PERFECTIONISM AND SELF-STIGMA:

THE MODERATING EFFECTS OF EXPOSURE TO MENTAL ILLNESS

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ABSTRACT

Mental health statistics show that Canadian university students have elevated reports of stress, anxiety, depression, attempted and completed suicides. Yet, despite the rising statistics, only a small percentage of these individuals are seeking help for their concerns. This disconnect has been attributed to the barriers, both systemic and personal, experienced when seeking psychological help. One of these barriers, self-stigma, has been correlated with a decreased likelihood of seeking help. Research has found that individuals exhibiting higher levels of perfectionism are more likely to experience self-stigma, making these individuals especially vulnerable to not seeking assistance. However, a recent study (Zeifman et al., 2015) reported that contact with mental illness impacted this relationship in a sample of high school students, which prompted the research question: what are the moderating effects of contact with mental illness on the relationship of perfectionism to self-stigma of seeking psychological help (in a university sample)? A group of university students (N=180) completed an online survey questionnaire comprised of a demographic questionnaire, the Multidimensional Perfectionism Scale (MPS, Hewitt & Flett, 1990), the Self-Stigma of Seeking Psychological Help scale (SSOSH, Vogel et al., 2006), and a Level of Contact Report (Holmes et al., 1999). Moderation analyses generated several findings. When level of contact with mental illness was low, for both self-oriented and socially prescribed perfectionism, there was no relationship between perfectionism and self-stigma. However, when contact with mental illness reached medium or high levels, there was a significant positive relationship between both types of perfectionism and self-stigma for seeking psychological help. As such, individuals who have a high exposure to mental illness who also exhibit high levels of either self-oriented or socially prescribed perfectionism are the most likely to experience self-stigma, and are therefore the least likely to seek psychological help. These findings are contrary to previous research, and are concerning given the vulnerable position of

individuals high in perfectionism to various psychological concerns. Implications of these findings for practice and directions for future research are discussed.

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CHAPTER 1

As awareness of the prevalence of mental health problems grows, so too does awareness of the increasing need for counselling and other mental health services. Unfortunately, although the Canadian population has staggering numbers of individuals requiring such services (e.g., eight percent of the adult population experiences major depression, and five percent exhibits symptoms of anxiety to a severe level of impairment), many of these individuals do not seek psychological help (Canadian Mental Health Association, 2016; National College Health Assessment, 2013; National College Health Assessment, 2016; Eisenberg, Golberstein, & Gollust, 2007). Some statistics indicate that up to 49% of individuals who felt they had suffered from depression or anxiety did not seek help from a physician or other professional (Canadian Mental Health Association, 2016). This would suggest that there are barriers, both systemic and personal, that hinder individuals from seeking assistance for their psychological concerns. Although many barriers (e.g., cost, transportation, difficulty recognizing symptoms, reliance on the self, etc.) have been well documented in previous research (Barker, Olukoya & Aggleton, 2005; Gulliver, Griffiths, & Christensen, 2010), stigma (both public and self-oriented) emerges *repeatedly* as one of the most commonly experienced barriers when seeking help (Bathje & Pryor, 2011; Clement et al., 2014; Corrigan et al., 2005; Jagdeo, Cox, Stein, & Sareen, 2009). As such, stigma is an important area of study, given the impact it may have on a person's likelihood of reaching out for help in a time of need.

Certain individual characteristics increase self-stigma, which decrease the likelihood of a person seeking help. One of these characteristics is perfectionism, which has also been associated with numerous mental health problems and disorders (e.g., anxiety, depression, Obsessive-Compulsive Disorder, bulimia, and other eating disorders) (Bastiani, Rao, Weltzin, & Kaye, 1995; Blatt, 1995; Frost et al., 1990; Frost & Steketee, 1997; Garner, Olmstead & Polivy, 1983;

Hayward & Arthur, 1998; Hewitt & Flett, 1991a; Slade, 1982). Perfectionism is a personal characteristic that leads individuals to pursue excellence in various domains of life, while adhering to stringent standards and high expectations (Frost et al., 1990; Hewitt & Flett, 1991b). Individuals high in perfectionism are predisposed to the development of various mental health disorders, and may also be experiencing higher levels of self-stigma for seeking psychological help. Indeed, Zeifman and colleagues (2015) found that higher levels of perfectionism were related to higher levels of self-stigma for seeking psychological help. Interestingly, in their research, this phenomenon was only reported for those participants who had low exposure to and contact with individuals who have mental health problems. Greater exposure to individuals with mental health problems mediated the effects that perfectionism had on increasing self-stigma (Zeifman et al., 2015). These findings would suggest that contact with mental illness may act as a protecting factor for individuals who are high in perfectionism.

Significance

This study is important given the context of the mental health crisis occurring in Canadian universities. In 2012 alone, Ryerson University in Toronto saw a 200 percent increase in demand from students in crisis situations (students who were homeless, suicidal, or very sick) (Lunau, 2012). In 2010 and 2011, Queen's University reported the suicides of four male students attending their school (Lunau, 2012). This problem is not only occurring in larger centers, but statistics demonstrate that it is also problematic in the Prairie Provinces. In 2011, the University of Alberta surveyed 1,600 students and found that 51 percent reported feeling that "things were hopeless," seven percent had seriously considered suicide, and one percent had attempted to end their life (Lunau, 2012). These numbers indicate that 16 of 1,600 students from the University of Alberta attempted suicide in the 12 months prior to the survey. The mental health crisis in

Canadian universities is support enough for an inquiry into why individuals stay away from seeking psychological help.

This was an important area for further investigation given individuals characterized by perfectionism may be vulnerable to mental health issues (Zeifman et al., 2015) in conjunction with their decreased likelihood of seeking psychological help as a result of increased self-stigma. Findings were anticipated to provide insight into the personal characteristics that affect access to healthcare, and to suggest implications for improving the efficiency and effectiveness of mental health service delivery (e.g., by targeting at-risk populations, and creating intervention strategies that are tailored to such individuals). Finally, this study increases awareness to the vulnerable condition of individuals exhibiting characteristics of perfectionism, and provides insight into intervention strategies that aim to normalize the action of seeking psychological help, and strategies that decrease the experience of self-stigma.

Statement of Purpose

The purpose of this study was to extend previous research on perfectionism and self-stigma for seeking psychological help, and to respond to a current gap in the literature. Until the present study was conducted, research in this area focused on a high school population, examined only two types of perfectionism, and the moderating effects of exposure to mental health problems had not been examined. The present study advanced understanding by a) collecting data using a university population, b) exploring the relationship of three types of perfectionism (self-oriented, other-oriented, and socially prescribed) on self-stigma for seeking psychological help, and c) examining the moderating effects of exposure to mental health problems on the relationship of perfectionism to self-stigma for seeking psychological help. The specific research question was as follows: what are the moderating effects of contact with mental illness on the relationship of perfectionism to self-stigma of seeking psychological help (in a university

sample)? A quantitative research design was used, and rigorous statistical analyses were conducted in order to better investigate the complex relationship between variables.

Parameters

The parameters of the study include its assumptions, delimitations, limitations, and definitions of several key terms. Using these parameters, the following sections describe the context and conditions in which the present research occurred.

Assumptions. The research methodology selected for the current study was a quantitative design. Specifically, a number of moderation analyses were conducted in order to better understand the mechanisms by which exposure to mental illness impacts the relationship between perfectionism and self-stigma for seeking psychological help. By choosing such a design, it was assumed that this methodology would best address the question at hand. It was assumed that the rigorous statistical methods used in moderation analyses would provide the most in-depth understanding of the many variables under study.

Furthermore, in choosing the instruments used to measure the three different variables present in the research question, it was assumed that these measures were capturing each construct completely and accurately (e.g., they are valid); however, it is also acknowledged that it is impossible to obtain *perfect* accuracy. It was assumed that using pre-established measures would provide a more valid representation of the variables as opposed to creating questions that the researchers *believed* to be relevant to the subject area.

Delimitations. This study was delimited to a Canadian university campus in the prairies, with particular social, political, and other environmental contexts specific to this area in a particular period of time. The aforementioned contextual factors placed constraints on the generalizability of the research findings. Similarly, the population was delimited to university students enrolled in a first or second year psychology course. Such a population was selected for

its accessibility and efficiency, but these recruitment methods have further implications for the generalizability of the research findings as well. Although the study and population were delimited in a way that constrains its generalizability, it was expected that similar findings would emerge in other Canadian universities. It should be noted, too, that while the study's sample may have reduced the generalizability of the findings, the research *method* selected for data collection increased the generalizability of the findings (i.e., using a quantitative research design and statistical analysis as opposed to a qualitative interview study for example). Although qualitative interviews can generate rich detail for understanding a particular research question, they typically involve a small sample size and have limited generalizability. Further, it was expected that the benefits of obtaining a statistical understanding of these relationships would outweigh the limitations of such a population and approach to research.

Limitations. As with all forms of research, limitations were inherent in the type of research that was selected, and the forms of measurement that were used. The former refers to concerns associated with quantitative methods, and the latter refers to issues of self-report measures.

Quantitative methods can be perceived as a problematic form of research because this method often follows an inflexible structure. As a result of this inflexibility, quantitative data places boundaries on what can be studied based on a given research question. In the present study, for example, perfectionism was measured based on the construct described by Hewitt and Flett (1991b), when in fact there are *many* conceptualizations of perfectionism. As such, this research was bound by a single understanding and measurement of perfectionism. It is also important to note that because this research was measuring a predetermined set of variables, it is possible that confounding variables were also at play (i.e., those who were not being studied or

have not yet been considered). However, quantitative data are also necessary given the present research question, as it allowed for the most rigorous analysis of a complex set of variables.

Self-report measures can also be perceived as problematic, as there is the possibility of social desirability biases, therefore leading to invalid or inaccurate response sets. Furthermore, similarly to the problem inherent in the quantitative method, self-report measures only allow for a bounded set of responses, when in fact a person's experiences may not fit a given number or a given response. However, self-report measures do allow a person's characteristics and experiences to be quantified, which in turn allows for rigorous statistical analyses. Furthermore, the benefits of self-report (e.g., low cost, little time, and easy administration to large samples, etc.) far outweigh the potential limitations of using such measures.

Definitions

Emerging adulthood: a developmental stage proposed by Jeffrey Arnett (Arnett, 2000) occurring from approximately 18 to 29 years of age (Arnett, 2014). Emerging adulthood is a distinct stage between adolescence and adulthood, and is characterized by identity exploration, instability, self-focus, feeling in-between, and possibilities (Arnett, 2000). This developmental stage is well represented in the university population, and is the primary population in the present study due to the high prevalence of mental health problems in this developmental stage (Statistics Canada, 2013).

Perfectionism: a personal characteristic affecting thoughts, feelings, behaviors, and especially evaluations of self and others. Perfectionism is typically characterized by setting high standards for the self or others, adhering strictly to those standards, and being motivated by a need for achievement or a fear of making mistakes (Frost et al., 1990; Hewitt & Flett, 1991b).

Self-stigma: the internalized psychological impact of possessing a stigmatizing characteristic (Bathje & Pryor, 2011). As a result of public stigma (the negative cognitive, affective, and

behavioral reactions to stigmatized attributes), self-stigma leads to decreased self-esteem, embarrassment, fear, and alienation (Bathje & Pryor; Link, Yang, Phelan, & Collins, 2004).

Mental illness: a wide range of mental health conditions or disorders that affect mood, thinking, and behavior, including anxiety, depression, schizophrenia, eating disorders, or addictions (Mayo Clinic, 2015).

Note: throughout this document, "mental health concern" was often used to replace "mental illness". Coming from a program that fosters a positivist approach, the term "mental health concern" is preferred as it is less pathological than "illness". However, in order to portray an accurate reflection of the studies being discussed, the term mental illness was used where previous researchers had also used that term.

The Researcher

The researcher was a student at the University of Saskatchewan, completing a Masters degree in Educational Psychology, and specializing in School and Counselling Psychology. The present thesis was conducted as part of the requirements for the aforementioned program. The researcher previously completed the Bachelor of Arts Honors degree in Psychology, also at the University of Saskatchewan. Training with a primary interest in counselling psychology, the researcher has developed a concern for mental health service use, and the numerous barriers individuals encounter when seeking out these services. One of the most commonly cited barriers is self-stigma, which was investigated in the present study. Furthermore, as a future psychologist, the researcher has a longstanding curiosity about mental health problems and disorders. Perfectionism, a personal characteristic that has been associated with *many* mental health problems, provided an interesting avenue to explore this interest, and it has implications for self-stigma as well. Finally, as an undergraduate, the researcher completed an unpublished thesis on the ways in which contact with stigmatized persons can improve attitudes towards the larger

stigmatized group. This topic was further explored in the present study, with a focus on how contact with mental illness (a highly stigmatized group) can act as a protective factor for individuals high in perfectionism by decreasing self-stigma for seeking psychological help. These three topics (self-stigma, perfectionism, and contact with stigmatized groups) converged in the present study to respond to a gap in the literature, and to address the research interests of the student investigator.

