Stigma Resistance versus Self-Stigma in University Students with Mental Health Problems

By

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Abstract

Self-stigma is the process by which an individual is aware of, agrees with, and internalizes demeaning societal stereotypes and prejudices. Stigma resistance is when an individual may be aware of societal stigma, yet they ignore or challenge the stereotypes and resist internalizing stigma. This current research examined self-stigma and stigma resistance in the realm of mental health help-seeking and mental illness (i.e., depression and anxiety). I aimed to investigate how intrapersonal factors and life experiences contributed to mental health stigma resistance. Study 1 employed online mixed method research with 366 participants to explore how self-compassion, self-coldness, and mental health self-efficacy may impact stigma resistance and potentially moderate the relationship between perceived and self-stigmas of help-seeking and of depression and anxiety. Study 2 utilized an Interpretive Phenomenological Analysis (IPA) approach with five participants with depression or anxiety to explore their lived experiences of resisting mental health stigma. Study 1 revealed that self-compassion had an approaching significant moderating effect on self-stigma of help-seeking, and self-efficacy had a significant moderating effect on self-stigma of depression and anxiety, yet self-compassion and self-efficacy, but not self-coldness, had main effects on mental health stigma resistance. Study 2 constructed six superordinate themes of stigma resistance: accepting one's mental health experiences, transparency about mental health experiences, blocking public stigma, taking actions to better oneself, receiving social support, and extending stigma resistance to others. Rather than focusing on reducing negative psychosocial factors, these findings point toward empowering traits and experiences that can be targeted to increase stigma resistance.

Dedication

For my Grandmum Joy, in loving memory of a radiant grandmother.

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Table of Contents

Introduction 1
Defining Stigma 2
Stereotypes and Prejudice 2
Discrimination 3
Types of Stigma 4
Structural Stigma 4
Stigma by Association 4
Public Stigma 5
Perceived Stigma 5
Anticipated Stigma 6
Self-Stigma 6
Mental Health Self-Stigma 7
The “Why Try” Effect 9
Impact of Mental Health Stigma on Help-Seeking 10
Help-Seeking Self-Stigma 11
Help-Seeking and Distress 13
Theoretical Models of Self-Stigma 14
Link’s Modified Labeling Theory 14
Corrigan and Colleagues’ Process Model of Self-Stigma 15
Coping with and Resisting Stigma 17
Coping with Stigma 18
Avoiding/Secrecy 18

Self-Restoring/Self-Protecting ... 19
Resilience to Stigma ... 20
Stigma Resistance ... 21
Anti-Stigma Efforts ... 22
Public Stigma Interventions ... 22
Personal Stigma Interventions/Therapeutic Approaches ... 23
Disclosure as a Form of Stigma Resistance ... 25
Impact of Stigma Resistance ... 27
Theoretical Models of Stigma Resistance ... 30
The Situational Model of Personal Response to Stigma ... 31
Thoits' Model of Resisting the Stigma of Mental Illness ... 31
Stigma Resistance Model at the Personal, Peer, and Public Levels ... 33
Integration of Models of Stigma Resistance ... 34
Study 1: Do Self-Compassion and Mental Health Self-Efficacy Moderate Relationships Between Perceived and Self-Stigma/Stigma Resistance? ... 35
Self-Compassion ... 36
Self-Coldness ... 40
Self-Compassion and Help-Seeking Self-Stigma ... 42
Competence/Self-Efficacy ... 43
Young Adults and Mental Health Stigma ... 45
Research Objective 1 ... 47
Hypothesis 1: ... 48

Note. Hypotheses 1: Self-compassion (and less self-coldness) and self-efficacy will negatively correlate with self-stigma and positively correlate with stigma resistance. 48
Research Objective 2 48
Hypothesis 2.......... 48
Hypothesis 3.......... 48
Hypothesis 4: 49
Research Objective 3 50
Methods.......... 50
Participants.......... 50
Demographics 50
Preliminary Mental Health Status and Use of Psychological Services Items 52
Study Measures.......... 53
Depression Anxiety Stress Scale (DASS-21). 53
Self-Compassion Scale. 53
Self-Perceived Overall Competence 54
Mental Health Confidence Scale 55
Stigma Scale for Receiving Psychological Health (SSRPH 55
The Self-Stigma of Seeking Psychological Help Scale (SSOSH). 56
Perceived Stigma of Depression and Anxiety Scale (PSDAS). 57
Self-Stigma of Depression and Anxiety Scale (SSDAS). 57
Stigma Resistance Scale (SRS). 58
Qualitative Questions on Self-Stigma Resistance.......... 59
Attention Questions. 59

Procedure ... 59
Data Screening ... 60
Data Analysis ... 61
Quantitative Analysis ... 61
Qualitative Thematic Analysis ... 62
Results ... 63
Descriptive Statistics for Main Constructs ... 63
Gender Differences ... 63
Correlations Between Self-Compassion, Self-Efficacy, Self-Stigma, and Stigma Resistance ... 64
Predicting Self-Stigma of Help-Seeking from Self-Compassion, Self-Coldness and Mental Health Self-Efficacy ... 66
Predicting Self-Stigma of Depression and Anxiety from Self-Compassion, Self-Coldness and Mental Health Self-Efficacy ... 69
Predicting Stigma Resistance from Self-Compassion, Self-Coldness and Mental Health Self-Efficacy ... 72
Thematic Analysis of Qualitative Data ... 74
General Mental Health Stigma Resistance ... 75
Coming to Terms with Experiences. ... 75
Opening Up about Struggles. ... 77
Becoming Comfortable with Seeking Help. ... 78
Sharing Experiences with Others ... 81
Education and Advocacy. ... 84
Righteous Anger. ... 86

Resisting with Self-Compassion ... 87
Self-Kindness ... 88
Self-Care ... 89
Normalizing Experiences as Common ... 91
Mindful Evaluations and Detachment. ... 93
Struggling with Practicing Self-Compassion ... 95
Resisting with Competence and Skills ... 96
Feeling Capable and Empowered ... 97
Not Suffering in All Areas of Life/Mental Health Coping Skills ... 99
Struggling with Perceiving and Displaying Competence. ... 101
Summary ... 103
Discussion ... 104
Help-Seeking Stigma ... 104
Gender ... 105
Self-Compassion ... 105
Self-Coldness and Distress ... 106
Mental Health Self-Efficacy ... 107
Mental Health Stigma and Stigma Resistance ... 108
Gender ... 108
Diagnosis ... 108
Perceived Stigma ... 109
Distress ... 109
Self-Compassion and Self-Coldness ... 110

Mental Health Self-Efficacy ... 111
Conclusion ... 112
Study 2: The Lived Experiences of Resisting Self-Stigma of Depression and Anxiety ... 113
Methods ... 114
Study Design ... 114
Participants ... 115
Participant #1 – Ava ... 117
Participant #2 – Cami ... 117
Participant #3 – Heather ... 117
Participant #4 – Jordan ... 117
Participant #5 – Nicholas ... 118
Procedure ... 118
Semi-Structured Interview ... 119
Interview Schedule ... 119
Analysis ... 119
Quality, Reflexivity, and Rigor ... 121
Results ... 122
Common Previous and Ongoing Experiences of Stigma ... 122
External Invalidation ... 122
Internalizing Stigma ... 123
Themes of Stigma Resistance ... 123
Accepting One's Mental Health Experiences ... 124
Coming to Terms with Experiences ... 124

Validating and Normalizing Experiences 126
Transparency about Mental Health Experiences 128
Opening Up. 128
Becoming Comfortable with Disclosure 130
Blocking Public Stigma 131
Not Being Defined by the Illness 131
Believing you are Sick not Weak. 133
Separating Self from Others' Opinions. 135
Taking Actions to Improve Mental Health 137
Self-compassion 137
Seeking Help. 139
Working Toward Recovery of Mental Health 140
Receiving Social Support 142
Receiving Compassion and Validation from Others. 142
Having a Network of Similar Others. 144
Increased Societal Awareness and Understanding. 146
Extending Stigma Resistance to Others 148
Having Compassion and Helping Others. 148
Spreading Awareness and Education. 149
Summary 152
Discussion 153
Connection to Literature Review Defining Stigma and Stigma Resistance 153
Theme One: Accepting One's Mental Health Experiences 155

