipolar disorder, major depressive and anxiety disorders (Boonstra, et al., 2012; Dell’Osso, Glick, Baldwin, & Altamura, 2013). Of the psychological factors examined in relation to mental health help-seeking, such as anticipated risks and benefits, self-concealment, social support and level of distress, self-stigma was found in a meta-analysis to have the greatest effect on attitude towards seeking professional help (Nam et al., 2013). With treatment gaps, expressed as the percentage of individuals who need treatment but do not receive care, ranging from 32.2% for schizophrenia to 78.1% for alcohol abuse, the need to address mental health stigma is clear (Kohn et al., 2004). In addition to psychoeducation, current self-stigma reduction strategies have mainly focused on bolstering self-esteem (Mittal et al., 2012; Yanos et al., 2015). The present set of studies examined self-compassion as a potential new target for reducing self-stigma and investigated factors that may interfere with efforts to improve attitude and intentions toward professional help-seeking.

Study One examined the relations among self-compassion and mental health related self-stigmas as well as attitudes, intentions, and willingness to seek professional psychological help. Consistent with our hypotheses, self-compassion was negatively associated with both public and self-stigma related to having mental illness and that of seeking help. Self-compassion uniquely predicted both forms of mental health self-stigma and was a stronger negative predictor of self-stigma for seeking help than global self-esteem. Further, regression analyses revealed that

different aspects of self-compassion may be more relevant for the different forms of self-stigma. Namely, self-kindness appears to be the most significant predictor of low self-stigma for *having mental illness*, whereas common humanity appears to be more important for reducing self-stigma for *seeking professional help*. Self-kindness is conceptualized as the tendency to respond to oneself with understanding and encouragement rather than harsh judgement and criticism and entails acceptance of suffering with the intention of comforting oneself when confronted with painful realities (Neff, 2003). Indeed, self-compassionate individuals are found to be less self-critical, ruminate less on negative thoughts and emotions, and are less likely to feel negatively about themselves when faced with personal failures and inadequacies (Blatt, 1995; Leary et al., 2007; Neff, 2003). This detachment from criticism may be the particular aspect of self-compassion that protects an individual from applying negative public stereotypes to themselves in the self-concurrence process of Corrigan's model of self-stigma.

Individuals who suffer from mental illness endorse feeling isolated and inferior to others, which makes it harder to reach out for help in moments of need. Common humanity is the recognition that life's challenges and personal failures are an unavoidable part of being human and encourages feelings of connectedness precisely during moments of suffering (Neff, 2003). Individuals with greater self-compassion have been shown to use language that indicates connection rather than isolation when writing about their weakness, such as being in favour of using plural pronouns "we" and making more social references to friends, family, and others (Neff, 2017). Neff (2017) concludes that self-compassion may decrease maladaptive emotional reactions partly because weaknesses feel less threatening when considered from the broader perspective that being human is to be imperfect. Indeed, participants in our study who indicated they would not feel inadequate for seeking professional help used similar language and

expressed sentiments that mirrored Neff's concept of common humanity. Common humanity was also the only significant predictor of low self-stigma for seeking help when considered simultaneously in a model with self-esteem. Common humanity is a unique aspect of self-compassion that goes beyond thinking well of oneself and was demonstrated in the present set of studies to be particularly relevant for seeking help related to mental health concerns.

Taken together, the results of Study One suggest that self-compassion is a protective factor that rivals self-esteem with regards to mental health self-stigmas. This is encouraging given that self-compassion is amendable to change and is associated with more stable feelings of self-worth and greater motivation towards self-improvement than self-esteem (Breines & Chen, 2012; Neff & Vonk, 2009; Smeets et al., 2014). An understanding of how the different components of self-compassion relate to the distinct forms of mental illness self-stigma may additionally inform future research investigating the underlying mechanisms of change with regards to stigma reduction. The ability to pinpoint key ingredients and protective factors for the different forms of mental health stigma would allow clinicians to tailor intervention strategies to maximize their efficacy in working with diverse clients in varying stages of their mental health recovery.