Thesis Organization

The following chapters of this thesis include a literature review (Chapter Two), a methodology section (Chapter Three), the results from the statistical analyses (Chapter Four), and a discussion of the implications of the findings (Chapter Five). The literature review offers background information and summaries of previous research that are necessary to an understanding of the current study. The importance of the study is outlined by numerous mental health statistics, which is followed by a discussion of several key variables: self-stigma, perfectionism, and contact with stigmatized groups. Following, the methodology chapter describes the research study beginning with a description of the participants that were recruited, followed by a description of the measures that were used to quantify the variables in question, the step-by-step procedure involved in the study, and ending with a description of the data and statistical analyses that were used. Next, the results chapter describes the research findings from various analyses, with accompanying graphs and tables. The final section, the discussion, interprets the research findings, and explores their implications in terms of the current literature and for practice and future research.

CHAPTER 2

Literature Review

The literature review begins with important mental health statistics for the Canadian population and for university students more specifically. Next, although the statistics suggested that a vast portion of the population could benefit from mental health services, there was a large discrepancy in the numbers of individual who did indeed seek help. As such, it was important to address why individuals did not seek mental health services, which was the focus of the section "Barriers to Help-Seeking." One of the many barriers reviewed in this section was stigma, and more importantly to the present study, self-stigma. As will be evident in the literature review, increased experience of self-stigma reduced the likelihood of an individual seeking help. Pertinent to the present study, two variables in particular impact the experience of self-stigma: perfectionism, and contact with stigmatized groups. Both variables were discussed, and their relationship to self-stigma was explored. At the end of the literature review chapter, key variables were linked together by an important study conducted by Zeifman and colleagues (2015).

Mental Health

The Canadian population is currently facing an alarming mental health crisis. According to the Canadian Community Health Survey – Mental Health (CCHS-MH) (Statistics Canada 2013), 10% of Canadians age 15 or older reported symptoms consistent with one of the following mental or substance use disorders in the previous 12 months: major depressive disorder, bipolar disorder, generalized anxiety disorder, alcohol, cannabis, or other substance use disorders. The most common disorder was depression (5.4% of the population), followed by substance use disorders (4.4%) and generalized anxiety disorder (2.6%) (Statistics Canada, 2013). Notably, individuals could only be counted in a single category, so the statistics were not inflated by the co-existence of these disorders. In total, this represents a staggering 2.8 million Canadians

exhibiting symptoms of a mental health disorder in a given year, which continues to increase when disorders *not* included in this particular survey are considered (e.g., Attention Deficit Hyperactivity Disorder, Eating Disorders, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, etc.) (Statistics Canada, 2013). This number also rises exponentially when the lifetime prevalence of these disorders is considered. For example, in the CCHS-MH (Statistics Canada, 2013), researchers found that one in three Canadians met the criteria for a mental or substance use disorder across the lifespan.

The mental health crisis in Canada also has economic repercussions. The economic cost of mental health across Canada is estimated at upwards of 14 billion dollars, and is said to represent one of the costliest conditions in the country (Stephens & Joubert, 2001). Economic losses come from factors such as absenteeism, diminished productivity, high levels of unemployment, and medical health expenditures (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2007). However, when the *indirect* costs of mental health problems are included, researchers have estimated much larger economic losses (Lim et al., 2007). Lim and colleagues (2007) argued that health related quality of life (HRQOL) is an important concept when considering the economic burden of mental health. HRQOL includes increases in pain and suffering, and is computed using an index score that is multiplied by a fixed monetary value (Lim et al., 2007). When the authors considered direct medical costs, short and long-term work losses, and the monetary losses related to HRQOL, the economic burden of mental health problems rose to 51 million dollars in Canada in a given year (Lim et al., 2007).

The value of economic losses is lower among youth ages 12 to 19 years (Lim et al., 2007). This is a result of being a small subset of the population, and a large portion of this age group is not employed, which leads to fewer work-loss costs. That being said, mental health disorders in this Canadian age group still represent the second highest health expenditures next

only to injuries (Canadian Mental Health Association, 2016). Although the economic costs vary widely given the number of factors in consideration, it is evident that the costs of mental health are tremendous among Canadian youth, and the population in its entirety.

Mental health and Canadian university students. Although the mental health statistics are concerning for the overall population, the statistics for young adults, emerging adults, are also problematic. Canadian youth (age 15-24 years) have the highest rates of mood disorders (major depressive, generalized anxiety, and bipolar disorder), and substance use disorders compared to any other age group (Statistics Canada, 2013). It is common to find higher rates of mood disorders and substance use disorders in youth as compared to older age groups in other countries such as the United States as well (Kessler et al., 2010). Evidence suggests that mental health problems affect significant proportions of the Canadian population, particularly its young adults. Consequently, the present study focused on this age group in a university setting.

As mentioned previously, mental health and substance use disorders are most prominent in the age range of 15 to 24 years (Statistics Canada, 2013). Therefore, students in Canadian universities are an important target population for emerging research in this area. University students face a multitude of challenges while they navigate the waters of emerging adulthood. Pressures from school, parents, relationships, and making career and other life choices all converge to create stresses that can diminish student's overall wellbeing (Martin et al., 2011). Mental health is only one aspect of wellbeing, which often declines as a result of these mounting pressures, or can be further exacerbated by disorders such as anxiety or depression (Martin et al., 2011). Evidence from the National College Health Assessment (2013) pointed to some alarming findings in a sample of Canadian university students: 37.5% of students felt so depressed that it was difficult to function, 56.5% experienced overwhelming anxiety, and 9.5% seriously considered suicide. Furthermore, in the previous 12 months, 28% of students reported that

anxiety had affected their academic performance, 17% reported that depression had affected their academic performance, and 39% reported that stress had impacted their academic performance in a negative way (NCHA, 2013). These statistics demonstrate that at any given time, upwards of one in five Canadian postsecondary students experience mental distress that negatively affects their academic performance.

Anxiety, depression, and stress not only impact students' academic performance, these conditions also affect students' overall wellbeing. As evidence of this, the NCHA (2013) reported that 54% of Canadian students reported feeling hopeless, 87% felt exhausted, and 89% of students reported feeling overwhelmed by all they had to do. More concerning, however, were the statistics reported for the destructive behaviors of suicide and self-harm: 6.6% of students had intentionally injured themselves, 9.5% of the students had seriously considered suicide in the last 12 months, and approximately 1% had actually attempted suicide (NCHA, 2013). Health Canada (2002) reports that suicide accounts for 24% of the deaths that occur in individuals between the ages of 15 and 24. These statistics underscore the importance of mental health for Canadian university students.

In 2016, the NCHA conducted a similar study for the Ontario University and College Health Association. A large-scale survey was administered to over 25,000 college and university students, and all of the major findings suggested increases in mental health concerns since the last survey completed in 2013. For example, 65% of students reported experiencing overwhelming anxiety, almost half reported feeling so depressed it was difficult to function, 13% had seriously considered suicide, and 2.2% reported *attempting* suicide in the last 12 months (NCHA, 2016). 2.2% of 25,000 students is the equivalent of 550 students attempting to end their lives. Although these numbers are only representative of the situation currently faced in Ontario, they are concerning nonetheless, and speak to the vast percentage of students requiring help.

With such significant numbers of students experiencing distress, one would expect that many students are also seeking help. However, the Canadian National College Health Assessment (2013) found that only 6.5% of the students experiencing distress were diagnosed or treated by a professional. In the NCHA's 2016 report, this number increased to 8.3%. This number represented the total percentage (males and females) of the respondents who had been diagnosed or treated by a professional for a wide array of mental disorders or other mental health conditions (NCHA, 2016). Although this increase was positive, and indicated that a greater number of students were seeking help, based on the statistics presented in the previous paragraph, the increase is insufficient to meet students' needs. According to an article published by CBC News (2016), Ontario campus counsellors are "drowning" in the demands for mental health services. The article explained that the demand for services for outweighs the capacity of counsellors to support students (CBC News, 2016).

In an earlier study conducted with an American university population, researchers screened students for both depression and anxiety (Eisenberg et al., 2007). Of those students who screened positively for a disorder, between 37% and 84% had not received any services for their concerns (Eisenberg et al., 2007). The large range of percentages cited above was dependent on the particular anxiety or depression disorder being referenced. Similar findings have been reported for the Canadian population at large, with the Mental Health Association (2016) reporting that 49% of respondents believed they had suffered a mental health issue, and never sought help from a health professional. Thus, even though a shocking number of individuals are experiencing debilitating levels of stress, only a limited number are seeking help for it. This suggests that there are a number of barriers, both systemic and personal, that inhibit individuals from seeking psychological help.

Barriers to Help-seeking

Barriers to seeking help are both internal to the person, and external. Barker and colleagues (2005) have explored this distinction, and differentiated the concepts of structural and personal determinants of help seeking. The authors maintained that individual factors such as personal beliefs, gender norms, coping skills, self-efficacy, and perceived stigma, all interact with structural factors including the national health system, accessibility, affordability of services, and social support to determine who seeks help (Barker et al., 2005). In the CBC article cited above (2016), one of the aforementioned barriers, accessibility, was the main barrier that students reported when seeking counselling services. At Carleton University, for example, as a result of an extensive wait list, students may wait up to four weeks to see one of five counsellors who serve over 30,000 students (CBC News, 2016). Unfortunately, long wait times are common for no-fee counselling services, and it is only one of many structural barriers that may deter someone from seeking psychological help. However, although the present study acknowledges the presence of structural or systemic barriers, the focus was primarily on those characteristics that are internal to the person.

Previous research has established a number of personal barriers that individuals experience on their journeys to seek help. For example, Gulliver and colleagues (2010) completed a systematic review of the quantitative and qualitative research on barriers to seeking counselling. Of the 22 studies reviewed, most were conducted in Australia or the United States, and the remainder was conducted in the United Kingdom and China (Gulliver et al., 2010). The authors found that stigma, embarrassment, a preference for reliance on the self, and problems recognizing symptoms were the most frequently cited obstacles to seeking help. Results from the Canadian Community Health Survey (Statistics Canada, 2013) also support an inability to recognize symptoms. That is, 30% of Canadians who had symptoms of a mental or substance use

disorder perceived their own mental health to be good or even excellent (Statistics Canada, 2013). This would suggest that there is a disconnection between physical symptoms and the perception or understanding of their presence. Similarly, in an earlier study conducted by Eisenberg and colleagues (2007), the authors outlined a number of *predictors* for not receiving helping services based on the responses of American university students attending a midwestern public university. The predictors included a lack of perceived need, being unaware of services or insurance coverage, skepticism about treatment effectiveness, low socioeconomic background, and being Asian or Pacific Islander (Eisenberg et al., 2007).

Qualitative research in this area has been conducted with the aim of gaining a better understanding of individuals' experiences seeking counselling (Mackinnon, 2008). From a phenomenological perspective, MacKinnon's (2008) thesis research uncovered four important themes for individuals seeking counselling: public and self-stigma, a reliance on the self, fear of judgment from the counsellor or others, and children as catalysts to seeking help. Qualitative research is an important avenue for better understanding individual's unique experiences, and it may allow for further exploration of new barriers to accessing help that have yet to be explored. Notably, a common theme emerged in much of the research outlined above, whether it was qualitative or quantitative – the importance of stigma in limiting a person's likelihood of seeking psychological help.

Stigma: A Barrier to Help-Seeking

According to Link and Phelan (2006), stigma is the result of five interrelated social processes: 1) a person is identified as "different;" 2) social norms deem "difference" to be undesirable, leading to the creation of negative stereotypes; 3) "difference" is defined by a single characteristic, which places the identified in a category; 4) labeled individuals experience status loss, blame, and discrimination; and 5) the ability to resist stigma labels depends on access to key

resources (e.g., money and social networks). Stigma has been further distinguished as public stigma and self-stigma (Corrigan, 2004). Corrigan and colleagues (2005) described public stigma as the typical societal response that people have towards stigmatizing attributes, and it is comprised of cognitive, affective, and behavioral reactions. The cognitive reactions include stereotypical beliefs about stigmatized persons (Corrigan & Watson, 2005), affective reactions include fear, irritation, or lack of pity and sympathy (Corrigan, 2004), and behavioral reactions may include overt discrimination, such as denying employment (Corrigan et al., 2005). Self-stigma, on the other hand, is the internalized psychological impact of possessing a characteristic deemed stigmatizing (Bathje & Pryor, 2011; Corrigan, 2004). People who experience self-stigma experience decreased self-esteem, self-efficacy (Bathje & Pryor, 2011), shame, fear, embarrassment, and alienation (Link et al., 2004). Public and self-stigma are closely related to Goffman's (1963) early conceptualizations of enacted and perceived stigma. Enacted stigma occurs when a person is actively discriminated against, whereas perceived stigma is a person's assumption or fear that others will discriminate, and it can result in modifications in behaviour and thought (Goffman, 1963). As alluded to earlier, research has identified stigma (public and self) as a major barrier for individuals seeking psychological help.