Theme Two: Transparency about Mental Health Experiences ... 156

Theme Three: Blocking Public Stigma ... 158

Theme Four: Taking Actions to Better Oneself ... 160

Theme Five: Receiving Social Support ... 162

Theme Six: Extending Stigma Resistance to Others ... 163

Conclusion ... 165

Connections Among Studies 1 and 2 ... 165

Stigma vs. Stigma Resistance ... 165

Self-Compassion, Self-Coldness, and Stigma Resistance ... 166

Mental Health Self-Efficacy, Perceived Competence, and Skills and Stigma ... 168

Limitations and Future Research ... 170

References ... 175

Appendices ... 207

List of Tables and Figures

Table 1 *Study 1 Participant Demographics* 51

Table 2 *Descriptive Statistics and Cronbach's Alphas for Study Scale* 63

Table 3 *Correlations of Predictor and Stigma Variables (All Participants)* 64

Table 4 *Correlations of Predictor and Stigma Variables (Females)* 65

Table 5 *Correlations of Predictor and Stigma Variables (Males)* 65

Table 6 *Hypothesis 2: Regression onto Self-Stigma of Help-Seeking* 67

Table 7 *Hypothesis 3: Regression onto Self-stigma of Depression and Anxiety* 70

Table 8 *Hypothesis 4: Regression onto Stigma Resistance* 72

Table 9 *Study 1: Themes Related to Stigma Resistance, Self-Compassion, and Competence* 74

Table 10 *Participant Demographic Information* 116

Table 11 *Study 2: Superordinate and Subordinate Themes Related to Stigma Resistance* 123

Figure 1 *Hypotheses of Expected Correlations* 48

Figure 2 *Hypotheses of Self-compassion, Self-Coldness, and Self-Efficacy as Moderators* 49

Figure 3 *Moderation of Self-Compassion between Help-Seeking Stigmas* 68

Figure 4 *Moderation of Mental Health Self-Efficacy between Depression and Anxiety Stigmas* 71

Stigma Resistance versus Self-Stigma in University Students with Mental Health Problems

Currently, mental health stigma is pervasive and acutely damaging throughout society (Hinshaw, 2007). Not only are mental health difficulties or mental illness associated with a lower quality of life due to the symptoms of the disease, but the stigma of mental illness can be a "double-edged sword" (Corrigan & Wassel, 2008), as there is also a personal demoralization with the stigma that may leave the individual to cope with double the burden of both disease and discrimination (Corrigan & Penn, 1997). In his seminal work on stigma, Goffman (1963) identified three forms of the discrediting or potentially discreditable attribute, being stigmas of 1) physical attributes (e.g., blindness), 2) group identity (e.g., Jewish), and 3) moral or character traits (e.g., addiction) (examples are Goffman's own). In early Greece, stigma referred to a tattoo or a mark, such as the branding of a slave (Goffman, 1963). Although in contemporary times, mental illness is not associated with a tattoo or a mark per se, the label or diagnosis and symptoms can make the mental illness apparent (Corrigan, 2000) and therefore subject to stigma (i.e., according to Goffman [1963], a stigma of moral or character traits). Luckily, not all individuals are negatively impacted by stigma and personal demoralization—people may even resist the stigma and improve in quality of life and attitudes towards themselves (see review by Firmin, Luther, et al., 2016).

The current research examined constructs and experiences associated with the stigma of mental health. My research planned to answer two main questions: 1) What intrapersonal factors relate to resistance to internalized mental health stigma and a reduction in help-seeking stigma? 2) What are the lived experiences of resisting internalizing stigma of depression and anxiety? Study 1 used a mixed methods approach to test the influence of two intrapersonal factors that are theorized to reduce internalized stigma (i.e., self-stigma; Corrigan et al., 2006): competence/self-

efficacy and self-compassion (Stringer et al., 2018). Study 2 qualitatively examined the experiences individuals with mental health difficulties (including diagnosed and undiagnosed mental illness) have in resisting the stigma of depression or anxiety. Both studies expanded the literature on mental health stigma and associated factors and experiences that help an individual resist internalizing stigma. The literature review begins with a general discussion of mental health-related stigma and subsequently narrows in on self-stigma and stigma resistance.

Defining Stigma

Stigma is a multifaceted construct that involves the coexistence of "labeling, stereotypes, separating, status loss, and discrimination" together in a situation with social, economic, or political power differences between people without a stigmatizing condition and people with the condition (Link & Phelan, 2001). Link and Phelan (2001) argued that the commonly seen cognitive components of labeling and stereotypes do not define stigma on their own, as the resulting harmful outcomes to the group without power (i.e., separation, status loss, and discrimination) are also crucial components of the stigma construct. Similarly, stigma has been defined as three social-cognitive structures: stereotypes, prejudices, and discrimination, occurring when society dictates a label (e.g., mental or physical ailment) as unfavorable (Sheehan et al., 2017). The three social-cognitive structures of stigma relate as such: belief and endorsement in common stereotypes may cause an emotional reaction in the form of prejudice that may establish the incentive for discriminatory behaviors (Corrigan & Shapiro, 2010; Corrigan & Wassel, 2008; Sheehan et al., 2017).

Stereotypes and Prejudice

Stereotypes and prejudice comprise judgmental thoughts and feelings toward those who deviate from "normal." In terms of mental health, common stereotypes are that people with a

mental illness are incompetent (e.g., not capable of real work; should be subjected to authoritarianism or benevolence), dangerous (e.g., unpredictable and potentially violent; should be socially restricted), blameworthy (e.g., lacking moral character) and that the mental illness is permanent (i.e., the individual is unchangeable; Corrigan, 2000; Corrigan & Shapiro, 2010; Sheehan et al., 2017). Prejudice is the emotional reaction resulting from the agreement with the public attitude. For example, one might feel afraid (i.e., prejudice) if one believes that all people with mental illness are incompetent, dangerous, and blameworthy (Corrigan & Shapiro, 2010; Corrigan & Wassel, 2008).

Discrimination

When individuals act on their prejudice directed toward an individual with mental health difficulties, they may show discriminatory behavior, including unfair treatment in terms of employment, housing, affiliation, and segregation, such as through hospitalizations or institutionalization (Corrigan, 2000; Corrigan & Shapiro, 2010). With society moving away from the institutionalization of those with mental illness, housing discrimination may be seen in the form of "psychiatric ghettoes" or urban neighborhoods predominantly resided in by individuals with mental illness due to deinstitutionalization and suburbanization of the more privileged outgroup (Hudson, 2012). Alternatively, discrimination may impact poor mental health, as multiple forms of discrimination (e.g., racism, heterosexism) are associated with a higher risk of depression (Vargas et al., 2020).

Link and Phelan (2001) have conceptualized discrimination at an individual level (e.g., a land-lord rejecting a housing application of an individual with a known diagnosis), at a structural level (e.g., less research funding for schizophrenia than other illnesses), as well as via a social psychological process within the stigmatized person. In this latter form of discrimination, there

may be no explicit unfair treatment from others, yet the stereotyped individual's worldview may lead to self-devaluation. For instance, individuals who internalize stigma may lose ambition to achieve goals, work towards recovery, or feel good about themselves (Corrigan et al., 2009; Corrigan et al., 2016).

Types of Stigma

Mental health or mental illness stigma can also be broken down into various types of stigma, including structural stigma, stigma by association, public stigma, perceived stigma, and self-stigma or internalized stigma. All types of stigma may have cognitive, affective, and behavioral components (Sheehan et al., 2017).

Structural Stigma

Societal stigmatizing beliefs that individuals with mental illness are incompetent, dangerous, and blameworthy may spur unfair treatment from a structural level (Sheehan et al., 2017). Structural stigma can be seen in the form of public and private sector policies (unintentionally or intentionally) restricting opportunities for the stigmatized group (Corrigan, 2004). Examples of structural stigma toward those with mental illness include inadvertent biases in the media, lessened quality of or access to care, communication exclusion, as well as more blatant restrictions such as from voting or holding public office and parental rights restrictions due to past history of mental illness (Sheehan et al., 2017).