Study One also attempted, but failed, to replicate the findings of the study by Heath and colleagues (2016), which demonstrated a small buffering effect of self-compassion on the relationship between perceived public stigma and anticipated self-stigma for seeking help. A smaller and more heterogeneous participant sample may have contributed to our failure to replicate the published findings by Heath et al. Incidentally, Heath and colleagues noted in their discussion of limitations that their study sample was composed predominately of European American students and encouraged more diverse sampling in future research. Low statistical

power is also a common replication issue and sampling variability often result in different estimates of effects size, even when the sample groups are drawn from a population with the same true effect (Payne et al., 2016; Standly & Spence, 2014). Further, we employed the method of mean centering to reduce issues of multicollinearity rather than standardizing variables prior to analysis as was done in Heath et al., which led to different regression beta coefficients. All of these factors are likely to have contributed to our failure to replicate; however, a failure to replicate does not necessarily indicate that a true relationship is not present. It is essential for future studies to investigate the buffering effects of self-compassion, utilizing sufficiently large sample sizes and with varying sample groups to determine whether a true effect exists.

Lastly, Study One examined the meaning and subjective experience of self-stigma for seeking professional help through qualitative inquiry. The resultant thematic analysis revealed two grouping of themes that contribute to our understanding of the impact of self-stigma of seeking psychological help. Specifically, the *intrapersonal* themes illustrated an anticipation of loss of autonomy deterring professional help-seeking, and *interpersonal* themes reflected a fear of social rejection and negative impact on significant relationships as a result of obtaining professional help. The qualitative findings illustrated the diverse manifestations of self-stigma, how self-stigma deters individuals from seeking the help that they need and affirmed the need for interventions. The qualitative findings also highlighted the culturally relevant and real-life barriers experienced by our sample of young adults that may not be adequately addressed in current stigma reduction strategies. In addition to enriching our understanding of self-stigma, the qualitative findings of Study One informed the hypotheses of Study Two regarding intermediate factors exerting influence on self-compassion and help-seeking, which were then examined using quantitative methodology.

In Study One, self-compassion was hypothesized to be associated with attitude and intentions towards seeking professional help due to the well-established connection between self-stigma and help-seeking attitudes (Nam et al., 2013). Surprisingly, although self-compassion was strongly related to the self-stigma measures, it was not correlated with help-seeking attitude and intentions. The qualitative analysis from Study One suggested that self-efficacy and self-competency may be deterrents to help-seeking that could explain the lack of direct association between self-compassion and help-seeking attitudes and intentions. Indeed, Study Two found evidence in support of self-efficacy as a suppressor variable that obscures the relationship between self-compassion and *attitude* towards professional help-seeking. Self-efficacy was also found to suppress the relationship between self-compassion and *intentions* to seeking help. Perceived self-competence on the other hand was only found to suppress the relationship between self-compassion and intentions to seek help, suggesting that self-competency may be more proximal to intentions, which in addition to attitude, is contingent on belief that a behaviour is socially accepted and personally important.

The findings above have several implications for clinical practice and consideration for self-stigma reduction research. In service of closing the treatment gap, it is crucial to be able to better identify those at risk of experiencing self-stigma for seeking professional help at any point of their mental health recovery, particularly seemingly high functioning and resilient individuals that may be flying under the radar. The examination of intervening variables offers an explanation for the lack of direct relationship between theoretically related constructs and uncovered significant psychological factors, self-efficacy and perceived self-competence, that have been largely overlooked in the context of self-stigma and help-seeking for mental illness. Lastly, it is important for clinicians and researchers to be aware that raising self-compassion and

individuals' sense of self-worth may not be sufficient to overcome internal psychological barriers to seek out available help. In the context of intervention, it may translate to being mindful of and directly addressing self-efficacy and self-competence as barriers to accepting professional help.