With regard to stigma, individuals often fear two things: their stigmatized characteristic being discovered by others (if it is invisible), or personally acknowledging one's own stigmatized attributes (Bathje & Pryor, 2011; Corrigan et al., 2005; Goffman, 1963). Because individuals do not desire a stigmatized label, they avoid mental health services altogether (Corrigan et al., 2005; Goffman, 1963; Parcesepe & Cabassa, 2013). Bathje and Pryor (2011) researched how public and self-stigma impact a person's attitudes towards seeking counselling and their intentions to do so. The results indicated that both public stigma and self-stigma influenced attitudes and intentions of seeking counselling in independent ways (Bathje & Pryor, 2011). Specifically, the sympathy

component of endorsing public stigma was strongly related to both self-stigma and attitudes towards seeking help (Bathje & Pryor, 2011). For example, individuals who had greater sympathy for an individual seeking help for depression were less likely to experience diminished self-esteem for seeking help themselves. Furthermore, other aspects of endorsing public stigma had more negative outcomes. For example, beliefs that a person could control their mental health problems and beliefs that individuals are to blame for their problems lead to more negative attitudes regarding help seeking, but did not impact self-stigma (Bathje & Pryor, 2011). Similarly, in an earlier study, Vogel, Wade and Hackler (2007) found that willingness to seeking counselling for mental health concerns was fully mediated by self-stigma. Specifically, perceptions of public stigma contributed to an experience of self-stigma, which then affected not only help-seeking attitudes, but also willingness to seek help (Vogel et al., 2007). These results suggest that although stigma has a direct impact on individual's likelihood of seeking help for mental health concerns, the mechanisms by which it occurs are complex and multifaceted.

A similar study conducted in Ontario and the United States investigated the association of various sociodemographic characteristics with negative attitudes toward seeking help for mental health concerns (Jagdeo et al., 2009). On average, of both Canadians and Americans combined, 17.5% of respondents said that they would not seek any help if they were struggling with serious emotional problems, and almost half stated that they would be embarrassed if their friends knew that they used mental health services (Jagdeo et al., 2009). Embarrassment, a consequence of self-stigma (Link et al., 2004), has been strongly associated with a reluctance to seek professional help for depression in other studies as well (Barney, Griffiths, Jorm, & Christensen, 2006). From the aforementioned research, some of the sociodemographic characteristics that were related to more negative attitudes to seeking mental health services were being male, young, single, and less educated. Furthermore, having substance abuse problems, a personality disorder, or never

having sought mental health services in the past all lead to more negative attitudes towards help seeking (Jadgdeo et al., 2009). These results indicated that although negative attitudes appear to be prevalent in both Canada and the United States, there are certain personal and structural characteristics that lead people to have *even more* negative attitudes towards help seeking for mental health concerns. Unfortunately, these negative attitudes only strengthen and perpetuate the stigma associated with mental health problems and seeking services.

A systematic review of qualitative and quantitative data found similar findings as those explored above (Clement et al., 2014). The authors reviewed 144 studies, the majority of which were from the United States or Canada, and the remaining were taken from Europe, Australia, New Zealand, Asia and South America in order to answer the question, "What is the impact of mental health-related stigma on help-seeking for mental health problems?" (Clement et al., 2014). The results indicated that there was a small to moderate size association between stigma and reduced help seeking (Clement et al., 2014), suggesting that individuals who possessed more negative attitudes towards mental health issues also conveyed a lesser likelihood of seeking help. It is important, however, to note that there has been an evidence-based independence reported between self-stigma of mental illness, and self-stigma of seeking psychological help (Tucker et al., 2013). The focus of the present study was strictly self-stigma associated with seeking psychological help.

Not only does stigma impact the likelihood of a person seeking help, it also impacts a person's wellbeing in a multitude of negative ways. Stigma has serious negative ramifications for the physical, psychological, and emotional wellbeing of individuals who experience it (Hatzenbuehler, 2014). To illustrate, Meyer (1995) studied the effects of stigma on the mental health of gay men. He found that, as a result of living in a heterosexist society, gay men experience chronic stress related to their stigmatization. The 741 men participating in the study

reported negative attitudes towards the self and expected/experienced discrimination, all of which led to elevated levels of distress and poorer mental health (Meyer, 1995). More recent studies have documented similar findings (Cochran, Sullivan, & Mays, 2003). A nationally representative sample of gay, bisexual, and heterosexual individuals in the United States of America evidenced sexual orientation-related differences in morbidity, distress, and use of mental health services. Cochran et al. (2003) found that gay and bisexual men had a higher prevalence of depression, experienced more panic attacks, and increased psychological distress as compared to heterosexual men. Mental health service use was also more frequent in the gay and bisexual groups. Finally, the US National Health Statistics Report indicated that gay, lesbian and bisexual individuals aged 18 and over demonstrated significantly more negative health-related behaviors such as smoking and drinking, experienced more psychological distress, and had less regular access to medical care (Ward, Dahlhamer, Galinsky, & Joestl, 2014). The evidence above demonstrates that stigmatized groups experience overwhelming physical, emotional, and psychological distress. These findings describe the unfortunate consequences of stigma and discrimination for individuals from sexual minority groups; however, it is important to acknowledge similar research for individuals with mental health concerns.

Corrigan and colleagues (2002) argued that discrimination against individuals with mental health concerns can take four forms: withholding help, avoidance, coercive treatment, and segregated institutions. In a survey distributed to 1,444 American residents, over half of the respondents reported being unwilling to spend time socializing with, working next to, or have a family member marry an individual with mental health problems (Martin, Pescosolido, & Tuch, 2000). These kinds of negative attitudes are likely contributing to the statistics reported in the following study. Farrelly and colleagues (2014) surveyed 202 individuals with a mental disorder (i.e., schizophrenia, major depressive disorder, and bipolar disorder), and found that 93%

anticipated experiencing discrimination, and 87% *had* experienced it in the previous year. A similar study surveyed individuals with major depressive disorder in 35 different countries (Lasalvia et al., 2013). Results demonstrated that 79% of respondents reported experiencing discrimination in at least one life domain in the last year (Lasalvia et al., 2013). As a result of their diagnoses, 37% of the participants had stopped themselves from initiating a close relationship, 25% had stopped themselves from applying for work, and 20% had stopped themselves from applying for education or training experiences (Lasalvia et al., 2013). In general, higher levels of discrimination were associated with more episodes of depression, lower levels of social functioning, and at least one hospitalization (Lasalvia et al., 2013).

Evidently, individuals with mental health concerns are affected by both anticipated and experienced discrimination, and this occurs for individuals all over the world. These studies demonstrate that the stigma associated with mental health problems leads to negative outcomes by overt and covert means. Yet, as previously alluded to, stigma also inhibits individuals' likelihood of seeking help. Therefore, stigma acts doubly to deteriorate mental health status while also standing as a barrier for individuals in need of psychological assistance.

Summary. While many factors influence the likelihood that a person will seek help for their psychological concerns, the most commonly cited barrier is stigma. Stigma can be differentiated into public stigma and self-stigma, both of which have detrimental effects for those who experience it. Pertinent to the present study is *self-stigma of seeking psychological help*. Interestingly, research has recently indicated that levels of perfectionism have implications for self-stigma of seeking psychological help, and therefore, have implications for accessing mental health services. Further, preliminary research has also indicated that contact with mental illness may also impact levels of self-stigma. However, research on this relationship is new and limited, and therefore required further inquiry.

Variables Impacting the Experience of Stigma

As evidenced in the previous sections, stigma is an important topic of inquiry, because it a) impacts and often decreases the likelihood that an individual will seek psychological help in a time of need, and b) has consequences for the mental, emotional, and physical health of individuals. Therefore, it is important to better understand the variables that impact the experience of stigma (both public and self-stigma), whether they may increase the experience of stigma (perfectionism), or decrease the endorsement of stigma (contact with stigmatized groups). The following sections address these two variables, specifically.

Perfectionism. As a result of the significant role it plays in a number of pathologies, perfectionism is a personal characteristic that has been studied extensively over the last thirty years (American Psychological Association, 2013; Blatt, 1995; Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991b; Hooley & Teasdale, 1989; Vaughn & Leff, 1983). Early research suggested that perfectionism had five major dimensions: excessive concern over making mistakes; high personal standards; perceptions of high parental expectations and high parental criticism; doubting the quality of one's own actions; and a preference for order and organization (Frost et al., 1990). Some of these dimensions may lead to more positive outcomes for a person (such as a preference for order and organization), whereas others may lead to negative outcomes (e.g., excessive concern over mistakes). As such, it has long been understood that perfectionism can have both positive and negative dimensions, which are associated with positive or negative outcomes for a person.

Similarly, Hamachek (1978) made an important distinction between "normal" and neurotic perfectionism. Hamachek (1978) argued that although normal perfectionism is characterized by high standards, it also allows for minor mistakes when judging the success of a performance. Neurotic perfectionism, on the other hand, allows little room for mistakes and

creates the perception that nothing is ever done to the fullest extent (Hamachek, 1978). A major distinction between the identifiers used to describe perfectionism is the *motivation* behind a person's behaviour. Normal perfectionism is motivated by a need for achievement, whereas neurotic perfectionism is motivated by a fear of making mistakes. In sum, perfectionism becomes problematic when high personal standards are accompanied by excessively critical evaluations of the self (Hamachek, 1978).

Other researchers have noted the "positive" and "negative" aspects of perfectionism as well (Terry-Short, Owens, Slade & Dewey, 1995). Much like the motivating factors outlined by Hamachek (1975), Terry-Short and colleagues (1995) argued that negative perfectionism occurs as a function of avoidance of negative consequences, and it is associated with concern over mistakes, perceived parental criticism, perceived parental expectations, and doubts about actions (Frost et al., 1990). On the other hand, positive perfectionism is associated with high personal standards, order and organization (Frost et al., 1990), and it occurs as a result of achievement or positive consequences. Consequences can be both internally rewarding to a person (they experience a self-esteem boost) and externally rewarding (they perceive approval from others). As outlined above, the positive and negative characteristics of perfectionism are differentially associated with the five dimensions of perfectionism initially proposed by Frost and colleagues (1990).

The positive and negative characteristics of perfectionism have also been described as adaptive and maladaptive perfectionism (Enns & Cox, 2002). Some examples of adaptive perfectionism include creating standards that are matched to a person's limitations and strengths, a sense of self that is independent of performance on any given task, and timely completion of tasks (Enns & Cox, 2002). Some characteristics of maladaptive perfectionism include a sense of self-worth that is dependent on performance, a tendency towards procrastination, and inflexible

or black and white thinking (Enns & Cox, 2002). There are also some characteristics of maladaptive perfectionism that overlap with previous researchers, such as fear of failure, and a focus on avoiding errors (Enns & Cox, 2002; Frost et al., 1990; Terry-Short et al., 1995).

In a more recent study, Stoeber and Otto (2006) conducted additional research on the positive aspects of perfectionism in hopes of illuminating some healthy dimensions of the construct. The authors found that *healthy* perfectionism leads to high levels of striving for perfection and low levels of perfectionistic concerns (concern over mistakes, doubts about actions, self-criticism, and fear of failure), whereas *unhealthy* perfectionism leads to high levels of striving for perfection *and* high levels of perfectionistic concerns (Stoeber & Otto, 2006). Therefore, although both groups have tendencies to strive for perfection, only those individuals exhibiting unhealthy or negative perfectionism will be detrimentally impacted by not meeting those standards. Thus, it is possible to have a healthy pursuit of perfectionism. The above sections outlined the positive and negative characteristics of perfectionism, and described a five-dimension model to better understand the complexity of perfectionism. However, important researchers in the field of perfectionism understand the construct from a three-dimension model, which is crucial for understanding the present study.

Hewitt and Flett (1991b) suggested a different conceptualization of perfectionism, dividing it into self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. Each of these types is differentially related to patterns of psychopathology and maladjustment. Self-oriented perfectionism involves setting high standards for the self and adhering strictly to these standards (Hewitt & Flett, 1991b). Self-oriented perfectionism is described as a motivating force that also has connections to anxiety, depression, and anorexia (Hewitt & Flett, 1991b). Other-oriented perfectionism is driven by beliefs and evaluations of others (Hewitt & Flett, 1991b). Individuals who rate highly on this construct tend to set high

standards for significant others, and evaluate the behaviour of others critically (Hewitt & Flett, 1991b). Socially prescribed perfectionism is defined as the perceived need to attain standards set by significant others (Hewitt & Flett, 1991b). These standards are perceived as excessive and unattainable, which leads to persistent perceived failure. Socially prescribed perfectionism can be linked to both positive and negative attributes. On one hand, a person may display leadership and may motivate others, while on the other hand, a person may blame others, lack trust in others, and express hostility, cynicism, and loneliness (Hewitt & Flett, 1991b). Research has outlined the problematic side of socially prescribed perfectionism (Hooley & Teasdale, 1989; Vaughn & Leff, 1983). Specifically, individuals are more likely to relapse into depression or schizophrenia if they perceive their significant supporters as more critical of them (Hooley & Teasdale, 1989; Vaughn & Leff, 1983). Unfortunately, perfectionism, which has been found to be relatively stable over time (Rice, Richardson, & Clark, 2012), has also been associated with a number of other mental health concerns and negative outcomes.