Stigma by Association

Not only are the stigmatized groups themselves affected by stereotypes toward those with mental illness, but there may be a stigma by association or "courtesy stigma" (coined by Goffman, 1963), wherein the negative stereotypes, prejudice, and discrimination toward those with mental illness apply to people who are connected to the stigmatized individual (Sheehan et

al., 2017). Stigma by association may be experienced on a more implicit level for acquaintances of individuals with mental illness, while individuals with more meaningful relationships with people with mental illness may experience stigma by association on both an implicit and explicit level (Pryor et al., 2012). For instance, shame and psychological distress surrounding the stigma may lead to increased social distance from individuals with mental illness for mental health providers, friends, and family of those with mental illness (Sheehan et al., 2017).

Public Stigma

Public stigma includes the public endorsement of beliefs, prejudice, and discrimination about particular conditions or minority groups (Sheehan et al., 2017). Social reactions to mental illness could be that of pity followed by wanting to help, or fear and anger followed by punishing behaviors, depending on how stable and controllable the mental illness is (Corrigan, 2000). Even if an individual with a mental illness can hide their condition from others (and perhaps avoid overt discrimination), he or she is still made vulnerable to what society believes about mental illness and how society behaves toward those with mental illness. Public stigma is also referred to as personal stigma, defined as an individual's personal beliefs and stereotypes about mental illness and mental health service use (Aromaa et al., 2011; Eisenberg et al., 2009).

Perceived Stigma

Additionally, whether accurate or not, how public stigma is perceived (i.e., perceived public stigma) may also directly affect the stigmatized group (e.g., Eisenberg et al., 2009; Vogel et al., 2006). Perceived stigma has been conceptualized as the perceptions of what most other people believe concerning a particular condition (e.g., depression; Griffiths et al., 2004). Perceived stigma is a preceding component of self-stigma (Vogel et al., 2013). Perceived stigma/perceived public stigma is the awareness of the stereotypes associated with stigma, while

self-stigma is when one adopts the stigma one is made aware of and applies it to oneself (Corrigan et al., 2006). Livingston and Boyd's 2010 meta-analysis on internalized stigma (sometimes synonymous with self-stigma) included measures of perceived stigma (e.g., Perceived Devaluation and Discrimination; Link, 1987), illustrating the conceptual overlap between the constructs of perceived and self-stigma.

Anticipated Stigma

Perceived stigma has also been referred to as anticipated social stigma and anticipated discrimination (e.g., Quinn et al., 2015), although anticipated stigma is considered to be related but distinct from perceived and self-stigma (Guarneri et al., 2019). Anticipated stigma is the anticipation of personally being perceived or treated unfairly if others were to know of one's concealable stigmatized identity (Quinn & Chaudoir, 2009).

Self-Stigma

Lastly, self-stigma is a form of stigma that looks at how the individual in the stigmatized group is affected when they internalize public stigma stereotypes and prejudices and personally incorporate negative viewpoints and behaviors into their life (Sheehan et al., 2017). Notably, perceived stigma, public stigma, and self-stigma have, at times, been used interchangeably throughout the literature (Xu et al., 2017), although the three forms of stigma have been deemed separate constructs (Grant et al., 2016).

When an individual internalizes society's attitudes and reactions, they might feel the burden of stigma and start to believe the stereotypes and negative connotations of the labels they have been given (Corrigan, 2004; Corrigan et al., 2006; Corrigan & Watson, 2002). An example of public mental health stigma might be the thought, "People with depression are weak." whereas a parallel example of self-stigma would be the thought, "I am weak because I have depression."

Help-seeking self-stigma is a similar yet separate construct to mental health self-stigma (Lannin et al., 2014). Just as an individual with a diagnosis of mental illness may perceive they will be judged and internalize the shame (Corrigan et al., 2006), an individual who is seeking treatment for mental health or emotional issues may similarly worry about what others will think of them, which can lead to feelings of shame and inadequacy (Lannin et al., 2014; Vogel et al., 2006).

Despite many types of stigma in the mental health literature (for an overview see Sheehan et al., 2017), this current dissertation mainly concentrates on self-stigma (i.e., mental health self-stigma and help-seeking self-stigma). Although much is being done and should be done about public stigma (Arboleda-Flórez & Stuart, 2012), this research is focused on a more intrapersonal level of understanding of mental health stigma due to harms from the internalization of stigma, or the self-stigmatization process. The current studies aim to explore ways to reduce self-stigma and, subsequently, the negative impact that self-stigma has on individuals with mental health difficulties. Both of my studies will tackle the issue of self-stigma and explore how individuals may resist intrapersonal stigma beyond societal stigma. Study 1 measures perceived (i.e., perceived public stigma attitudes) and self-stigma attitudes and also assesses what intrapersonal factors reduce the strength of the relationship between the two forms of stigma. Study 2 analyzes individuals' experience of resisting stigma, particularly resistance to self-stigma.

Mental Health Self-Stigma

Self-stigma of mental illness can have harmful effects, making it a high-priority topic for basic and applied research. Mental illness itself is a burden on the individual suffering, as well as in broader contexts, with mental illness as the most massive global burden of disease in terms of years lived with disability (Vigo et al., 2016). In addition to this global burden are the harsh stereotypes and negative labels that become highly internalized. According to a large-scale

European study with members of mental health charity organizations, moderate or high levels of self-stigma were present for 22% of individuals with depression or bipolar disorder (Brohan, Gauci, et al., 2010) and for 42% of people with schizophrenia (Brohan, Elgie, et al., 2010). Notably, these findings come from individuals who are utilizing mental health services and may be using stigma coping strategies, making these numbers a potential underestimation of the prevalence of self-stigma (Brohan, Elgie et al., 2010; Brohan, Gauci, et al., 2010).

In a systematic review and meta-analysis, specific psychosocial and psychiatric outcomes related to self/perceived stigma of mental illness, as the variables were combined under the term "internalized stigma" (Livingston & Boyd, 2010). The meta-analysis included 45 studies on adults diagnosed with a mental illness (primarily schizophrenia spectrum, mood or anxiety disorders), primarily based in North America, Europe, and Asia, with 57% of the reported ethnicities Caucasian. Various measures of self-stigma and perceived stigma were found to have negative associations with other psychosocial variables, including empowerment, mastery, hope, self-esteem, self-efficacy, quality of life, and social support (Livingston & Boyd, 2010). As for psychiatric outcomes, self/perceived stigma was found to be positively associated with psychiatric symptom severity and negatively associated with treatment adherence (Livingston & Boyd, 2010). However, no sociodemographic variables (i.e., sex/gender, age, education, employment, marital status, income, and ethnicity) were strongly correlated with levels of stigma (Livingston & Boyd, 2010).

The causality between self/perceived stigma and the aforementioned variables was not clarified by Livingston and Boyd (2010), yet it has been speculated that psychosocial and medical treatment factors may themselves disempower individuals with mental illness, which could perpetuate more negative outcomes (Corrigan, 2004). For instance, self-stigma is

associated with a reduced recovery orientation (i.e., less beliefs that one can achieve remission and normal self; Ritsher et al., 2003). More recently, self-stigma has been found to lower the effectiveness of both the medication and treatment of anxiety disorders (Ociskova et al., 2018).

Identifying as having a mental illness and internalizing the stigma can lower an individual's personal agency, including lessening their chances of claiming positive and potent identities related to work, family, and academia (Harkness et al., 2016). The reduction in self-esteem and personal agency that comes with self-stigmatization may compel the individual toward maladaptive interactions and disengagement from former social roles. For example, individuals with chronic mental illness may adopt a sick role, wherein they become exempt from normal societal roles and become desocialized (Harkness et al., 2016).

The "Why Try" Effect

Many studies have found that self-stigma is associated with poorer well-being and treatment outcomes. For instance, self-stigma correlated positively with a diminished sense of personal recovery (Corrigan et al., 2016), long-term suicidal ideation (Oexle et al., 2017), and, even after controlling for depression and shame-proneness, self-stigma negatively correlated with self-esteem, self-efficacy, and quality of life (Rüsch et al., 2006). This reduction in self-efficacy and well-being may be explained by a sense of "why try" once an individual identifies as having a mental illness and internalizes the negative associations with mental illness. The "why try" phenomenon occurs when an individual internalizes stigmatizing stereotypes and loses faith that they can achieve personal goals (Corrigan et al., 2009; Corrigan et al., 2016). The consequences of the "why try" effect show a significant impact of stigma, both emotionally and behaviorally: people give up on themselves and their goals (Corrigan et al., 2016). Individuals who internalize stigma may lose self-respect and consequently not want to pursue goals because

everything seems futile (Corrigan et al., 2016). Corrigan and colleagues (2016) used a path model analysis, showing "why try" as an outcome of self-stigma, yet due to the cross-sectional nature of the study, the consequence of "why try" may be a result of the mental illness itself or other variables.