Study Two also endeavoured to extend the findings of Study One by exploring whether a brief one-time self-compassion intervention would have an impact on mental health related self-stigma and professional help-seeking. Though our intervention did not significantly increase participants' self-compassion, it was fruitful to find that our sample of young adults was able to easily engage in the self-compassion exercise, indicating its feasibility with the potential to improve its effectiveness by offering a longer and/or more intense intervention. Future studies may also wish to specifically create or modify self-compassion exercises to directly address self-stigma beliefs regarding participating in professional psychological services. Qualitative inquiry may be particularly helpful in determining the contents of interventions. For instance, the themes derived from the qualitative analysis of Study One may be incorporated in guided self-compassionate meditations or targeted in self-compassionate writing activities. The proof of concept study by Krieger et al., 2016 suggests that individuals particularly resistant to seeking professional help due to shame and other difficulties with self-disclosure may be more receptive to engaging in online interventions. Youth is a particularly vulnerable population that is likely to embrace technological interfaces in psychological treatments and other mental health endeavours. Favourable outcomes from an online encounter may also incite individuals to engage in more intensive psychological services in person.

The current research suffers from the usual limitations of self-report studies such as self-presentational biases. Another important limitation of the current line of research is the cross-sectional nature of the data, which does not lend itself to interpretations about causality. In

particular to Study Two, a longitudinal study assessing self-compassion over different time points would be able to establish the cause and effects of the associations that were found. Further, the samples employed in the present research also limit the generalizability of the findings. All of the participants in the current set of studies were recruited from the same research participant pool of undergraduate students, which precludes the ability to draw inferences on individuals in different age groups and stages of life. Additionally, though participants in the current research endorsed high levels of psychological distress, and clinically significant issues are likely present, future studies should examine the relationship found in the current set of studies with a clinical sample where the effects are likely to be more pronounced. Though the sample group was ethnically diverse, multicultural factors were not specifically examined in the current research. Given the increasing multiculturalism in modern society, future studies would benefit from exploring the influence of cultural beliefs on individuals' experience of self-compassion, self-stigma, and professional help-seeking with regards to mental health.

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Appendix A: Sample Self-Compassion Letters

Letter A:

“Hey friend. I know you may feel like there's so much to do and that you have such a long way to go, but you are doing so great right now and you are working very hard towards your goal. There is only so much one person can do and of course there is no way you can be the perfect person because some mistakes along the way are okay and are also part of the journey. Don't think so much about the one goal you have, but the journey to get there and all the fun you can have getting there. You have so many people around you that are supporting you, so don't feel like anyone is pressuring you or expecting anything from you. At the end of the day, no matter what decisions you make and what path you choose to take, the people who truly care for you will only be concerned about whether YOU are happy and pleased with where you are. So don't be so caught up with what everyone thinks when you make decisions about how to live, but think about you and only you! Whenever you're struggling, don't keep it to yourself like I know you do, but share the load with the people you care about (LIKE ME) to help you ease the hardship. I know how difficult your journey was and is, and we're all extremely proud of you for everything you've done already and everything you will be doing in the future. No matter what happens, all of us know that you're capable of anything and whatever you choose to do, you will succeed. Lastly, I want you to know that your value to me does not lie in what you've accomplished or what you are planning to do but who you are right now. You don't have to do anything for my acceptance or love because I am already well pleased with you.”

Letter B:

“Dear perfectly imperfect you, I know that it is hard to accept your flaws and all, but I am writing this letter to you so you remember why you are perfectly imperfect. You're an artist, what kind of artist would you be without your flaws? If you met all your standards and all your expectations to its fullest capabilities, how could you produce such beautiful art? I know it is hard for you to accept yourself, I know it is hard for you to see the beauty that I see, but it is there. You don't need your mother's long and full curls to be beautiful, your short nappy hair is you and it is beautiful. I know your heart stretches for miles and miles and sometimes it isn't big enough to harness the pain of your loved ones that make you tear, but your thought for them is enough. It is not your fault that they are going through what they're going through, it will be okay, and you are not responsible. Perfectly imperfect you, I want you to remember that God made you in his image and that you will find your way. It is okay to be weak, it is okay to be vulnerable and it is okay to ask for help. Your family can handle your pain, your mother will be there for you if you need her. It is okay to need the people in your life. You are strong, you are loving and your have a heart bigger than you would like to admit. Being vulnerable is what can make you strong, let others in and let them see you and all that you are because that you is what is beautiful. Dear perfectly imperfect you, you are perfectly imperfect and I wish you'd see what I see, what your mother sees, what everyone around you, except you, can see.