Perfectionism is correlated with a number of psychopathological symptoms. In some early research, Pacht (1984) linked perfectionism to a number of disorders including (but not limited to) alcoholism, depression, anorexia, and OCD. Additional researchers have provided support for the relationship of perfectionism to eating disorders (Bastiani et al., 1995; Garner, et al., 1983; Slade, 1982), depression (Blatt, 1995; Frost et al., 1990; Hewitt & Flett, 1991a), and OCD (Frost & Steketee, 1997). Hayward and Arthur (1998) studied perfectionism specifically in post-secondary students, and found that when using the Hewitt and Flett's (1991b) multidimensional approach to perfectionism, both self-oriented and socially prescribed perfectionism were associated with symptoms of anxiety and depression in these students. Although perfectionism can motivate a need for achievement, it can also produce unrealistic expectations that may be catalysts for psychological distress in university students.

Contact with stigmatized groups. Some research suggests that contact with stigmatized persons may decrease negative attitudes towards the larger stigmatized group. For example, Pettigrew and Tropp (2006) found that positive intergroup contact between members of different groups could improve intergroup relations and challenge negative attitudes towards stigmatized groups. Intergroup contact theory was originally devised for racial and ethnic groups, but Pettigrew and Tropp's (2006) analyses demonstrated that the phenomenon is present for various other groups as well. The other target groups examined included gay individuals, persons with physical disabilities, individuals with mental disabilities, the elderly, and individuals with mental illness (Pettigrew & Tropp, 2006). The most positive outcomes (e.g., the largest prejudice reduction) occurred for contact between gay and straight individuals, whereas contact between healthy and mentally ill individuals was one of the smaller effects. Nonetheless, the results remained statistically significant at a *p*-value of less than .001.

Furthermore, it has also been found that simply recalling a nostalgic memory with a person from a stigmatized group (overweight or mentally ill) leads to more positive attitudes towards those groups (Turner, Wildschut, & Sedikides, 2012; Turner et al., 2013). These findings suggest that real and imagined contact with a person from a stigmatized group can lead to more positive attitudes towards the stigmatized group as a whole. These findings are important for the present study, and are alluded to in a later section.

The above sections covered the topics of mental health in Canada with a specific focus on university students, barriers to seeking help, stigma, perfectionism, and contact with stigmatized groups. However, a key study by Zeifman and colleagues (2015) merits special discussion because of its pertinence to the present study.

Linking Self-Stigma, Perfectionism, and Group Contact

Zeifman and colleagues (2015) studied the relationship between perfectionism and self-stigma for seeking psychological help amongst high school students. The authors wanted to better understand how perfectionism impacts a person's likelihood of seeking help, and how this relationship is affected by having previous contact with a person with mental health problems. A sample of 86 Grade 10 students (46 females; 40 males) completed the Child and Adolescent Perfectionism Scale (Flett, Hewitt, Boucher, Davidson, & Munro, 1997), the Self-Stigma of Seeking Psychological Help Scale (Vogel, Wade, & Haake, 2006), and a Level of Contact Report (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). The Level of Contact Report measures an individual's exposure to individuals with mental illness. Students were placed in either the high-contact group (friend, family member or self who had a mental illness) or the low-contact group (limited or no prior contact with mental illness). Results demonstrated that for individuals in the low-contact group, self-oriented perfectionism had a significant relationship with self-stigma for seeking psychological help ($p < .01$). Specifically, as levels of self-oriented perfectionism increased, so too did levels of self-stigma for seeking psychological help. This relationship was found to be predictive in a regression analysis. Socially prescribed perfectionism, on the other hand, was not significantly correlated with self-stigma for seeking help, but it obtained near significance ($p = .07$). Furthermore, Fisher *r* to *z* transformations demonstrated that level of contact had a significant impact on the relationship of self-stigma to self-oriented perfectionism. Specifically, there was a significant difference between the high and low contact groups when considering the relationship of perfectionism to self-stigma for seeking help. As such, the authors concluded that self-oriented perfectionism may predict self-stigma for seeking psychological help, but only for individuals who have limited contact with person's experiencing mental illness.

The present study extended this research (Zeifman et al., 2015) by using a university population, examining three types of perfectionism as opposed to two, and investigating the moderating effects of exposure to mental health problems on the relationship between types of perfectionism and the self-stigma of seeking psychological help. As noted previously, university populations are primarily emerging adults, who experience high levels of stress, and are at risk of developing mental health problems. Furthermore, individuals in the university population experience numerous barriers in their pursuit of help for mental health concerns. It has been posited that perfectionism too acts as a barrier to seeking help, as it increases the experience of self-stigma for these individuals. However, as Zeifman and colleagues (2015) have shown, contact with stigmatized groups may affect the relationship of perfectionism to the experience of self-stigma, and may prove to be a useful intervention tool in the future. Therefore, the research question was "what are the moderating effects of contact with mental illness on the relationship of perfectionism to self-stigma of seeking psychological help (in a university sample)?" The hypothesis was as follows: Exposure to people experiencing mental health problems will be a significant moderator of the relationship of perfectionism (self-oriented, other-oriented, and socially prescribed) to self-stigma for seeking psychological help.

CHAPTER 3

Methodology

The following methodology chapter describes the present research study. It begins with a description of the participants who were recruited, how they were recruited, and how they accessed the study. Next, the chapter describes the measures used to quantify the variables in question; their content, structure, scoring, and psychometric properties. Finally, the procedure is explained in a step-by-step manner, including the data analyses and the steps involved in a moderation analysis.

Participants

The target population for this study was university students in the Prairie Provinces. As alluded to earlier, this population is primarily composed of individuals in the emerging adulthood stage of development. The sample was derived of university students enrolled in a first or second year psychology course. All participants (n = 180) were recruited through the university's psychology participant pool. The present study relied on nonprobability sampling (convenience sampling), which allowed for the generation of a large sample size in a timely and inexpensive fashion. The limitations of a convenience sample, such as under-representation or overrepresentation of particular groups within a sample (e.g., lower generalizability), are outweighed by the benefits inherent in the time, costs, and sample size associated with a convenience sample. All participants were compensated for their involvement (i.e., they received class credit upon completion of the survey). Such compensation is standard procedure when using the psychology participant pool. All participants provided their consent before completing the survey (see Appendix A), and no participants were excluded from the study (aside from incomplete data sets and extreme completion times of under two minutes or over two hours).

A total of 215 participants responded to the online survey; of those participants, 187 data sets were answered in full. Incomplete data sets were removed, and an additional seven cases were excluded as a result of extreme completion times. Most completion times were between five and 15 minutes, with an average of 14 minutes. Extreme outliers (e.g., under two minutes or over two hours) were removed. The final sample was comprised of 180 participants, ranging in age from 17 to 35 years (135 females: M_{AGE} = 19.84, *SD* = 2.60; and 45 males: M_{AGE} = 20.24, *SD*= 3.62). Participants reported between one and eight years of university education, with an average of 2.13 years (*SD*= 1.42). The majority of the participants were enrolled in Arts and Sciences (80%), and the remainder represented the following colleges: Business (7.2%), Kinesiology (6.1%), Education (3.3%), Agriculture and Bioresources (1.7%), Social Work (0.6%), Pharmacy and Nutrition (0.6%), and Nursing (0.6%). Participants declared a range of ethnicities, including White or Caucasian (60.6%), and Asian or Pacific Islander (27.2%), with the remaining 12.2% of the participants representing First Nations, Native, Metis, Black or African American, East Indian, Hispanic or Latino, and Middle Eastern or Arab students.

Instruments

The Fluidsurveys questionnaire was administered online, and was comprised of four parts: the demographics questionnaire, the Multidimensional Perfectionism Scale (Hewitt & Flett, 1990), the Self-Stigma of Seeking Psychological Help Scale (Vogel et al., 2006), and the Level of Contact Report (Holmes et al., 1999). The question types were variable, including Likert-type, yes/no, and open-ended questions. The measures were administered in the same order for all participants, following the order presented below.

Demographic questionnaire. Participants answered five demographic questions pertaining to gender, age, ethnicity, type of education, and length of education. Questions of gender and ethnicity offered a response bank, with an "Other" option if their selection was not

listed. The remaining questions (age, years of university, and college) were open-ended and required a text response. See Appendix B for a complete copy of the online survey.

Multidimensional Perfectionism Scale (MPS). Participants also completed the Multidimensional Perfectionism Scale (MPS) (Hewitt & Flett, 1990). The MPS is a 45-item questionnaire that assesses three types of perfectionism: self-oriented perfectionism (15 items), other-oriented perfectionism (15 items), and socially prescribed perfectionism (15 items) (Hewitt & Flett, 1990). Items are rated on a Likert-type scale, with responses ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). An independent score is generated for each type of perfectionism, with scores ranging from 15 to 105, and Hewitt and Flett (1990) argued that higher scores in each reflect progressively unhealthier levels of perfectionism. Total scores in each scale were computed after reverse coding those items that were phrased as negative statements. Sample statements for self-oriented perfectionism include "When I am working on something, I cannot relax until it is perfect" and "I strive to be as perfect as I can be." Sample statements for other-oriented perfectionism include "Everything that others do must be top-notch quality" and "I have high expectations of the people who are important to me." Sample statements for socially prescribed perfectionism include "I find it difficult to meet others' expectations of me" and "The people around me expect me to succeed at everything I do." Hewitt and Flett have examined the reliability and validity of their measure, and have found adequate degrees of both, as well as it being relatively free from response bias (Hewitt & Flett 1989; 1991a; 1991b). The measure was also found to have adequate reliability and validity within a psychiatric population (Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991). In the present sample, Cronbach's alpha for all 45 items in the scale was found to be 0.86 overall, which is a "good" level of reliability according to the guidelines offered by George and Mallery (2003). Cronbach's alphas were also computed for the three individual subscales, and their reliabilities were as follows: 0.85 for the self-oriented

perfectionism subscale, 0.58 for the other-oriented perfectionism subscale (analysis of the item-total statistics did not demonstrate significant improvements in Cronbach's alpha with the removal of specific items), and 0.81 for the socially prescribed perfectionism subscale. The self-oriented and socially prescribed perfectionism subscales yielded good reliability, whereas the other-oriented perfectionism subscale yielded poor reliability, according to George and Mallery's guidelines (2003).

Self-Stigma of Seeking Psychological Help Scale (SSOSH). Participants then completed the Self-Stigma of Seeking Psychological Help scale (SSOSH*)* (Vogel et al., 2006). The SSOSH is comprised of 10 items, and it evaluates respondents' comfort or concern over seeking psychological help from a therapist (Vogel et al., 2006). Items are rated on a Likert scale, with responses ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Total sum scores are computed for each individual and range from 10 to 50. Within this range, 10-22 represents low levels of stigma, 23-32 represents medium levels of stigma, and 33-50 represents high levels of stigma. Total scores were computed after reverse coding those items that were phrased as negative statements. Sample questions include "Seeking psychological help would make me feel less intelligent," "It would make me feel inferior to ask a therapist for help," and "If I went to a therapist, I would be less satisfied with myself." According to Zeifman and colleagues (2015), the SSOSH has been strongly correlated with university students' attitudes toward seeking help. Further, the SSOSH has been predictive of seeking psychological help within a two-month period, and differentiated those participants who sought psychological services from those who did not (Vogel et al., 2006). The SSOSH also has good reliability (.91), with a test-retest reliability of .72, and an internal consistency range of .86-.90 (Vogel et al., 2006). In the current sample, Cronbach's alpha was 0.83, which is considered a good level of reliability (George & Mallery, 2003), and is fairly consistent with previous measures of reliability.

Level of Contact Report. Participants then completed a Level of Contact Report (Holmes et al., 1999). This was a 12-item questionnaire that assessed respondents' exposure to individuals with "mental illness", with items ranked from 1 (least exposure) to 12 (most exposure). Items were ranked based on the consensus of experts and clinicians in the field (Holmes et al., 1999). Participants were asked to first read all of the statements, and then place a check mark beside the statement(s) that best depicted their experience with persons who have "mental illness." Statements ranged from no contact ("I have never observed a person that I was aware had a severe mental illness"), to medium levels of contact ("I have worked with a person who had a severe mental illness at my place of employment"), and finally high contact ("I have a severe mental illness"). The present study established three levels of contact with mental illness (high, medium and low contact), based on the mean and standard deviation of this measure for this particular sample. See the Results chapter for more information on how these groups were created.