Impact of Mental Health Stigma on Help-Seeking

Although mental illness self-stigma and help-seeking self-stigma have been identified as distinct constructs (Tucker et al., 2013), the stigma that an individual may perceive and/or internalize about having mental health difficulties may extend to stigma about seeking help for psychological services themselves. People who wish to hide their illness may avoid engaging in activities that reveal a diagnosis (e.g., label avoidance; Sheehan et al., 2017), and treatment services may, in turn, be avoided or given up to avoid the label and associated stigma. For example, stigma was identified as a barrier to care-seeking by more than one out of five individuals in a meta-analysis of 27,572 participants (Clement et al., 2015). This meta-analysis examined the median correlations of variables across studies, showing varied associations between help-seeking and different types of mental health stigma, including anticipated stigma (median d = -.15), perceived public stigma (median d = -.02), stigma endorsement/personal stigma (median d = .05), self-stigma (median d = -.23), and treatment stigma (median d = -.41). Another review and meta-analysis identified how negative attitudes toward people with mental illness (OR = .82) and toward mental health help-seeking (OR = .80) were associated with less active help-seeking, while self-stigma and perceived public stigma were not significantly associated with active help-seeking (Schnyder et al., 2017).

Help-Seeking Self-Stigma

Mental illness stigma is a significant barrier to help-seeking (Clement et al., 2015). Help-seeking self-stigma occurs when an individual is aware of and internalizes negative attitudes toward seeking help for mental health, feels inadequate for seeking help, and worries what others will think of them for getting mental health services (Vogel et al., 2006). This is also called treatment stigma (Clement et al., 2015). Both mental illness self-stigma and help-seeking self-stigma are linked to negative self-perceptions, shame, demoralization, and reduced self-esteem (Lannin et al., 2014).

A study was conducted with undergraduate students in the United States examining the relationships between perceived public stigma of both mental illness and help-seeking as well as self-stigma of both mental illness and help-seeking (Lannin et al., 2014). Structural equation modeling revealed that self-stigma of both mental illness and help-seeking mediated the effects of perceived public stigma on reduced self-esteem and intentions to seek counseling (Lannin et al., 2014). This analysis illustrated that public stigma might directly impact self-stigma, leading to self-esteem decrement along with a negative impact on attitudes and behaviors of help-seeking for psychological services (Lannin et al., 2014).

Gender, culture, and economic and professional background also influence the variability of help-seeking attitudes and behaviors. Meta-analyses on help-seeking attitudes have shown that in many studies men were less likely than women to hold positive views toward help-seeking and less likely to seek support, although some studies have noted either a lack of gender differences or opposing results (Nam et al., 2010). This discrepancy across gender may be due to gender role conflict (reviewed by Nam et al., 2010), including masculine scripts of manly self-reliance and guarded vulnerability (Johnson et al., 2012; Vogel et al., 2011).

The literature reveals that expectations about counseling (i.e., help-seeking experiences) are differentiated by the personality factors of neuroticism (sensitive, emotional), extraversion (sociable, active), and openness to experience (intellectually curious and behaviorally flexible) (Schaub & Tokar, 1989), with the most robust relationship being between openness to experience and help-seeking (Bathje et al., 2014). There is also a difference in gender for these constructs: for men, neuroticism, openness, and agreeableness (trusting, sympathetic, cooperative) were correlated with help-seeking attitudes; for women, openness and extraversion were correlated with help-seeking attitudes (Kakhnovets, 2011).

Some cultural and ethnic minorities are more likely to experience the stigma of help-seeking, including Asian Americans and Arabic students in the United States and Israel and Pacific Islanders (Clement et al., 2015; Eisenberg et al., 2009). Cultural factors are likely to impact mental health service use, depending on the general knowledge people have about mental health, social networks, and family values (Corrigan et al., 2014; Yang et al., 2014). For instance, Asian Americans may be prone to family shame concerning mental illness (Yang et al., 2014).

Some factors associated with not seeking help or engaging in services include a lack of perceived need, being unaware of insurance coverage, distrust about the effectiveness of the service, as well as ascribing to dominant masculine norms (Eisenberg et al., 2007; Latalova et al., 2014; Vogel et al., 2011). The anticipation that professional helpers (e.g., general practitioners, psychiatrists, psychologists, and counselors) will be condescending, that one will be regarded as unbalanced or neurotic, and whether one worries that other people would think less of them have also had an impact on help-seeking intentions (Barney et al., 2006). A meta-analysis of 19 studies found that the top three variables that impacted help-seeking attitudes were self-stigma of

seeking help, anticipated benefits of disclosing to a counselor, and willingness to self-disclose (Nam et al., 2013). These factors correlated with help-seeking attitudes at a more significant level than public stigma, anticipated risks of disclosure, depression, social support, and self-concealment (Nam et al., 2013). Additionally, a recent meta-analysis found that endorsement of a biogenetic cause of mental illness was associated with a positive attitude toward help-seeking (with the caveat being that biogenetic beliefs increased beliefs of dangerousness; Baek et al., 2023).

Help-Seeking and Distress

There is some variability in the literature as to the relationship between help-seeking and distress. In a study with United States college students, psychological distress was significantly related to help-seeking self-stigma but not to help-seeking attitudes (e.g., inclination to seek help; Surapaneni et al., 2018). Additionally, a meta-analysis found no significant relationship between attitudes toward help-seeking and levels of psychological distress (Nam et al., 2013). One study found that distressed students with anxious attachment styles had more favorable attitudes toward seeking help due to a higher perceived need, while the same pattern was not found for individuals with avoidant attachment styles (Vogel & Wei, 2005). In a nonclinical sample, a study found that college students with moderate or severe psychological distress were less likely to endorse seeking professional help than students with mild levels of distress (Kim et al., 2015). The authors considered that higher levels of distress (including depression symptomatology) might interfere with problem recognition, which may be related to varying degrees of mental health literacy (i.e., knowledge and beliefs about mental disorders and treatment; Kim et al., 2015). Overall, distress may impact help-seeking and self-stigma of help-seeking (e.g.,

Surapaneni et al., 2018, Vogel & Wei, 2005), yet more research is needed to clarify the relationship between these variables.

Theoretical Models of Self-Stigma

How does an individual come to internalize stigma and self-stigmatize oneself for having a label or for seeking treatment for a condition? As the current research focuses on self-stigma, I compared various theoretical models to understand and operationally define the construct. Theoretical frameworks for how self-stigma occurs and affects individuals include the modified labeling theory (Link, 1982, 1987; Link et al., 1989) and the process model of self-stigma (Corrigan et al., 2006).

Link's Modified Labeling Theory

Classic labeling theories show how the "I" is inherently connected to society (i.e., Cooley's [1902] looking-glass self says that people see themselves according to how they perceive others to see them), how people labeled as "deviant" become outsiders and see themselves as "deviant" (e.g., Becker, 1963), and how labeling influences identity formation and asserts the stability of the mental illness (Scheff, 1984). As an extension of these theories, Link's Modified Labelling Theory (Link, 1982, 1987; Link et al., 1989) described that labeling is an indirect way to prolong mental illness as the stereotypes learned early in life from society are personally incorporated. Through a socialization process, individuals learn what "normal" is, followed by learning that possession of stigma is discrediting (Goffman, 1963). This conception of what it means to be stigmatized creates expectations that individuals with a label of mental illness will be devalued and discriminated against, and it leads to a fear of rejection if and when they receive the label (Link, 1982, 1987). More current research has identified that perceived public stigma predicts self-stigma (and not vice versa; Vogel et al., 2013), further supporting

Link's Modified Labeling Theory, which emphasizes the harm that perceptions of negative public attitudes can have on individuals who hold the stigmatized identity (Link, 1982, 1987).