You friend,”

Appendix B: Study 1 Consent Form

Informed Consent Form

Study Name: Beliefs About Mental Illness - Part 1

Researchers: Wenfeng Zhao, Ph.D. Candidate, Department of Psychology, York University

Purpose of the Research: The objective of the present study is to explore how personality factors relate to attitudes and beliefs about mental illness. Your participation will be a part of a program of studies that will contribute to understanding of ways to support individuals with mental health concerns. You will be asked to answer a series of self-report questionnaires online. You may encounter questions of a personal nature involving private attitudes and personality traits. Research studies like this one relies on you answering honestly, however, you may choose not to answer any questions that you prefer not to. The study is designed to last no more than one hour for which you will receive 1 URPP credits. This research is conducted under the supervision of Dr. Joel Goldberg, Department of Psychology, York University. This research has been reviewed and approved by York University's Human Participants Research Ethics Committee.

Risks and Benefits: There are no foreseeable risks or discomfort associated with this study and benefits include experiencing the research process firsthand along with the study details provided to you at the end of the experiment. It is important to note that you are *free to withdraw* without penalty at any time or to refrain from answer any questions you would rather not answer. If you decide to withdraw from this study, your responses will not be used and they will be securely destroyed.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participation at any time. Your decision not to volunteer will not influence your relation with the researchers involved in the study or with York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. If you decide to stop participating, you will still be eligible to receive the promised URPP credits.

Confidentiality: All information you supply during the research will be held in confidence and your name will not appear in any report or publication of the research. Your data will be safely stored in a locked facility and in electronic form protected by password and only research staff will have access to the information. The data collected will be stored for 7 years, after which time documents will be confidentially shredded and electronic data will be deleted. Confidentiality will be protected to the fullest extent and in the event that you withdraw from the study, all associated data collected will be immediately destroyed.

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Wenfeng Zhao, Ph.D. Candidate, by e-mail at wendyz37@yorku.ca. This research has been reviewed and approved by the York University's Human Participants Research Ethics Committee within the context of York's Senate policy on Research Ethics. If you have any questions about this process, or about your rights as a participant in the study, please contact Ms. Alison Collins-Mrakas, Manager, Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail acollins@yorku.ca).

Legal Rights and Signatures:

By clicking "I accept" below, you are indicating your consent to participate in the Beliefs About Mental Illness Study. This means you have understood the nature of this project and wish to participate. You are not waiving any of your legal rights by signing this form.

Appendix C: Study 2 Informed Consent Form

Informed Consent Form

Study Name: Beliefs About Mental Illness - Part 2

Researchers: Wenfeng Zhao, Ph.D. Candidate, Department of Psychology, York University

Purpose of the Research: The objective of the present study is to explore how personality factors relate to attitudes and beliefs about mental illness. Your participation will be a part of a program of studies that will contribute to understanding of ways to support individuals with mental health concerns.

We believe that writing about yourself deepens self-reflection. You will be asked to write about your experiences and answer a series of self-report questionnaires online. You may encounter questions of a personal nature involving private attitudes and personality traits. Research studies like this one relies on you answering honestly, however, you may choose not to answer any questions that you prefer not to. The study is designed to last no more than one hour for which you will receive 1 URPP credits. This research is conducted under the supervision of Dr. Joel Goldberg, Department of Psychology, York University.

This research has been reviewed and approved by York University's Human Participants Research Ethics Committee.

Risks and Benefits: There are no foreseeable risks or discomfort associated with this study and benefits include experiencing the research process firsthand along with the study details provided to you at the end of the experiment. It is important to note that you are *free to withdraw* without penalty at any time or to refrain from answer any questions you would rather not answer. If you decide to withdraw from this study, your responses will not be used and they will be securely destroyed.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participation at any time. Your decision not to volunteer will not influence your relation with the researchers involved in the study or with York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. If you decide to stop participating, you will still be eligible to receive the promised URPP credits.