Procedure

This study relied on non-experimental research utilizing a quantitative approach, and a causal (explanatory) design. This methodology was selected because it was the most statistically rigorous method to better understanding the mechanisms by which exposure to mental illness moderated the relationship of perfectionism to self-stigma for seeking psychological help. Qualitative research would not allow for such a rigorous examination of the particular question at hand, and the many variables involved. For clarification, the independent variable in this study was perfectionism, the dependent variable was self-stigma for seeking psychological help, and the variable moderating the relationship between the aforementioned variables was contact with mental illness. Data were collected on a single group of participants over a three-week period, with no intervention implementation. This study was approved by the University of

Saskatchewan's Ethics Review Board. The following procedures were followed in order to collect sufficient data to answer the research question:

1) At the university where students were recruited, participants in first and second year psychology courses were able to participate in a wide variety of undergraduate and graduate research studies to obtain additional class credit. The present study was one of the studies available for additional class credit.

2) The recruitment notice was posted on the university's psychology participant pool website (sona-systems), and potential participants were invited to participate in a study regarding perfectionism and help-seeking behaviors.

3) If the participants were interested in the study, a website link was provided that directed participants to a FluidSurveys questionnaire.

> Note: FluidSurveys is an online survey tool, accessible to individuals and groups alike, and used to create surveys, gather data from respondents around the world, and analyze data. The university currently uses this platform as its primary survey tool, and it was therefore selected for this study.

4) Once linked to the website, participants were informed on the purpose and procedures of the survey, and asked to provide consent in order to proceed.

5) Participants then completed the survey components in the following order: demographics, the Multidimensional Perfectionism Scale, the Self-Stigma for Seeking Psychological Help scale, and finally the Level of Contact Report.

6) Following completion of the survey, participants were debriefed using a written (online) form and thanked for their participation (See Appendix C).

7) After three weeks of data collection, the survey was closed and responses were exported to SPSS for data cleaning and analysis.

Data analysis. First, data were cleaned and checked to eliminate incomplete data sets, as well as data sets with outlying completion times. Next, descriptive statistical analyses were performed on the sample group to obtain a clear understanding of the sample's characteristics. For example, measures of central tendency (means and percentiles) were computed, as well as measures of dispersion (standard deviations and ranges). Next, correlation analyses were conducted to assess the strength and direction of the relationships among the three types of perfectionism, as well as between the types of perfectionism and reports of self-stigma for seeking psychological help. Finally, three moderation analyses were conducted to establish whether level of contact with mental illness moderated the pre-existing relationship of perfectionism to self-stigma for seeking psychological help.

In order to examine the moderating effects of level of contact with mental illness on the relationship of perfectionism to self-stigma for seeking psychological help, a number of total scores were computed. A total score was calculated for the dependent variable (self-stigma of seeking psychological help) and the independent variables (self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism). For the moderating variable, level of contact with mental illness, participants were placed in one of three groups (high, medium, or low contact) based on mean-centered values reported on this measure.

The introduction of a moderator specifies when an independent variable is related to a dependent variable, and it changes the size or the direction of a relationship between two variables. Therefore, the addition of level of contact with mental illness was expected to change the relationship of the three types of perfectionism to self-stigma of seeking psychological help. To establish whether a moderation occurred, the SPSS PROCESS add-on developed by Andrew

F. Hayes[1] was utilized. Moderation has occurred if the interaction term is significant (i.e., the *p*-value for the interaction between the independent variable and the moderator is less than 0.05), and the model accounts for a significant portion of the variance in the dependent variable (i.e., the *R* square change is significant). To examine the moderation effect further, effects of the independent variable (the types of perfectionism) on the dependent variable (self-stigma of seeking psychological help), conditional on different values of the moderator, were assessed. For the present research, these conditions were when contact with mental illness was low, medium, and high. Simple Slopes Analysis was used to create graphs of the moderation effects for each subtype of perfectionism in order to interpret the statistical findings. Results were considered significant at or below the *p*-value of .05.

[1] See this website to download the add-on: http://www.processmacro.org/download.html

CHAPTER 4

Results

The purpose of the present study was to examine the moderating effects of level of contact with mental illness on the relationship of three types of perfectionism to self-stigma for seeking psychological help. It was hypothesized that level of contact with mental illness would be a significant moderator of the aforementioned relationship; however, as the analysis was exploratory, no directional hypotheses were made. As such, the relationship of perfectionism (self-oriented, other-oriented, and socially prescribed) to self-stigma for seeking psychological help would change (become stronger *or* weaker) depending on participants' level of contact with mental illness (high, medium, or low). The following chapter describes the results that were obtained through descriptive and inferential statistical analysis. First, findings from correlation analyses are reported, followed by a discussion of how level of contact was measured and how groups were established, and finally, the results of three moderation analyses are reported.

Descriptive Statistics

After removing terminated data sets (e.g., participants were informed that if they terminated participation, their data would not be used for study), as well as data sets with extreme completion times (e.g., under two minutes or over two hours), 180 participants remained. The remaining participants had a mean age of 19.94 (SD = 2.88), the majority identified as White or Caucasian (60.6%), and 80 percent of the participants were enrolled in Arts and Sciences. For further demographic statistics from the sample, please refer back to "Participants" in Chapter 3.

Participants were asked to respond to several instruments, including the MPS, the SSOSH, and the Level of Contact Report. For a summary of the means and standard deviations for male and female participants on the three subscales of perfectionism, the SSOSH, and the Level of Contact Report, see Table 4.1 below.

Table 4.1: Means and Standard Deviations for Males and Females for all Measures

	Males		Females		Total Sample	
	M	*SD*	*M*	*SD*	*M*	*SD*
Self-Oriented Perfectionism	69.56	10.83	73.85	13.42	72.78	12.93
Other-Oriented Perfectionism	60.24	9.36	59.13	8.54	59.41	8.74
Socially Prescribed Perfectionism	59.09	11.63	59.02	11.99	59.04	11.87
SSOSH	25.98	6.01	26.27	6.89	26.19	6.67
Level of Contact Report	7.71	2.87	7.60	3.00	7.63	2.96

Note: *M* denotes mean; *SD* denotes standard deviation.

Overall, there were no statistically significant differences between the male and female means across all administered measures. Female participants had slightly higher levels of self-oriented perfectionism, and slightly elevated levels of self-stigma for seeking psychological help; however, no meaningful differences were revealed between genders. Interestingly, scores on the SSOSH range from 10-50, suggesting that on average, this particular university sample exhibits only medium levels of self-stigma for seeking psychological help ($M = 26.19$, $SD = 6.67$).

Correlations

Pearson correlation coefficients were computed between the three types of perfectionism, as well as the scores from the Self-Stigma of Seeking Help Scale (SSOSH) (see Table 4.2). Results from these correlations indicated that the three types of perfectionism (self-oriented, other-oriented, and socially prescribed) are correlated, exhibiting small to moderate size associations (Cohen, 1988). Thus, the more a participant reports the behaviors present in any one

subtype of perfectionism, the more they report behaviors present in the remaining two types. Furthermore, significant correlations were noted between SSOSH and self-oriented perfectionism ($r(178) = 0.181$, $p = 0.015$), as well as SSOSH and socially prescribed perfectionism ($r(178) = 0.196$, $p = 0.008$). Therefore, higher ratings of both self-oriented and socially prescribed perfectionism were related to higher reports of self-stigma for seeking psychological help. No significant correlations were noted for other-oriented perfectionism.

Table 4.2: Pearson Correlation Coefficients for the MPS Subscales and the SSOSH

	Self-Oriented Perfectionism	Other-Oriented Perfectionism	Socially Prescribed Perfectionism	SSOSH
Self-Oriented Perfectionism	--	0.363*	0.443*	0.181*
Other-Oriented Perfectionism	0.363*	--	0.286*	0.069
Socially Prescribed Perfectionism	0.443*	0.286*	-	0.196*
SSOSH	0.181*	0.069	0.196*	--

Note: Correlations marked by (*) indicate significant correlations at $p < 0.05$.

Moderation Analysis

Level of contact with mental illness was measured using the Level of Contact Report (Holmes et al., 1999). Twelve statements describing various levels of contact were presented, and participants were asked to indicate which statement(s) best described their experience with persons with mental illness. If more than one statement was selected, the *higher*-level item was used to rank participants' responses. Based on the mean level of contact reported for all participants ($M = 7.63$, $SD = 2.96$), three statistical groups were established. The low contact group was defined as participants who had scores less than one standard deviation below the

mean (i.e., below 4.67), the medium contact group was defined as participants who had scores within the interval of one standard deviation around the mean (i.e., 4.67 to 10.59), and the high contact group was defined as participants who had scores higher than one standard deviation above the mean (i.e., 10.59 to 12). As such, level of contact was mean-centered, and groups of contact were established using these values. Given this measurement of level of contact with mental illness, 26.1% of the sample was in the low contact group, 62.2% were in the medium contact group, and 11.7% were in the high contact group. To explore the effect of level of contact with mental illness on the relationship of perfectionism to self-stigma for seeking psychological help, three moderation analyses were conducted.

Self-oriented perfectionism and self-stigma for seeking psychological help. The results from the moderation analysis demonstrated that there was a significant interaction between self-oriented perfectionism and level of contact ($b = 0.026$, $t = 2.13$, $p = 0.035$), indicating that the relationship between self-oriented perfectionism and self-stigma for seeking psychological help is moderated by level of contact with mental illness. The addition of the interaction model accounted for 2.2% of the variance in self-stigma of seeking help, $\Delta R^2 = 0.022$, F (1, 176) = 4.53, $p = 0.035$. To interpret the significance of this interaction, simple slopes analyses were conducted. The conditional effect of self-oriented perfectionism on self-stigma for seeking psychological help at different levels of contact indicated that: A) when level of contact with mental illness was low, there was not a significant relationship between self-oriented perfectionism and self-stigma for seeking psychological help ($b_{low} = 0.014$, $t = 0.258$, $p = 0.797$); B) at the medium level of contact with mental illness, there was a significant positive relationship between self-oriented perfectionism and self-stigma for seeking psychological help ($b_{medium} = 0.091$, $t = 2.38$, $p = 0.0186$); and C) when level of contact with mental illness was high, there was a significant positive relationship between self-oriented perfectionism and self-stigma for seeking

psychological help (b_{high} = 0.168, t = 3.17, p = 0.0018). A comparison between the regression coefficients of medium and high contact conditions revealed that the relationship between self-oriented perfectionism and self-stigma for seeking psychological help was stronger for people with a higher level of contact. See Figure 4.1 for a graph of the simple slopes associated with low, medium and high levels of contact with mental illness.

Figure 4.1: Simple Slopes Analysis for the Moderation Effect of Level of Contact with Mental Illness and Self-Oriented Perfectionism

Using the Johnson-Neyman technique, the zone of significance was established. A minimum score of seven on the Level of Contact Report (e.g., item seven states: "my job includes providing services to persons with severe mental illness") was required on the level of contact report in order for the relationship of self-oriented perfectionism to self-stigma for seeking psychological help to be significant. See Appendix B for the rank order of each item. Therefore, those participants who reported a minimum value of seven on the level of contact report showed a significant relationship of self-oriented perfectionism to self-stigma for seeking psychological help.

These results suggested that when level of contact with mental illness was low, self-oriented perfectionism was not related to participants' levels of self-stigma for seeking psychological help. However, at medium and high levels of contact with mental illness, as levels of self-oriented perfectionism increased, levels of self-stigma for seeking psychological help also increased. Therefore, individuals with a high level of exposure to mental illness who also exhibited high levels of self-oriented perfectionism were the most likely to experience self-stigma for seeking psychological help.

Other-oriented perfectionism and self-stigma for seeking psychological help. The results from the moderation analysis demonstrated that overall, the interaction was non-significant ($b = 0.013$, $t = 0.67$, $p = 0.504$), indicating that the relationship between other-oriented perfectionism and self-stigma for seeking psychological help was not significantly moderated by level of contact with mental illness. However, analysis of Figure 4.2 suggests that level of contact with mental illness does impact the relationship of other-oriented perfectionism to self-stigma of seeking psychological help, although not to a statistical degree. As evidenced in the graph, as level of contact with mental illness increased, the relationship of other-oriented perfectionism to self-stigma for seeking psychological help became more positive. However, regression analyses did not yield any statistically significant findings.