Labeling is a key element in the stigmatization process for adults. For example, a sample of both mental health patients as well as untreated community residents believed that mental health patients would be rejected and devalued, with both groups endorsing secrecy, withdrawal, and education to cope with a fear of rejection (Link et al., 1989). People had negative beliefs about how those with mental illness would be treated regardless of whether or not they were receiving treatment (Link et al., 1989), which illustrates how socialization with labels may cause internalization of stigma before one even receives a label. Several studies using Link's (1987) Perceived Devaluation and Discrimination scale have revealed a strong negative relationship between perceived stigmatization and positive psychosocial variables (e.g., hope, empowerment, self-esteem; see meta-analysis by Livingston & Boyd, 2010). On the other hand, labeling theories may be less pertinent for children, as a systematic review in the United Kingdom found that labeling was not a substantial factor associated with the stigmatization of mental health issues compared to the blatant behaviors that did increase stigmatization among children aged 7-19 (Kaushik et al., 2016).

Corrigan and Colleagues' Process Model of Self-Stigma

Newer theoretical models expand on how the devaluation of the label comes into effect when the individual has a label or identifies with the condition. Corrigan and colleagues' (2006) process model describes how a three-level process of stereotype agreement, self-concurrence, and self-esteem decrement create self-stigma. This process model of self-stigma was later conceptualized as "three A's": awareness, agreement, and application of the stereotype to the self, with the results of this process being self-esteem decrement and related adverse outcomes

(e.g., Corrigan et al., 2009). Stereotype awareness is based on the construct of perceived discrimination and devaluation (Link, 1982, 1987). Stereotype agreement is distinguished from stereotype awareness, as it describes when the individual not only perceives the same stereotypes the public does but also agrees with them (Corrigan et al., 2006). Self-concurrence is when individuals believe that the perceived stereotypes apply to them (Corrigan et al., 2006). Corrigan and colleagues (2006) stated that this process of self-concurrence is when the individual can be harmed by self-stigma, as they start to think, for example, that they are incompetent, worthless, and to blame for their illness.

The final part of the process is self-esteem decrement, wherein the individual experiences diminished self-esteem due to the agreement and self-application of negative stereotypical beliefs (Corrigan et al., 2006). Internalized stigma may render adverse outcomes beyond low self-esteem, including feelings of shame, low self-efficacy, and demoralization (Corrigan, 2004; Link, 1982, 1987). Self-esteem decrement has been conceptualized as a part of the self-stigma process (Corrigan et al., 2006), although others have conceptualized self-esteem decrement as an outcome rather than a process of self-stigma (e.g., Drapalski et al., 2013). Notably, most of the studies on empowerment and stigma were cross-sectional (Firmin et al., 2016), so it is possible that empowerment, and related constructs, such as self-efficacy, are both predictors and outcomes of stigma and stigma resistance.

The Self-Stigma of Mental Illness Scale (SSMIS) follows the definition set out by Corrigan and colleagues (2006) in measuring self-stigma with subscales of stereotype awareness, stereotype agreement, self-concurrence, and self-esteem decrement. The initial two studies with the SSMIS included participants with psychiatric disabilities (as determined by the Social Security Administration) and found the three levels of self-stigma were significantly

intercorrelated (Corrigan et al., 2006). The study also revealed that the three levels of self-stigma were distinguished from stereotype awareness and that self-concurrence and self-esteem decrement were also significantly associated with measures of self-esteem and self-efficacy, even after partialling out depression scores. In a more recent cross-sectional study, among a sample from MTurk (an online crowdsourced sampling platform), stereotype agreement predicted stereotype self-concurrence, which predicted diminished self-esteem; however, awareness of stereotypes did not predict agreement with stereotypes (Corrigan et al., 2016). This current study further supported the process of self-stigma coming from stereotype agreement and application and subsequently impacting one's sense of self (Corrigan et al., 2006).

Considering the mentioned theories of self-stigma, self-stigma can be conceptualized as the anticipation of a label leading to rejection (i.e., aspects of perceived stigma; Link, 1987), the agreement with stereotypes, and the application of stereotypes to oneself (Corrigan et al., 2006). For the current research, theoretical models (i.e., Corrigan et al., 2006; Link, 1987) will be integrated in order to define self-stigma as a process wherein an individual with mental health difficulties internalizes and applies stigmatizing attitudes and stereotypes to oneself, experiencing negative feelings about oneself and anticipating negative social reactions on the basis of having or receiving help for a mental health difficulty.

Coping with and Resisting Stigma

Beyond the internalization of stigma, people may react and respond to stigma in a myriad of ways. For instance, there may be avoidance (e.g., Link et al., 1991), self-protection (Shih, 2004), resilience (Stringer et al., 2018), or outright stigma resistance (e.g., Thoits et al., 2011). While much research has focused on the negative impact of stigma, I was interested in

identifying the opposite of self-stigma and exploring how individuals become empowered in the face of stigma.

Coping with Stigma

The literature on stress coping has a theoretical basis in stress models. Lazarus and Folkman's (1984) classic coping model delineated that individuals may perceive stressors as a threat or challenge, impacting the subsequent response to the stressor. The theorists explained how psychological stress is related to the personal characteristics each person has: to a similar situation, one person may respond with a depressed mood, another with anger, and another with indifference. The coping responses following the appraisal of a stressful encounter can vary in their degrees of effectiveness (Fletcher & Sarkar, 2013). In terms of coping with stigma, individuals may respond to stigma by dealing with the emotional aspects of the stereotypes, prejudice, and discrimination in both beneficial and damaging ways (Frost, 2011). Besides self-stigmatization, individuals may deal with stigma by avoiding, self-restoring, or resisting stigma via challenging or deflecting (Thoits, 2011).

Avoiding/Secrecy

As discussed, label avoidance (Sheehan et al., 2017) and treatment stigma (Clement et al., 2015) may occur for individuals struggling with hidden mental health problems. According to Goffman (1963), a stigma may be less visible or perceptible (e.g., mental illness stigma contrasted with obvious physical characteristics of racial/ethnic stigma), allowing for the potentially stigmatized person to lie or hide information. Once a diagnosis is revealed or help is sought, a potentially stigmatized person can be discredited and rendered into a visibly stigmatized person (Goffman, 1963). This threat of being discredited may lead individuals to avoid treatment, assessment, and a label or to keep any association with mental health a secret.

Recent studies have evidenced that secrecy with a diagnosis of bipolar disorder was associated with stereotype agreement (Au et al., 2019) and that concealing a mental health problem was strongly associated with anticipated discrimination (Isaksson et al., 2018). Secrecy may increase the salience of the stigmatized issue, as suppression can backfire and increase the intrusiveness of the issue being kept secret (Lane & Wegner, 1995). In fact, the coping strategies of secrecy, avoidance, and withdrawal may attempt to ameliorate labeling effects, yet these strategies were shown to increase psychological distress concerning the stigma (Link et al., 1991). Ultimately, it would be expected for avoidance and secrecy of mental illness and labels to be related to increased distress and negatively related to stigma resistance.

Self-Restoring/Self-Protecting

Shih (2004) reviewed three different self-protective strategies that individuals who are subject to stigmatization may use to avoid the adverse effects of stigma. The first process is compensating in skills, controlling how one presents themselves, and disconfirming stereotypes. The second process is using strategic interpretations of the social environment with in-group comparisons in order to increase one's sense of self-efficacy and minimize discrimination. The third process is drawing on multiple identities, as particular identities may be stigmatized sometimes and not others (Thoits, 2011). If the individual is using these strategies passively in order to avoid harmful outcomes (e.g., being a victim), then the individual is merely coping with stigma (Shih, 2004). This coping framework likens to a self-restoring response to stigma (e.g., using a self-protection strategy of comparing outcomes with own stigmatized group or selectively valuing only the positive attributes of the group; Crocker & Major, 1989), which is differentiated from stigma resistance (Thoits, 2011). On the other hand, these self-protective strategies can be employed in an empowering manner if the individual is actively seeking

positive outcomes and is thriving rather than just surviving (Oyserman & Swim, 2001; Shih, 2004).

Resilience to Stigma

The constructs of resilience and coping are differentiated in the literature, with resilience influencing an appraisal of a situation that leads to minimal disturbance by the individual while coping refers to the strategies utilized following the stressful situation (Fletcher & Sarkar, 2013). Resilience is the interactive influence of positive adaptive traits within the context of a stress process (Fletcher & Sarkar, 2013). Resilience also refers to a set of stress-buffering attributes that is gradually acquired (Alvord & Grados, 2005) as well as the ability to bounce back from adversity in a strengthened state (Maluccio, 2002). Positive emotions may be a means for resilience, as individuals with characteristics of resilience have used positive emotions to moderate stress reactivity (Ong et al., 2006) as well as to bounce back both cognitively and physiologically after negative emotional arousal (Tugade & Fredrickson, 2004).