Confidentiality: All information you supply during the research will be held in confidence and your name will not appear in any report or publication of the research. Your data will be safely stored in a locked facility and in electronic form protected by password and only research staff will have access to the information. The data collected will be stored for 7 years, after which time documents will be confidentially shredded and electronic data will be deleted. Confidentiality will be protected to the fullest extent and in the event that you withdraw from the study, all associated data collected will be immediately destroyed.

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Wenfeng Zhao, Ph.D. Candidate, by e-mail at wendyz37@yorku.ca. This research has been reviewed and approved by the York University's Human Participants Research Ethics Committee within the context of York's Senate policy on Research Ethics. If you have any questions about this process, or about your rights as a participant in the study, please contact Ms. Alison Collins-Mrakas, Manager, Research Ethics, 309 York Lanes, York University (telephone 416-736-5914 or e-mail acollins@yorku.ca).

Legal Rights and Signatures:

By clicking "I accept" below, you are indicating your consent to participate in the Beliefs About Mental Illness Study. This means you have understood the nature of this project and wish to participate. You are not waiving any of your legal rights by signing this form.

Appendix D: Demographics

Please enter your study ID.

Please indicate your age:

Please indicate your gender:

Male Female Other _____

What is your ethnic affiliation?

Caucasian	African American
Hispanic	Asian/Pacific Islander
Middle Eastern	Indigenous Tribe
Other _____	

What is your level of income?

0-10,000 dollars	10,000-20,000 dollars
20,000 – 30,000 dollars	30,000 – 40,000 dollars
40,000-50,000 dollars	More than 50,000 dollars

Appendix E: Self-Compassion Scale
(Neff, 2003)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never									Almost always
1	2	3	4	5					

- _____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
- _____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- _____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
- _____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
- _____ 5. I try to be loving towards myself when I'm feeling emotional pain.
- _____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
- _____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
- _____ 8. When times are really difficult, I tend to be tough on myself.
- _____ 9. When something upsets me I try to keep my emotions in balance.
- _____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
- _____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
- _____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- _____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- _____ 14. When something painful happens I try to take a balanced view of the situation.
- _____ 15. I try to see my failings as part of the human condition.
- _____ 16. When I see aspects of myself that I don't like, I get down on myself.
- _____ 17. When I fail at something important to me I try to keep things in perspective.
- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.
- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix F: Self-Compassion Scale-Short Form
(Raes, Pommier, Neff, & Van Gucht, 2011)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never					Almost always
1	2	3	4	5	

- _____ 1. When I fail at something important to me I become consumed by feelings of inadequacy.
- _____ 2. I try to be understanding and patient towards those aspects of my personality I don't like.
- _____ 3. When something painful happens I try to take a balanced view of the situation.
- _____ 4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- _____ 5. I try to see my failings as part of the human condition.
- _____ 6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- _____ 7. When something upsets me I try to keep my emotions in balance.
- _____ 8. When I fail at something that's important to me, I tend to feel alone in my failure
- _____ 9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- _____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
- _____ 11. I'm disapproving and judgmental about my own flaws and inadequacies.
- _____ 12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Appendix G: The Rosenberg Self-Esteem Scale
(Rosenberg, 1965)

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

- | | | | | | |
|-----|--|----|---|---|----|
| 1. | On the whole, I am satisfied with myself. | SA | A | D | SD |
| 2. | At times, I think I am no good at all. | SA | A | D | SD |
| 3. | I feel that I have a number of good qualities. | SA | A | D | SD |
| 4. | I am able to do things as well as most other people. | SA | A | D | SD |
| 5. | I feel I do not have much to be proud of. | SA | A | D | SD |
| 6. | I certainly feel useless at times. | SA | A | D | SD |
| 7. | I feel that I'm a person of worth, at least on an equal plane with others. | SA | A | D | SD |
| 8. | I wish I could have more respect for myself. | SA | A | D | SD |
| 9. | All in all, I am inclined to feel that I am a failure. | SA | A | D | SD |
| 10. | I take a positive attitude toward myself. | SA | A | D | SD |