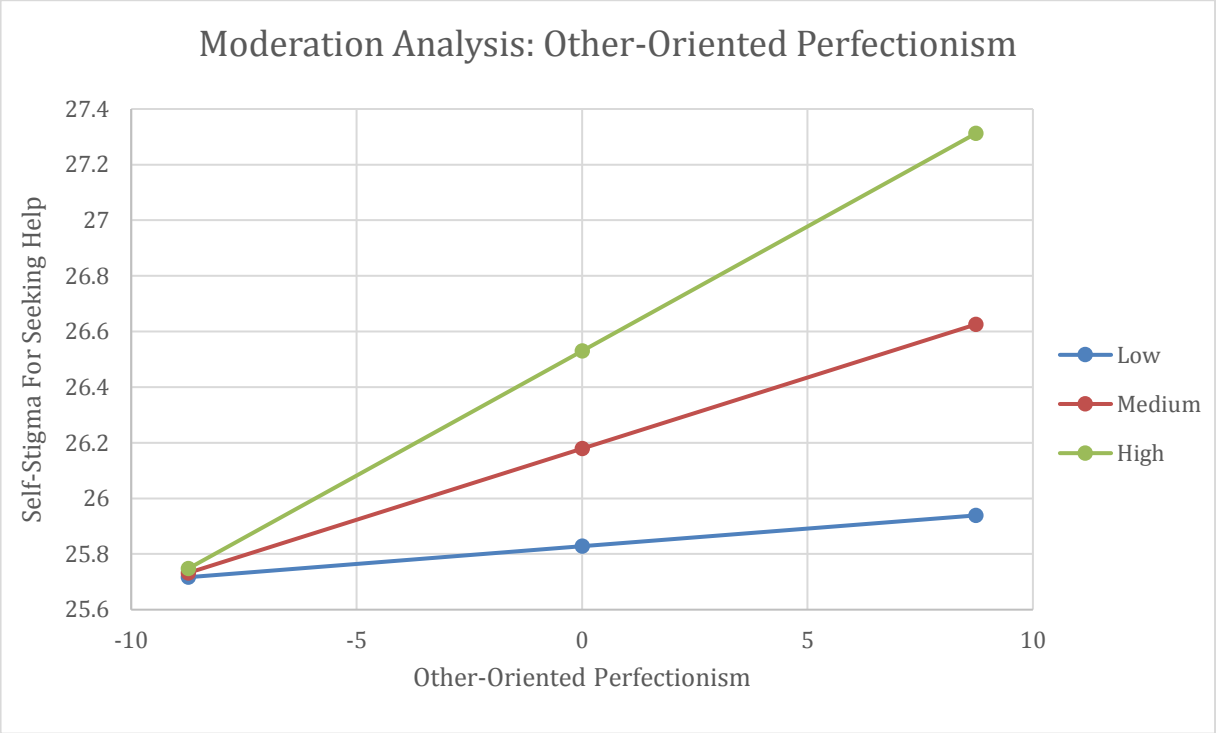

Figure 4.2: Simple Slopes Analysis for the Moderation Effect of Level of Contact with Mental Illness and Other-Oriented Perfectionism

These findings suggested that regardless of the level of contact with mental illness (high, medium, or low), other-oriented perfectionism did not have a statistically significant relationship to self-stigma for seeking psychological help (see Table 4.2). The non-significant correlation could be due to the low reliability of the other-oriented perfectionism subscale. Cronbach's alpha of 0.58 suggests that the other-oriented perfectionism scale can only account for approximately 58% of the variance in self-stigma for seeking psychological help.

Socially prescribed perfectionism and self-stigma for seeking psychological help. The results from the moderation analysis demonstrated that overall, there was not a significant interaction between socially prescribed perfectionism and level of contact with mental illness (b= 0.0226, t = 1.90, p= 0.059), indicating that the relationship between socially prescribed perfectionism and self-stigma for seeking psychological help was not significantly moderated by level of contact with mental illness. However, conditional effects of level of contact were found

to be significant. The conditional effect of socially prescribed perfectionism on self-stigma for seeking psychological help at different levels of contact indicated that: A) when level of contact with mental illness was low, there was not a significant relationship between socially prescribed perfectionism and self-stigma for seeking psychological help (b_{low} = 0.0437, t = 0.829, p = 0.408); B) at the medium level of contact with mental illness, there was a significant positive relationship between socially prescribed perfectionism and self-stigma for seeking psychological help (b_{medium} = 0.112, t = 2.76, p = 0.0063); and C) when level of contact with mental illness was high, there was a significant positive relationship between self-oriented perfectionism and self-stigma for seeking psychological help (b = 0.177, t = 3.30, p = 0.0012). A comparison between the regression coefficients of medium and high contact conditions revealed that the relationship between socially prescribed perfectionism and self-stigma for seeking psychological help was stronger for people with a higher level of contact with mental illness. A non-significant overall interaction effect between socially prescribed perfectionism and level of contact with mental illness but significant conditional effects might be due to low power and sample size. See Figure 4.3 for a graph of the simple slopes associated with low, medium, and high levels of contact with mental illness.

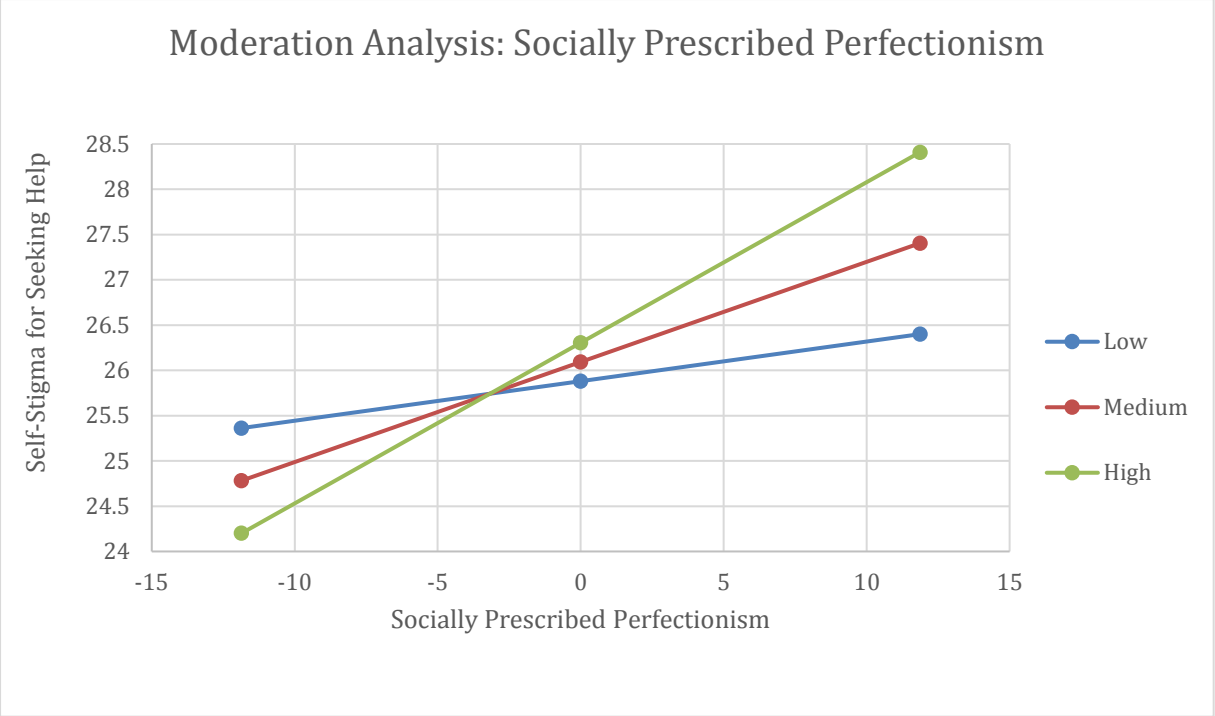

Figure 4.3: Simple Slopes Analysis for the Moderation Effect of Level of Contact with Mental Illness and Socially Prescribed Perfectionism

Using the Johnson-Neyman technique, the zone of significance was established. A minimum score of six (e.g. item six states: "I have worked with a person who had a severe mental illness at my place of employment") was required on the level of contact report in order for the relationship of socially prescribed perfectionism to self-stigma for seeking psychological help to be significant. Therefore, those participants who reported a minimum value of 6 on the level of contact report, showed a significant relationship of socially prescribed perfectionism to self-stigma for seeking psychological help.

These results suggested that when level of contact with mental illness was low, there is no relationship between levels of socially prescribed perfectionism and self-stigma for seeking psychological help. However, at medium and high levels of contact with mental illness, as levels of socially prescribed perfectionism increased, levels of self-stigma for seeking psychological help also increased. Therefore, individuals with a high level of exposure to mental illness who

also exhibited high levels of socially prescribed perfectionism were the most likely to experience self-stigma for seeking psychological help.

Summary of Results

Initial findings demonstrated significant positive correlations between all three types of perfectionism. As such, as levels of any one type of perfectionism increased, the remaining types increased as well. Therefore, although the types of perfectionism are defined by different characteristics (high expectations for the self; high expectations of others; perceived high expectations for the self *by* others), they are correlated, and reflect a broader definition of perfectionism altogether. Further correlation analyses indicated significant positive correlations between self-oriented perfectionism and self-stigma for seeking psychological help, and between socially prescribed perfectionism and self-stigma for seeking psychological help. The small associations indicated that as levels of both self-oriented and socially prescribed perfectionism increased, levels of self-stigma for seeking psychological help also increased. Therefore, greater levels of these two types of perfectionism were associated with greater reports of self-stigma for seeking psychological help. However, these relationships were more complex, and were further analyzed for a potential moderation effect of a third variable: level of contact with mental illness.

For both self-oriented perfectionism and socially prescribed perfectionism, there was no relationship to self-stigma for seeking psychological help when level of contact with mental illness was low. However, as level of contact increased to medium and high levels, the relationship of both self-oriented and socially prescribed perfectionism to self-stigma for seeking psychological help became stronger. As such, when level of contact with mental illness was medium or high, low reports of perfectionism were related to low levels of self-stigma, and high reports of perfectionism were related to high levels of self-stigma. Please see Chapter 5 for a more detailed discussion of the interpretation of these findings, as well as their implications.

CHAPTER 5

Discussion

As one of the populations most vulnerable to developing mental health disorders, university students (most of whom are emerging adults) were selected as the target population for the present study. Although mental health statistics for this particular population are alarming, statistics representing the small proportion of these individuals who actually seek help for their mental health concerns are even more unsettling. An explanation for this disconnect can be found in the barriers individuals experience when both contemplating and seeking help for psychological concerns. Both systemic (e.g., high cost, limited accessibility) and personal (e.g., preferring to rely on the self, embarrassment) barriers act together to decrease the likelihood that an individual will seek mental health help. Of these barriers, self-stigma has emerged in the research literature as one of the most commonly cited reasons for not seeking assistance. Self-stigma is defined as the internalized psychological impact of public stigma, and includes feelings of shame, embarrassment, fear, and decreased self-esteem (Bathje & Pryor, 2011). Higher levels of self-stigma are associated with a decreased likelihood of seeking psychological help. In a recent study (Zeifman et al., 2015), researchers found that high levels of perfectionism may also contribute to high levels of self-stigma for seeking help. However, this relationship was only observed for participants who had low exposure to mental illness. The purpose of the present study was to better understand the role that contact with mental illness plays in the relationship of perfectionism to self-stigma, and the specific research question was as follows: what are the moderating effects of contact with mental illness on the relationship of perfectionism to self-stigma of seeking psychological help (in a university sample)? What follows is a description of the study's findings, and their importance in the context of the current literature as well as implications for future research and practice.

Findings

Gender differences. Initial descriptive analyses demonstrated no gender differences in levels of perfectionism across all three types. These findings were convergent with previous research examining the differences in domains of perfectionism across genders and age groups (Stoeber & Franziska, 2009). In this research, although no gender differences were observed for overall domains of perfectionism (self-oriented and socially prescribed), gender differences were noted in more specific areas such as spelling, investments/purchases, hygiene, and orderliness (Stoeber & Franziska, 2009). It should be noted, however, that these findings were based on a relatively small sample of males (14 out of 109 participants). Despite the small sample, additional evidence for a lack of gender differences in perfectionism can be found in research from Flett, Blankstein, Hewitt, and Koledin (1992), in their examination of perfectionism and procrastination in college students.

Contrarily, in a study examining the psychometric properties of the MPS for use with clinical samples, Hewitt and colleagues (1991) reported a number of gender differences in perfectionism. Specifically, in the psychiatric patient group, men had significantly higher levels of other-oriented perfectionism, whereas women had significantly higher levels of socially prescribed perfectionism. Further, in the community sample of outpatient participants, men again had significantly higher levels of other-oriented perfectionism (Hewitt et al., 1991). Additionally, research shows gender differences in more domain-specific areas of perfectionism, such as among intercollegiate student-athletes (Dunn, Gotwals, & Dunn, 2005). Taken altogether, the evidence is mixed with regards to whether there are gender differences in perfectionism; however, in the present study, such differences were not observed.

Furthermore, in the current study, descriptive analyses did not show gender differences in self-stigma for seeking psychological help, which would suggest that men and women from this

sample were equally likely to seek help (as the SSOSH is predictive of seeking counselling). These findings were unexpected, given that men have been found to underutilize counselling services as a result of poorer attitudes regarding seeking professional help (Gonzalez, Alegria, & Prihoda, 2005). In North America, traditional masculine norms assume that men should be stoic, controlled, and self-sufficient; these characteristics are not generally consistent with help-seeking (Mahalik et al., 2003). As such, behaviours associated with vulnerability and weakness (such as psychological help seeking) are often viewed as negative and are thus avoided (Pederson & Vogel, 2007). Researchers have suggested that men may be more likely to internalize public stigma, or in other words, may be more likely to experience self-stigma, which in turn decreases the likelihood of an individual seeking counselling (Vogel, Wade, & Hackler, 2007). However, results from the present study do not support these findings. It is possible that as a result of the significant portion of non-Caucasian participants (approximately 40%), adherence to traditional North American masculine norms varied, which may have affected self-stigma for seeking help. Evidence to support this theory comes from previous research that found that higher endorsement of dominant masculine beliefs was related to less favourable attitudes towards seeking psychological help, and greater self-stigma (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Therefore, it is possible that cultural diversity in the present sample lead to differing beliefs about help-seeking and different experiences of self-stigma for seeking psychological help.