Ongoing mental health resilience research has pinpointed a dynamic process of biological, psychological, social, and ecological systems interacting in ways that account for an individual's ability to sustain or even improve their well-being in the face of stress or adversity (Ungar & Theron, 2020). A scoping review on resilience in higher education revealed how resilience is tied in with students' abilities to cope with social, mental, emotional, and educational challenges (Brewer et al., 2019). Interventions that target resilience for students include the promotion of self-efficacy, mindfulness trainings, facilitating social connections, and allowing for exposure to developmentally appropriate challenges (Brewer et al., 2019). Self-care and help-seeking for managing stress were also noted as important factors in building resilience (Brewer et al., 2019).

Ultimately, resilience to stigma can be conceptualized as the opposite on a spectrum of self-stigmatization (Shih, 2004; Stringer et al., 2018). Shih (2004) wrote that developing resilience to stigma would differ from a “coping” model and include empowerment in creating positive outcomes. Stringer and colleagues (2018) theorized that resilience is overcoming adversity associated with stigma and altering negative views of the self that align with societal stigma. Resilience to stigma may include strength and determination in the face of prejudice and discrimination, ultimately preventing the damaging effects of stigma (Stringer et al., 2018). One approach towards resilience is making meaning of one’s situation and attributing the cause of stigma to society, rather than believing oneself is at fault, in turn increasing self-esteem (Frost, 2011).

Stigma Resistance

Stigma resistance has been defined as challenging or deflecting one’s identification with the harmful stereotypes (Thoits, 2011). The definition was expanded by Firmin, Luther, and colleagues (2017) as “an ongoing, active process of using one’s experiences, skills, and knowledge to develop a positive identity” (p. 2). Using the latter definition, stigma resistance appears to be a form of resilience, wherein an individual is encountered with adversity (i.e., stigmatizing stereotypes, prejudice, and discrimination), and they learn to be empowered and thrive in these circumstances. Similar to the construct of resilience, stigma resistance may begin with basic coping or management of stigma (e.g., avoidance, self-restoring), yet it goes beyond coping to create a positive transformation for the individual (Firmin, Luther, et al., 2017; Shih, 2004; Stringer et al., 2018; Thoits, 2011).

Anti-Stigma Efforts

Stigma resistance may be understood according to stigma reduction interventions at the societal level (Arboleda-Flórez & Stuart, 2012) as well as at a personal level targeting internalizing or self-stigma (Mittal et al., 2012). Disclosure of mental health problems or diagnoses is also conceptualized as a form of stigma resistance (Corrigan et al., 2015).

Public Stigma Interventions

How do people respond to the stigma of mental illness ever-present in society? Due to the profoundly negative impact of mental illness stigma, there has been stigma intervention to reduce stereotypes, prejudice, and discrimination towards individuals with mental illness (Arboleda-Flórez & Stuart, 2012). As early as 1952, researchers Cumming and Cumming attempted a stigma intervention of sharing knowledge on mental illness in a town in Saskatchewan, Canada (Link & Stuart, 2017). This attempt was ultimately unsuccessful, demonstrating early on that prejudiced views can be immutable (Link & Stuart, 2017). Also, large-scale efforts to debunk myths and stereotypes surrounding mental illness may only be a temporary fix as new myths arise (Corrigan & Penn, 1999).

Additional approaches aimed at reducing public stigma include education and contact-based approaches (Arboleda-Flórez & Stuart, 2012). Educational methods include challenging common stereotypes of mental illness by debunking myths about mental illness, such as the actual rates of violence surrounding individuals with mental illness (Corrigan et al., 2012). Contact-based methods include filmed social contact (Koike et al., 2018), contact-based educational symposiums (Stuart et al., 2011), as well as in-person and imaginary exposure (Morgan et al., 2018). Contact that is local, credible, and continuous is most effective (Corrigan, 2011). Connection with a stigmatized group can increase empathy and perspective-taking,

reducing prejudice (Pettigrew & Tropp, 2008). Contact-based interventions data have approximated small to medium reductions in stigma (Morgan et al., 2018). For adults, contact was found to have a greater effect size than educational interventions (Corrigan et al., 2015), although contact was inferior to education for adolescents (Corrigan et al., 2012), while contact and education-based anti-stigma interventions were equal among college students (Kosyluk et al., 2016), implying that stage of life and age may be important to consider. Corrigan and colleagues (2012) argue that contact may be more effective in shifting attitudes, while education has more of an impact on changing behavioral intentions (i.e., social distance).

Personal Stigma Interventions/Therapeutic Approaches

There are connections between public stigma resistance and personal stigma resistance against internalizing stereotypes and prejudice (Firmin et al., 2017), the latter form of stigma being the target of the current research. The development of specific self-stigma interventions (i.e., interventions that alter stigmatizing beliefs and attitudes of the individual) is a relatively new approach in the research literature on stigma reduction (Mittal et al., 2012). Some strategies employed to reduce self-stigma include enhancing self-esteem, empowerment, and hope, while increasing goal-seeking (Mittal et al., 2012), which would counteract the “why try” effect associated with self-stigma (Corrigan et al., 2009). Arboleda-Flórez and Stuart (2012) reviewed basic self-management skills that target stigma, including peer-supported self-learning, recovery-oriented supports, and services that target empowering the individual not to be defined by their label. Stigma interventions at a personal level may take place in a clinical setting with therapeutic approaches.

In clinical settings, cognitive behavior therapy (CBT) targets “irrational” self-stigmatizing thoughts and alteration of cognitions or beliefs (Hayward & Bright, 1997; Mittal et

al., 2012). CBT elements may work alongside techniques including psychoeducation, cultivating a holistic conception of mental illness, and enhancement of coping skills and other self-management skills (Hayward & Bright, 1997; Mittal et al., 2012). A program using a cognitive therapy approach for people with serious mental health problems yielded a decrease in self-stigma and an increase in self-acceptance beliefs and self-esteem after six weeks (MacInnes & Lewis, 2008). The procedure administered psychoeducation about mental health diagnoses and the impact of mental health problems. The topic of stigma was also defined and explored. The program also included discussing experiences of mental health problems and stigma, learning about the components of self-acceptance concerning stigmatizing attitudes, as well as promoting involvement and empowerment in mental health treatment (MacInnes & Lewis, 2008). Particularly for therapeutic intervention for self-stigma of severe mental illness, psychoeducation components have proved superior to CBT and social skills training (Tsang et al., 2016).

Also, Acceptance and Commitment Therapy (ACT; Hayes et al., 1999; Hayes et al., 2012) has been successful in reducing stigma for substance use (Luoma et al., 2008, Luoma et al., 2012) and weight self-stigma (Palmeira et al., 2017; Potts et al., 2022), with the research suggesting the potential impact that mindfulness and acceptance components may have on self-stigma. For instance, a pilot RCT study used ACT for weight intervention, not by directly targeting physical activity and eating behaviors, but rather by targeting weight self-stigma (Potts et al., 2022). ACT for stigma focuses on psychological flexibility, which includes experiencing situations and thoughts for what they are, loosening grips on prejudiced opinions, and being mindful of self-evaluations of shame and fear (Krafft et al., 2018). ACT for stigma and shame also comprises components of increasing psychological flexibility, human connections, compassion, and self-compassion (Krafft et al., 2018; Luoma & Platt, 2015). Notably, both

cognitive therapy and ACT focused on self-acceptance with efficacious results (e.g., MacInnes & Lewis, 2008; Luoma et al., 2008). Lastly, peer-facilitated group interventions for self-stigma show promise for improvement in empowerment and self-efficacy, despite inconclusive findings regarding their impact on self-stigma (Burke et al., 2019).