Appendix H: Self-Stigma of Mental Illness Scale

(Adapted from Self-Stigma of Depression Scale; Barney, Griffiths, Christensen, & Jorm, 2010)

Please indicate how you would think or feel if you had a mental illness using the scale ranging from (1) Strongly agree to (5) Strongly disagree

IF I HAD A MENTAL ILLNESS I WOULD...

1. Feel ashamed
2. Feel embarrassed
3. Feel inferior to other people
4. Feel disappointed in myself
5. Think I should be able to cope with things
6. Think I should be able to “pull myself together”
7. Think I should be stronger
8. Think I only had myself to blame
9. Feel I wouldn’t contribute much socially
10. Feel inadequate around other people
11. Feel like I was good company
12. Feel like a burden to other people

Appendix I: The Devaluation-Discrimination Scale
(Link, 1987)

Please answer from: (1) strongly agree to (6) strongly disagree

1. Most people would willingly accept a former psychiatric patient as a close friend.
2. Most people would believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.
3. Most people believe that a former psychiatric patient is trust as trustworthy as the average citizen.
4. Most people would accept a fully recovered former psychiatric patient as a teacher of young children in a public school.
5. Most people believe that entering a psychiatric hospital is a sign of personal failure.
6. Most people would not hire a former psychiatric patient to take care of their children, even if he or she had been well for some time.
7. Most people think less of a person who has been in a psychiatric hospital.
8. Most employers will hire a former psychiatric patient if he or she is qualified for the job.
9. Most employers will pass over the applicant of a former psychiatric patient in favor of another applicant.
10. Most people in my community would treat a former psychiatric patient just as they would treat anyone.
11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental disorder.
12. Once they know a person has been in a psychiatric hospital, most people will take his or her opinions less seriously.

Appendix J: The Self-Stigma of Seeking Help Scale
(Vogel, Wade, & Haake, 2006)

For each item below, please indicate whether you (1) *strongly disagree*, (2) *somewhat disagree*, (3) *agree and disagree equally*, (4) *somewhat agree*, or (5) *strongly agree*.

	Strongly Disagree		Agree/Disagree Equally		Strongly Agree
1. I would feel inadequate if I went to a therapist for psychological help.	1	2	3	4	5
2. My self-confidence would NOT be threatened if I sought professional help.	1	2	3	4	5
3. Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
4. My self-esteem would increase if I talked to a therapist.	1	2	3	4	5
5. My view of myself would not change just because I made the choice to see a therapist.	1	2	3	4	5
6. It would make me feel inferior to ask a therapist for help.	1	2	3	4	5
7. I would feel okay about myself if I made the choice to seek professional help.	1	2	3	4	5
8. If I went to a therapist, I would be less satisfied with myself.	1	2	3	4	5
9. My self-confidence would remain the same if I sought help for a problem I could not solve.	1	2	3	4	5
10. I would feel worse about myself if I could not solve my own problems.	1	2	3	4	5

Appendix K: The Social Stigma for Receiving Psychological Help Scale
(Komiya, Good, & Sherrod, 2000)

Please answer the following from (1) Strongly Disagree to (4) Strongly Agree

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.
2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems
3. People will see a person in a less favourable way if they come to know that he/she has seen a psychologist
4. It is advisable for a person to hide from people that he/she has seen a psychologist
5. People tend to like less those who are receiving professional psychological help

Appendix L: The Attitude Towards Seeking Professional Help Scale-Short Form
(Fischer & Farina, 1995)

To what extent do you agree or disagree with the statements below:

Please answer from: 1=agree to 4 = disagree or don't know

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
3. If I were experiencing a serious emotional crisis at this point in my life. I would be confident that I could find relief in psychotherapy.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counseling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
10. Personal and emotional troubles, like many things, tend to work out by themselves.