Relationships among the types of perfectionism. The correlation coefficients outlined in Table 4.2 suggested small to moderate size associations among the three types of perfectionism (e.g., self-oriented, other-oriented, and socially prescribed). Hewitt and Flett (1991b) suggested that perfectionism was not unidimensional, but instead, had both personal and social dimensions. They conceptualized these dimensions as three components of overall

perfectionistic behavior that reflected whom the perfectionistic behaviour is *directed* at (self or other-oriented), or to whom the behaviour is *attributed* (socially prescribed). Hewitt and Flett (1991b) suggested that some degree of overlap is expected among the three types of perfectionism, because all three components have either an implicit or explicit focus on attaining high standards. Hewitt and Flett (1991b) also argued that the subscale constructs were indeed distinct, and did not simply reflect alternate forms of the same dimension. However, in the present study, the correlation among self-oriented and socially prescribed perfectionism, the lower correlations among these two types and other-oriented perfectionism, as well as the similar pattern of findings for both self-oriented and socially prescribed perfectionism suggests that there is a high degree of overlap between at least two of the three constructs. It could be argued then, that perfectionism is a two-dimensional model representing both inward expressions of the characteristic (e.g., self-oriented perfectionism: high expectations for the self; socially prescribed perfectionism: *perceived* high expectations for the self *by* others), and outward expressions of the characteristic (e.g., other-oriented perfectionism: high expectations for others). Hewitt and Flett (1991b) may have alluded to this understanding or distinction when they described perfectionism as having both "personal" and "social" dimensions.

Indeed, the conceptualization of perfectionism has been approached from many perspectives over the last several decades, and to date, there remains little agreement as to how it should be perceived and measured accurately. Frost and colleagues (1990) argued for the use of a five-dimension model, Terry-Short and colleagues (1995) argued for the terms positive and negative perfectionism, Ens and Cox (2002) argued for the use of adaptive and maladaptive perfectionism, and Stoeber and Otto (2006) preferred the terms healthy and unhealthy perfectionism. See "Future research" for further suggestions on how this question should be addressed by later research.

Relationships of perfectionism to self-stigma for seeking psychological help. Table 4.2 presented the correlation coefficients for all three types of perfectionism with self-stigma for seeking psychological help. As evidenced in the table, two of those relationships were significant: self-oriented and socially prescribed perfectionism were positively correlated with self-stigma for seeking psychological help. This relationship demonstrated that as levels of these types of perfectionism increased, levels of self-stigma for seeking psychological help also increased. Therefore, individuals who exhibited high levels of self-oriented and socially prescribed perfectionism were the least like to seek help for psychological concerns.

To date, only one other study has researched the relationship of perfectionism, as measured by the MPS, with self-stigma for seeking psychological help (Zeifman et al., 2015). In that study, the authors were testing a hypothesis that individuals high in perfectionism were prone to experiencing higher levels of self-stigma. This association was hypothesized based on the knowledge that perfectionism can be characterized by a drive for absolute perfection, accompanied by a tendency to evaluate the self and others critically, and based on stringent standards (Hewitt & Flett, 1991b). Some individuals with perfectionism exhibit a need to be seen as in control of their emotions, and therefore view distress as weakness (Flett, Hewitt, & Heisel, 2014). These beliefs, in conjunction with unrealistically high standards, set an individual up for the experience of self-stigma (shame, embarrassment, and reduced self-esteem). As such, the significant positive correlations between perfectionism and self-stigma in the current study were expected. However, although this was the hypothesis provided by Zeifman and colleagues (2015), their study did not produce these findings. The results of their study only indicated statistically significant results when participants reported low levels of contact with mental illness. This finding will be explored further in the following section.

It is important to note that the discrepancy in findings noted above might be attributed to various causes. First, the sample used for both studies was different; the present study targeted university students (primarily emerging adults), whereas the previous research targeted adolescents attending high school. Next, each study used a different measure of perfectionism. Although both studies used Hewitt and Flett's (1991b) conceptualization of perfectionism, Zeifman and colleagues (2015) relied on an adapted version of the scale that has been validated for children and adolescents (the Child and Adolescent Perfectionism Scale-CAPS) versus the present study, which used the standard version of the MPS (Hewitt & Flett, 1991b). Further, the instruments measuring level of contact with mental illness were slightly different, with the present study relying on all 12 items of the Level of Contact Report, and Ziefman et al. (2015) using only 8 of the 12 items. Finally, the earlier research (Ziefman et al., 2015) had a relatively small sample (N=86), whereas the present research obtained a total of 180 participants. Overall, although the present research was informed by the earlier study by Zeifman and colleagues (2015), there are differences in the samples and instruments that might have resulted in discrepant findings.

Moderating effects of contact with mental illness. Moderation analyses examining the effects of contact with mental illness on the relationship of perfectionism to self-stigma produced important findings for two of the types of perfectionism: self-oriented and socially prescribed perfectionism. For both types of perfectionism, there was no relationship to self-stigma for seeking psychological help when level of contact with mental illness was low. Therefore, if participants reported low exposure to mental illness, levels of perfectionism (high, medium, or low) were unrelated to a participant's experience of self-stigma. This would suggest that as long as an individual had limited contact with persons with mental illness, perfectionism would not influence the likelihood that this person would seek help. These findings were unexpected, given

that Zeifman and colleagues (2015) reported opposing results. In their research, it was *only* when levels of contact were low that a significant positive relationship between perfectionism and self-stigma for seeking psychological help was observed (Zeifman et al., 2015). It is possible that discrepant findings were again the result of differences in samples and instruments; however, other suggestions to explain these divergent findings are explored further at the end of this section.

For both self-oriented perfectionism and socially prescribed perfectionism, when levels of contact with mental illness were medium or high, there was a significant positive relationship to self-stigma for seeking psychological help. Therefore, for participants who reported medium or high exposure to mental illness, high perfectionism was associated with high self-stigma for seeking psychological help, and low levels of perfectionism were associated with low self-stigma for seeking psychological help. These findings indicated that perfectionism was an important variable in predicting an individual's likelihood of seeking counselling, but only when contact with mental illness was medium or high. It was also found that for both self-oriented perfectionism and socially prescribed perfectionism, the relationship between perfectionism and self-stigma was significantly stronger at higher levels of contact when compared to medium levels. Therefore, levels of perfectionism had the most impact on self-stigma (and therefore the greatest impact on likelihood of seeking counselling) when contact with mental illness was highest. This finding was counterintuitive, as it contests previous research, and thus, deserved further exploration.

Typically, research has suggested that contact with mental illness improves attitudes towards stigmatized groups and reduces stigma. It is believed that contact with people with mental illness reduces stigma by challenging the stereotypical beliefs a person may hold regarding individuals with mental health problems (Angermeyer, Matschinger, & Corrigan,

2004). Couture and Penn (2003) reported this finding, and suggested that personal familiarity with individuals with mental illness may be the *most* effective means of reducing stigma. A personal connection to, or familiarity with mental illness allows individuals to create their own schemas of mental illness, rather than internalizing the dominant societal view. Research has shown that this exposure, or personal familiarity, has led to decreased stigma towards individuals with mental illness, and a decreased desire for distance from these individuals (Alexander & Link, 2003). This phenomenon has been observed for other groups of stigmatized people (e.g., gay persons, elderly persons), not just individuals with mental health concerns (Pettigrew & Tropp, 2006). Given the results of the aforementioned research, the results from the present study are unexpected, as the opposite finding emerged.

It is possible that while contact with individuals with mental illness may reduce *public* stigma, it does not reduce the *self*-stigma that has been learned, internalized, and normalized (Bathje & Pryor, 2011). As such, as individuals obtain exposure to persons with mental illness, though their attitudes may improve towards the larger stigmatized group, and they may engage in fewer acts of overt and covert discrimination, the psychological impact of stigma remains (e.g., the fear, shame, and embarrassment associated with identifying as a stigmatized person, remains). For individuals exhibiting high levels of perfectionism, this may be further compounded by their excessively high standards for the self (self-oriented perfectionism), or the standards thought to be set for the self by others (socially prescribed perfectionism). More specifically, because individuals high in perfectionism have such stringent standards for their behaviour and achievements, and are so highly critical of their actions, although they may report improved attitudes towards individuals with mental health concerns as a result of greater contact, it does not translate to their feelings or expectations of themselves. Importantly, these hypotheses are only suggestions, and have not yet been verified by research.

An additional suggestion for the discrepancy in research findings was that higher contact with individuals with mental health problems might also denote a greater awareness of the debilitating effects of mental illness and the harsh realities of the stereotypes these individuals face. This awareness of stigma and discrimination may make individuals less likely to associate themselves with a stigmatized label, and less likely to seek help for their own challenges. Again, characteristics of perfectionism may compound these effects as a result of their excessively high standards for the self. Though the current study had many strengths as a result of the novel findings outlined above, the research was not without its limitations.

Limitations

The current study had several limitations, most of which were related to the sample that was obtained as well as the instruments that were used. Although the sample was delimited to university students enrolled in a first or second year psychology course, it was expected that these students would represent a larger variety of colleges. However, demographic information suggested that upwards of 80% of the sample was comprised of Arts and Sciences students, which limits the generalizability of the findings. It may be valuable to examine the present research question with university students who are enrolled in highly competitive programs (e.g., medicine, dentistry, law, etc.), as these populations may exhibit higher levels of perfectionism, perhaps related to a greater need for achievement. Also related to the sample limitations was the number of students representing each level of contact with mental illness. Although groups of contact with mental illness were established using the mean and standard deviation of responses from this specific sample, equal numbers of participants across groups were not identified. Therefore, there was a larger representation of individuals in the medium contact group because most scores centered around the mean (62%), and only 11% of the participants were in the high

contact group. In the latter group, it is possible that high scores from these participants could have inflated the scores on perfectionism and the SSOSH measure.

Additional limitations to the present study may be associated with the instruments that were used. First, the MPS was selected to measure three different types of perfectionism. Although the overall scale reliability was sufficient, Cronbach's alpha for one of the subscales, other-oriented perfectionism, was weak and insufficient to establish reliability. It is possible that no significant findings emerged when this subscale was concerned because its reliability was so low. Of the other scales that were selected, the Level of Contact Report also offered potential limitations. Item 12 represented the highest level of contact with mental illness: "I have a mental illness." This item denotes a level of familiarity with mental illness that is different from the remaining items. Other items in the scale pertained to seeing a person with mental illness depicted in a movie, working at a place where an individual had a mental illness, or knowing a friend or family member who had a mental illness. Having a mental illness is suspected to be a much different experience than knowing someone with a mental illness, and is likely to offer a different relationship to self-stigma for seeking psychological help. The Level of Contact Report also relied on terminology that could be considered outdated. The scale used the terms "severe mental illness," which could be replaced with less pathological language such as "serious mental health problems." It may also be valuable to provide examples of what exactly this term constitutes, whether it relates to anxiety or depression, or more severe conditions such as personality disorders. It may be of value to explore the use of an updated or different measure of contact with mental illness, one that does not include the self having a mental illness and does not use the terms "severe mental illness."

Practical implications. Despite suggestions from many previous researchers, as evidenced in the present study, contact with mental illness may not be a valuable intervention

strategy for individuals who exhibited high levels of perfectionism. It may, in fact, work in an undesirable manner by actually increasing vulnerability to self-stigma and decreasing a person's likelihood of seeking help. As such, it might be more important for intervention strategies to target individuals high in perfectionism, and support the positive, healthy, or adaptive characteristics of perfectionism, while also challenging the negative, unhealthy, and maladaptive characteristics.

It is possible that the findings from this research have implications for screening tools used in the counselling intake process. Because perfectionism is associated with a variety of mental conditions and disorders, and because individuals exhibiting perfectionism often complete "unexpected" suicides (Flett, et al., 2014), they are truly a vulnerable population. During the intake process, it may be useful to screen students for perfectionism, as well as level of contact with people with mental illnesses. With this information, individuals who report elevated levels of self-oriented or socially prescribed perfectionism could be prioritized on the waiting lists. Furthermore, the present research suggested that on the Level of Contact Report, items 6 and 7 were the threshold items at which point contact with mental illness became a significant influence on the relationship of perfectionism to self-stigma. Therefore, individuals who score high on the perfectionism measures, and who also report levels of contact equal to or greater than item 6 (See Appendix B for the rank order of each item.), are at elevated risk of experiencing the shame, fear, embarrassment, decreased self-esteem and decreased self-efficacy that often accompanies self-stigma when seeking help. It is also important to note that individuals scoring high on both of these measures are also the least likely to seek help, and thus, these clients should be prioritized, in order to avoid the addition of a systemic barrier (e.g., long wait times as a result of limited resources) further impeding this individual's journey to seeking psychological help.