Disclosure as a Form of Stigma Resistance

Stigmatization of mental health is related to treatment avoidance, shame, and secrecy (Corrigan et al., 2015; Kaushik et al., 2016). Pachankis (2007) outlined a cognitive-affective-behavioral model of the psychological implications of concealing a stigma. Cognitive implications include mental preoccupation with covering the mental illness and hypervigilance around being discovered. Affective implications include feeling shame and other negative emotions by the very nature of having to hide something. Behavioral consequences include constant self-monitoring and impression management, along with social avoidance and isolation spurred by a fear of negative evaluation. To break the cycle of concealment, Pachankis (2007) suggests both self-acceptance and disclosure (when safe and appropriate).

Disclosure as an intervention strategy may aid in stigma resistance, as disclosure can reduce the preoccupation, shame, and fear of negative evaluation due to a mental illness (Corrigan et al., 2010; Corrigan et al., 2015). A study on "coming out" with a diagnosis assessed 85 individuals with serious mental illness, finding that the benefits of being out mediated the impact that self-stigma has on the quality of life (Corrigan et al., 2010). Benefits of coming out about one's mental illness were associated with affirming strategies (i.e., speaking out against unjust stigma) as well as being detached from public stigma (i.e., viewing stigmatizing situations as irrelevant; Corrigan et al., 2010). Disclosure of mental illness is also a way to share problems and seek support (Corrigan et al., 2015), further enhancing the journey of recovery.

Often the decision between choosing to conceal or disclose a mental illness is likened to gay people's process of determining whether or not to "come out of the closet" (Corrigan & Matthews, 2003). In cases of one revealing a stigmatizing condition, one may be more likely to conceal if they believe they are the only one with the stigma and may also perceive consequences of being discovered, such as rejection or physical violence (Pachankis, 2007). Revealing a label with a discrediting stigma may also make the stigmatized individual prone to detrimental self-fulfilling prophecies (Corrigan & Matthews, 2003). Other costs to disclosure may include disapproval of mental illness or the disclosure itself, gossip and exclusion, being pitied, or being questioned by others (Corrigan et al., 2013). On the other hand, some benefits of disclosure include less worry about hiding, more openness and honesty in interactions, and opportunities to learn from others (Corrigan et al., 2013).

Additional benefits include that selective disclosure can both decrease stigmatization and enhance social support (Bos et al., 2009), and in turn, being "out" increases the chance that social support will have a positive impact on the individual's overall physical and mental health (Weisz et al., 2016). The disclosure processes model (DPM) supports these findings, as it shows that positive social support (rather than neutral or negative evaluation) can positively mediate the effect of disclosure on well-being (Chaudoir & Fisher, 2010). The DPM delineates that prior to the process of disclosure there may be positive goals of acceptance and hopefulness or avoidant-focused goals to prevent rejection or anxiety (Chaudoir & Fisher, 2010). The ensuing disclosure of a stigmatized identity is impacted by several mediators (i.e., alleviation of inhibition in sharing personal information, social support, changes in social information, and subsequent interactions), which all impact the well-being of the individual and society's norms for whether disclosure is acceptable or not (Chaudoir & Fisher, 2010).

A program for "coming out proud" about one's mental illness was created to help individuals disclose to friends, neighbors, colleagues, and other people in their life (Corrigan et al., 2013). The program considers the pros and cons of disclosure, provides strategies for coming out, and focuses on pride and allowing for individuals with a mental illness to feel a sense of agency and self-determination, whether or not their symptoms have abated (Corrigan et al., 2013). In a sample of 1,393 college students, men and White people were more likely than women and non-White people to want to disclose or "come out" with a diagnosis (Corrigan et al., 2015).

Impact of Stigma Resistance

The "Why Try" model of self-stigma can also be inverted to show that empowering the individual with increased self-esteem and self-efficacy can mediate the effects of self-stigma on behavioral pursuits and increase success in life goals (Corrigan et al., 2009). In other words, they have reciprocal effects on one another. Empowerment as the opposite of the “Why Try” effect may be an example of righteous anger in the face of stigma (Corrigan & Watson, 2002). Despite the research that shows the significance of stigma internalization, generally more than half of people with an illness may show stigma resistance and even more so empowerment (i.e., self-esteem, self-efficacy, and power) in the face of mental illness stigma (Brohan, Gauci, et al., 2010; Sibitz et al., 2009). In the GAMIAN-Europe study, 60-63% of individuals with depression and bipolar illnesses had moderate or high levels of stigma resistance and empowerment (Brohan, Gauci, et al., 2010), while 49-50% of individuals with schizophrenia reported moderate to high levels of stigma resistance and empowerment (Brohan, Elgie, et al., 2010). Among a large sample of individuals on MTurk who identified as having a mental illness or having seen a psychiatrist for treatment, 69% were aware of stigmatizing beliefs about mental illness, although

only 3% agreed with the stereotypes, and fewer applied the stereotypes to themselves (Corrigan et al., 2016).

Sibitz and colleagues (2009) found that for patients with schizophrenia and schizoaffective disorder, stigma resistance was positively correlated with empowerment, self-esteem, and quality of life and negatively associated with stigma measures and depression. Additional structural equation modeling revealed that a lack of empowerment and an increase in stigma (both self and perceived) led to depression, which then resulted in a poor quality of life (Sibitz et al., 2009). More recent research with another sample with individuals diagnosed with schizophrenia or a schizoaffective disorder supported these findings: stigma resistance was positively associated with social functioning, self-esteem, problem-centered coping, and symptoms of hostility (compared to Corrigan and Watson's 2002 righteous anger) and excitement (O'Connor et al., 2018).

A meta-analysis of 48 studies (with two-thirds of participants with a schizophrenia-spectrum disorder) found significant relationships between stigma resistance and well-being factors, such as self-efficacy/self-esteem ($r = .60$), recovery from mental illness ($r = .51$), hope ($r = .54$), as well as a negative effect size with self/perceived stigma ($r = -.57$), showing that stigma resistance could be a crucial factor for mental health recovery (Firmin et al., 2016). Also, this meta-analysis found that race (e.g., a higher percentage of White participants), mean age, and education level moderated the relationship between stigma resistance and self/perceived stigma, while race also moderated the relationship between stigma resistance and overall outcomes (Firmin et al., 2016). A further analysis of the moderating effect of race (coded as "White" vs. "people of color") found that in a sample with severe mental illness, the negative relationship between self-stigma and stigma resistance was stronger for White participants than for

participants of color (O'Connor et al., 2018). Notably, the majority of these mentioned studies measured stigma resistance with the 'stigma resistance' subscale on the Internalized Stigma of Mental Illness Scale (ISMIS; Ritsher et al., 2003), which includes items that tap into the resistance of both public and self-stigma. Moreover, the subscale generally showed poor internal consistency (Cronbach's alpha ranged from $\alpha = 0.03$ to 0.76; Firmin et al., 2016).

Within the past few years, a new measure called the Stigma Resistance Scale (SRS) was created by Firmin, Luther, and colleagues (2017), which evidenced good internal consistency ($\alpha = .93$). The SRS is based on the model of stigma resistance at a personal, peer, and public level based on the personal believes of individuals with mental illness (Firmin, Luther, et al., 2017), which conceptualized stigma resistance as comprising self-other differentiation, personal identity, personal cognitions, peer stigma resistance, and public stigma resistance. The SRS had significant positive relationships with self-efficacy, recovery attitudes, and quality of life and significant negative relationships with perceived public stigma, overall psychiatric symptoms, and defeatist beliefs (Firmin, Lysaker, et al., 2017).

Ultimately, not all individuals with mental health difficulties succumb to stigma, as resistance is found in a large percentage of people experiencing mood disorders and psychosis (Brohan, Elgie, et al., 2010; Brohan, Gauci, et al., 2010). Stigma resistance is positively associated with several psychosocial variables, including empowerment, self-esteem, quality of life, social functioning, problem-centered coping, self-efficacy, and recovery attitudes (Firmin et al., 2016; Firmin, Lysaker, et al., 2017; O'Connor et al., 2018; Sibitz et al., 2009). It is also negatively associated with self-stigma, perceived public stigma, depression, and overall psychiatric symptoms (Firmin et al., 2016; Firmin, Lysaker, et al., 2017; Sibitz et al., 2009). Stigma resistance shows much promise for well-being and recovery (Firmin et al., 2016; Firmin,

Lysaker, et al., 2017). Most notably, stigma resistance needed further research with the newly created scale with good psychometric reliability (SRS; Firmin, Lysaker, et al., 2017), as the majority of previous research using the construct of stigma resistance used an unreliable scale (Firmin et al., 2016). In addition, further research was called for to explore what other personal variables are related to stigma resistance (Firmin et al., 2016), which could point toward potential precursors or impacts of this construct.