Appendix M: The Intentions to Seek Counselling Inventory
(Cash, Bagley, McCown, & Weise, 1975)

Below is a list of issues people commonly bring to counseling. How likely would you be to seek counseling if you were experiencing these problems?

Please answer from 1= very likely to 4 = very unlikely or don't know

1. Weight control
2. Excessive alcohol use
3. Relationship differences
4. Concerns about sexuality
5. Depression
6. Conflict with parents
7. Speech Anxiety
8. Difficulties dating
9. Choosing a major
10. Difficulty in sleeping
11. Drug problems
12. Inferiority feelings
13. Test anxiety
14. Difficulty with friends
15. Academic work procrastination
16. Self-understanding
17. Loneliness

Appendix O: The General Population-Clinical Outcomes in Routine Evaluation
(Sinclair, Barkham, Evans, Connell, & Audin, 2005)

Please indicate how often you have experienced the events described below over the last week:

(0)	(1)	(2)	(3)	(4)
not at all	only occasionally	sometimes	often	most of the time

I have felt tense, anxious or nervous
 I have felt I have someone to turn to when things go wrong
 I have felt OK about myself
 I have felt able to cope when things go wrong
 I have been troubled by aches, pains or other physical symptoms
 I have been happy with the things I have done
 I have had difficulty getting to sleep or staying asleep
 I have felt warmth or affection for someone
 I have been able to do most things I needed to
 I have felt criticized by other people
 I have felt unhappy
 I have been irritable when with other people
 I have felt optimistic about my future
 I have achieved the things I wanted to

Appendix P: Social Desirability Scale
(Ballard, 1992)

Listed below are a number of statements concerning personality attitudes and traits. Read each item carefully and circle whether the statement is *true* or *false* as it pertains to you personally.

- | | | |
|---|------|-------|
| 1. I sometimes feel resentful when I don't get my way. | True | False |
| 2. On a few occasions, I have given up doing something because I thought too little of my ability. | True | False |
| 3. There have been times when I felt like rebelling against people in authority even though I knew they were right. | True | False |
| 4. No matter who I'm talking to, I'm always a good listener. | True | False |
| 5. I can remember "playing sick" to get out of something. | True | False |
| 6. There have been occasions when I took advantage of someone. | True | False |
| 7. I'm always willing to admit it when I make a mistake. | True | False |
| 8. I sometimes try to get even rather than forgive and forget. | True | False |
| 9. When I don't know something I don't at all mind admitting it. | True | False |
| 10. I am sometimes irritated by people who ask favours of me. | True | False |
| 11. I have never deliberately said something that hurt someone's feelings. | True | False |

Appendix Q: The General Self-Efficacy Scale
(Schwarzer & Jerusalem, 1995)

Please indicate to what extent the following statements are true for you:

1 – Not at all true 2 – Hardly true 3 – Moderately true 4 – Exactly true

1. I can always manage to solve difficult problems if I try hard enough
2. If someone opposes me, I can find the means and ways to get what I want
3. It is easy for me to stick to my aims and accomplish my goals
4. I am confident that I could deal efficiently with unexpected events
5. Thanks to my resourcefulness, I know how to handle unforeseen situations
6. I can solve most problems if I invest the necessary effort
7. I can remain calm when facing difficulties because I can rely on my coping abilities
8. When I am confronted with a problem, I can usually find several solutions
9. If I am in trouble, I can usually think of a solution
10. I can usually handle whatever comes my way

Appendix R: The Self-Competence Scale
(Tarfarodi & Swann, Jr., 1995)

To what extent do you agree or disagree with the statements below:

(1) 'strongly disagree' to (5) 'strongly agree':

1. Owing to my capabilities, I have much potential.
2. I don't succeed at much.
3. I have done well in life so far.
4. I perform very well at a number of things.
5. I am a capable person.
6. I do not have much to be proud of.
7. I am talented.
8. I am not very competent.
9. I deal poorly with challenges.
10. I perform inadequately in many important situations.