Last, for the purposes of intervention strategies, it is important to approach mental health concerns using a strength-based, positive approach. Employing terms such as "healthy" or "unhealthy", "adaptive" or "maladaptive" may be more helpful than using terms such as "normal" and "neurotic". The term "normal" can be harmful and can perpetuate the pathological and stereotypical beliefs currently associated with perfectionism. Health/unhealthy or adaptive/maladaptive are terms that suggest that there is room for growth, development, and learning, which is the focus of a strength-based approach. It will be important to emphasize and encourage those aspects of perfectionism that are healthy, while exploring the ways that unhealthy characteristics of perfectionism may be hindering a person from reaching their full potential.

Future research. Further research on perfectionism is needed. For example, the various conceptualizations of perfectionism (multidimensional, unidimensional, neurotic versus normal, adaptive versus maladaptive, health versus unhealthy, etc.) need further investigation to compare their empirical basis and their utility in developing a reliable, valid tool to operationalize and measure the construct of perfectionism. As alluded to in an earlier section of this chapter, it may also be valuable to explore the development or use of an updated measure of contact with mental illness. The stance of the present study's researcher is that the item, "I have a mental illness," is problematic and should not constitute an example of contact with mental illness. Lived experience of mental illness seems to be a different experience altogether, and therefore should not be included in this type of measure. Indeed, caregivers of individuals with severe mental illness have to cope with stresses such as burden from caring for a dependent, and the psychological impacts of depression (Saunders, 2003), whereas a person with severe mental illness may experience stressors such as symptom management and social isolation. Future research may also benefit from exploring what other personality traits are associated with self-

stigma, in order to establish whether perfectionism acts alone, or in conjunction with other traits. Finally, the present study would benefit from replication, in order to establish whether the findings were contextual to this particular time, sample, and place, or whether they are reliable findings. As stated earlier, a replication study may prove interesting if a population enrolled in more competitive academic programs was targeted, such as students enrolled in medicine, dentistry, pharmacy, or law.

Conclusion

The present study aimed to explore the effects of contact with mental illness on the relationship of perfectionism to self-stigma for seeking psychological help. The main findings suggested that exposure to mental illness becomes an important variable in the equation only at medium and high levels of contact. At these levels, both self-oriented and socially prescribed perfectionism were related to self-stigma for seeking psychological help. Specifically, higher levels of perfectionism were related to greater reports of self-stigma. These findings suggested that individuals high in perfectionism, who have medium or high contact with individuals with mental illness, experienced levels of self-stigma of seeking psychological help that will likely prevent them from seeking counselling or other forms of mental health help. These findings are especially problematic given the great vulnerability of individuals exhibiting characteristics of perfectionism to various mental health disorders. So, while they are vulnerable to developing many mental health concerns, and are at a greater risk of suicide (Flett et al. , 2014), they are also more vulnerable to not reaching out and seeking help. It is likely that this reluctance to seek assistance is related to the characteristics associated with perfectionism: high expectations of the self, high criticism of the self, and stringent standards, to name a few (Frost et al., 1990).

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Appendix A

Consent Form & Invitation to Participate

Perfectionism and Seeking Psychological Help

My name is Erica Thomson. I am a graduate student in the College Education at the University of Saskatchewan, and I am conducting a research study as part of the requirements for my Master's degree in School and Counselling Psychology.

I am studying perfectionism and its relationship to seeking psychological help, and I would like to invite you to participate. If you decide to participate, you will be asked to complete a 75-item questionnaire that will take approximately (20 minutes*). You can expect demographic questions (age, gender, years of education, etc.), questions assessing your levels of perfectionism, questions regarding your feelings on seeking psychological help, and questions about your exposure to individuals experiencing mental health problems.

Please note that you may omit any questions you wish without penalty or consequence. As well, participation is confidential. Study information will be kept in a secure location at the University of Saskatchewan College of Education. The results may be published, but your identity will not be revealed. Please do not leave your name or any identifying information on the questionnaire.

**If you are signing up for this study through sona-systems, you will receive class credit for your participation in the study. If you withdraw from the study prior to the conclusion, you will still be granted class credit. **

Taking part in the study is your decision. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering. Participation, non-participation or withdrawal will not affect your grades in any way. ***If you begin the study and later decide to withdraw, you will still receive research credit and there are other research credit opportunities available to satisfy your research requirement.***

We will be happy to answer any questions you have about the study. You may contact me at ekt853@mail.usask.ca, or my faculty advisor, Jennifer Nicol at jennifer.nicol@usask.ca if you have study-related questions or problems. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office at the University of Saskatchewan at 306-966-4053.

By signing the line below, you provide your full consent to participate in this study, and for your data to be used in aggregate form for analyses.

Participant Signature:_____

With kind regards,
Erica Thomson (ekt853@mail.usask.ca)

Appendix B

Survey

What is your gender?

Male _____

Female_____

Other _____

What is your age in years? (Please indicate the number on the line below)

_____

What is your ethnicity?

White or Caucasian _____

Hispanic or Latino _____

Black or African American _____

First Nations or Native _____

Asian or Pacific Islander _____

Other _____

How many years of University have you completed, including this year? (i.e., if you are a first year student, your answer will be 1.)

_____

What College are you currently attending? (i.e., Arts and Sciences, Engineering, Education, etc.)

_____

Multidimensional Perfectionism Scale (Hewitt & Flett, 1991b)

Rate your agreement or disagreement to the following statements with regards to your own thoughts and behavior. Where:
1=strongly disagree
2=disagree
3=somewhat disagree
4=neither disagree nor agree
5=somewhat agree
6=agree
7=strongly agree

1. When I am working on something, I cannot relax until it is perfect

1 2 3 4 5 6 7

2. I am not likely to criticize someone for giving up too easily

1 2 3 4 5 6 7

3. It is not important that people I am close to are successful

1 2 3 4 5 6 7

4. I seldom criticize my friends for accepting second best

1 2 3 4 5 6 7

5. I find it difficult to meet others' expectations of me

1 2 3 4 5 6 7

6. One of my goals is to be perfect in everything I do

1 2 3 4 5 6 7

7. Everything that others do must be of top-notch quality

1 2 3 4 5 6 7

8. I never aim for perfection on my work

1 2 3 4 5 6 7

9. Those around me readily accept that I can make mistakes too

1 2 3 4 5 6 7

10. It doesn’t matter when someone close to me does not do their absolute best

1 2 3 4 5 6 7

11. The better I do, the better I am expected to do

1 2 3 4 5 6 7

12. I seldom feel the need to be perfect

1 2 3 4 5 6 7

13. Anything that I do that is less than excellent will be seen as poor work by those around me

1 2 3 4 5 6 7

14. I strive to be as perfect as I can be

1 2 3 4 5 6 7

15. It is very important that I am perfect in everything I attempt

1 2 3 4 5 6 7

16. I have high expectations for the people who are important to me

1 2 3 4 5 6 7

17. I strive to be the best at everything I do

1 2 3 4 5 6 7

18. The people around me expect me to succeed at everything I do

1 2 3 4 5 6 7

19. I do not have very high standards for those around me

1 2 3 4 5 6 7

20. I demand nothing less than perfection of myself

1 2 3 4 5 6 7

21. Others will like me even if I don’t excel at everything

1 2 3 4 5 6 7

22. I can’t be bothered with people who won’t strive to better themselves

1 2 3 4 5 6 7

23. It makes me uneasy to see an error in my work

1 2 3 4 5 6 7

24. I do not expect a lot from my friends

1 2 3 4 5 6 7

25. Success means that I must work even harder to please others

1 2 3 4 5 6 7

26. If I ask someone to do something, I expect it to be done flawlessly

1 2 3 4 5 6 7

27. I cannot stand to see people close to me make mistakes

1 2 3 4 5 6 7

28. I am perfectionistic in setting my goals

1 2 3 4 5 6 7

29. The people who matter to me should never let me down

1 2 3 4 5 6 7

30. Others think I am okay, even when I do not succeed

1 2 3 4 5 6 7

31. I feel that people are too demanding of me

1 2 3 4 5 6 7

32. I must work to my full potential at all times

1 2 3 4 5 6 7

33. Although they may not say it, other people get very upset with me when I slip up

1 2 3 4 5 6 7

34. I do not have to be the best at whatever I am doing

1 2 3 4 5 6 7

35. My family expects me to be perfect

1 2 3 4 5 6 7

36. I do not have very high goals for myself

1 2 3 4 5 6 7

37. My parent rarely expected me to excel in all aspects of my life

1 2 3 4 5 6 7

38. I respect people who are average

1 2 3 4 5 6 7

39. People expect nothing less than perfection from me

1 2 3 4 5 6 7

40. I set very high standards for myself

1 2 3 4 5 6 7

41. People expect more from me than I am capable of giving

1 2 3 4 5 6 7

42. I must always be successful at school or work

1 2 3 4 5 6 7

43. It does not matter to me when a close friend does not try their hardest

1 2 3 4 5 6 7

44. People around me think I am still competent even if I make a mistake

1 2 3 4 5 6 7

45. I seldom expect others to excel at whatever they do.

1 2 3 4 5 6 7

Self-Stigma for Seeking Psychological Help (Vogel, Wade, & Haake, 2006)

Rate your agreement or disagreement to the following statements with regards to your own thoughts and behavior. Where:
1= strongly disagree
2= disagree
3= agree and disagree equally
4= agree
5= 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 professional 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

Level of Contact Report (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999)

Please read each of the following statements carefully. **AFTER** you have read all the statements below, place a check by the statements that best depict your exposure to persons with a severe mental illness. (You can check as many or few that apply to you)

3____ I have watched a movie or television show in which a character depicted a person with mental illness.

8____ My job involves providing services/treatment for persons with a severe mental illness.

2____ I have observed, in passing, a person I believe may have had a severe mental illness.

5____ I have observed persons with a severe mental ill- ness on a frequent basis.

12____I have a severe mental illness.

6____ I have worked with a person who had a severe mental illness at my place of employment.

1____ I have never observed a person that I was aware had a severe mental illness.

7____ My job includes providing services to persons with a severe mental illness.

9_____A friend of the family has a severe mental illness.

10____I have a relative who has a severe mental illness.

4____ I have watched a documentary on the television about severe mental illness.

11____I live with a person who has a severe mental ill- ness.

Appendix C

Debriefing Form

Study Title: Perfectionism: A Barrier to Seeking Psychological Help

THANK YOU FOR PARTICIPATING IN THE STUDY!

Previous research has identified a number of barriers that individuals face when seeking psychological help. One of the barriers that has recently emerged is perfectionism. Self-oriented perfectionism is exhibited by very high standards for the self, followed by an experience of failure and disappointment when those standards are not met. Previous research has also found that self-oriented perfectionism leads to a higher level of self-stigma for seeking help. In other words, these individuals have internalized the stigma associated with mental health problems, and they have experienced the impacts of that (decreased self-esteem, low self-efficacy, fear, shame, embarrassment, etc.). Therefore, it is suspected that individuals high in perfectionism experience failure when they believe they need psychological help, and the fear or embarrassment caused by self-stigma inhibits them from seeking that assistance. However, these findings are only present for those individuals who have had very little contact with an individual experiencing mental health concerns. Exposure to mental health problems appears to mediate the power of perfectionism in increasing self-stigma for seeking psychological help. To date, research has only established this phenomenon in a high school population with two types of perfectionism (self-oriented and socially prescribed). The present study aims to replicate these findings with a university population, and with three types of perfectionism (self-oriented, other-oriented and socially prescribed) instead of two.

To achieve this, we are asking that participants respond to a 75-item questionnaire regarding their levels of varying types of perfectionism, their levels of self-stigma for seeking psychological help, and their level of contact with individuals who have mental health problems. It is expected that the higher your score on all three types of perfectionism, the higher your levels of self-stigma for seeking psychological help. It is also expected that this will only occur for those individuals who have had very low exposure to individuals experiencing mental health concerns.

This study is conducted for a Master's thesis project. Results from this study may be published and or presented at a conference; however, your data will remain in aggregate form and therefore will be completely confidential. If you would like to see the results of our study we would be happy to provide you with a final copy of the project once it is complete.

There is minimal risk associated with participation in this study; however, in the unlikely event that you experience any issues you wish to explore in a therapeutic context, the University's counseling department information is listed below.

If you have any questions or concerns about this study, do not hesitate to contact the student or her supervisor.

Student: Erica Thomson- ekt853@mail.usask.ca
Professor: Jennifer Nicol- jennifer.nicol@usask.ca

Alternatively, you can contact the Head of the Department of Education Psychology at 306-966-6931 or the Office of Research Services at 306-966-4053.

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