Furthermore, qualitative studies evaluating the experience of stigma of various mental health and related issues have also discussed topics in the realm of stigma resistance. For instance, engaging in or being informed about various health treatments was at times described as an empowering experience for youth taking psychiatric medications for mental illness (Kranke et al., 2011) and youth partaking in mental health services in foster care (Villagrana et al., 2018) as well as for adults with hepatitis C in the context of mental health problems (Ware et al., 2015) and black mental health consumers (Alvidrez et al., 2008). Resisting the stigma of mental health treatment was more likely if they thought it was not a bad thing to go to therapy (Villagrana et al., 2018) and viewed their own health as more important than the beliefs and reactions of other people (Alvidrez et al., 2008). Also, a sample of 18 people with lived experience of mental illness spoke of stigma resistance by doing positive things for other people or working hard to be competent at work, school, or in relationships; however, the latter was deemed a difficult task in the face of self-stigma and low self-esteem (MacKay et al., 2015).

Theoretical Models of Stigma Resistance

As the current study narrows in on both self-stigma and stigma resistance, I reviewed the various models of stigma resistance that are present in the literature. Three theoretical frameworks that explicate how stigma may at times not be internalized and may be resisted

instead are Corrigan and Watson's (2002) situational model, Thoits' (2011) model of resisting the stigma of mental illness, and Firmin, Luther, and colleagues' (2017) stigma resistance model at the personal, peer, and public levels.

The Situational Model of Personal Response to Stigma

The situational model of the personal response to mental illness stigma explores how a label will not always cause an individual to be devalued, as it depends on the different situational experiences that the individual in a stigmatized group would have (Corrigan & Watson, 2002). The model delineates three types of reactions to stigma: a loss of self-esteem, righteous anger, or ignoring the public stereotypes and prejudice. For the first situation, personal responses to stigma may result in self-esteem loss if negative responses from others are perceived and applied to oneself (e.g., Corrigan et al., 2006). For the second situation, high group identification with positive self-perceptions of the stigmatized condition may lead to a response of righteous anger rather than feeling devalued; this response may also include personal empowerment to achieve goals even in the midst of stigma (i.e., the inverse of the "why try" effect; Corrigan et al., 2009). For the third situation, it is also possible to acknowledge the public stereotypes, yet ignore them altogether, as one may not perceive the negative responses to be legitimate and may only compare oneself to others with mental illness rather than those without (Corrigan & Watson, 2002).

Thoits' Model of Resisting the Stigma of Mental Illness

Likewise, Thoits (2011) identified different groups of people/situational responses to stigma, including self-stigmatization (e.g., awareness, agreement, and application of stereotypes; Corrigan et al., 2009), avoiding (e.g., withdrawing or keeping an identity a secret) and self-restoring (e.g., using a self-protection strategy of comparing outcomes with one's own

stigmatized group or selectively valuing only the positive attributes of the group; Crocker & Major, 1989), challenging, and deflecting. Thoits' (2011) model of resisting the stigma of mental illness focused on the two last strategies: challenging and deflecting as ways of resisting stigma.

Challenging resistance would be confronting and fighting the stigma, pushing back against the stereotypes by either disagreeing with them or rejecting them (Thoits, 2011). Thoits (2011) emphasized how this resistance can happen at both a personal (e.g., disagreeing with a biased statement) and collective (e.g., activism, contact with a stigmatized person) level. A study on 3,005 mental health service users in England coping with mental health stigma found that 51% of participants endorsed challenging others because of discriminating behavior towards one's mental health status (Isaksson et al., 2018). Individuals who identified with a challenging coping style (compared to concealing) had greater confidence to challenge stigmatization (Isaksson et al., 2018).

Deflecting resistance is refusing to be identified by the harmful stereotypes and attitudes (Thoits, 2011). This may include recognizing but dismissing the stereotypes toward those with mental illness, believing that one's mental illness identity is only a small part of who one is (e.g., having many self-aspects and managing one's stigmatized identity; Howard, 2006; Linville, 1987), and being able to block the outside force that may threaten the self-esteem of the stigmatized individual (Thoits, 2011). Deflecting resembles individuals being empowered to come out with a diagnosis because they detach themselves from the stereotypes and view the stigma as irrelevant (Corrigan et al., 2010).

Thoits and Link (2016) examined the impact of stigma resistance tactics of challenging and deflecting versus concealment tactics of secrecy and avoidance in a population of inpatients diagnosed with psychosis. Challenging beliefs were measured with qualitative interviews that

asked if participants have disagreed with others who say something stigmatizing or tell others their behavior is stigmatizing or treating them in a stigmatizing way. Deflecting beliefs were measured as the individual not believing they currently or had ever had a mental illness or needed treatment, despite being an inpatient. Comparing deflection vs. concealment, they found that the deflecting resistance tactics were associated with less depression and higher self-esteem, while concealment tactics (e.g., avoiding people you know because you were hospitalized for mental illness) were associated with more depression and poorer self-esteem (Thoits & Link, 2016). Moreover, the strategy of challenging stigma has been recognized as empowering, as the more individuals confront societal biases, the greater the personal well-being and self-esteem one has (Thoits & Link, 2016).

Stigma Resistance Model at the Personal, Peer, and Public Levels

In the more current literature, stigma has been conceptualized at the personal, peer, and public levels (Firmin, Luther, et al., 2017). Firmin, Luther, and colleagues conducted a qualitative grounded-theory study with 24 individuals with serious mental illness (SMI; in this case they had a diagnosis of bipolar disorder, schizophrenia spectrum disorder, major depression disorder, or borderline personality disorder), with the participants either also being peer-service providers (n = 10) or consumers of mental health services (n = 14). At the personal level, participants endorsed resistance by not believing the stigma or challenging stigmatizing thoughts, being empowered through education and recovery and "proving stigma wrong," as well as identifying the mental illness as only a small part of who they are of their overall positive sense of identity. One participant from the study said the following: "It's not internalizing it-not just accepting what they say. It's facing it. It's evaluating it." (Firmin, Luther, et al., 2017, p. 187). At the peer level, resistance was engendered through helping others with one's lived experiences. At

the public level, participants resisted stigma by challenging and confronting the stigma through education, disclosure, and advocacy.

Integration of Models of Stigma Resistance

Comparing the models of stigma resistance, all three had an aspect of challenging in order to foster stigma resistance. Thoits' (2011) strategies for challenging stigma are akin to the righteous anger presented in the situational model (Corrigan & Watson, 2002). Similarly, challenging strategies were identified in the model of stigma resistance at the personal, peer, and public levels: at the personal level, individuals would challenge stigmatizing thoughts and empower themselves through recovery to prove the illness wrong, while at the peer and public levels, individuals would challenge stigma directly in advocacy work and indirectly in disclosure of experiences (Firmin et al., 2017). Additionally, the three models had aspects of deflection or ignoring stereotypes, although the latest model did not support this form of stigma resistance as strongly as the challenging aspect. Thoits' (2011) strategies for deflecting stigma (i.e., "that's not me") are akin to the third situational response to stigma (i.e., ignoring the stereotypes altogether), as both include a distancing of oneself from the stereotypes. Some participants in Firmin, Luther, and colleagues (2017) identified being able to resist stigma by not believing the stigma, however, the participants felt as if "deflecting" was too passive a term for their experience of stigma resistance and described an importance in "facing" and "evaluating" the stigma (p. 187).

All of the models may be situated within essential moderators of stigma (Corrigan & Watson, 2002). One moderator is the time since the acquisition of stigma (e.g., more extended time with the stigmatized disorder increases the amount of time to learn self-protection strategies; Crocker & Major, 1989). Another is the concealability of stigma (e.g., increased concealability may lead to identity ambivalence and preoccupation, while decreased

concealability may enhance the benefits of self-protection strategies; Pachankis, 2007). Another moderator is the perceived responsibility and controllability of the stigmatizing condition (Corrigan & Watson, 2002). In addition, factors that may make resistance more likely include decreased illness severity (e.g., prognosis may not be as poor as the stereotypes suggest, so one does not apply the stereotype to oneself), familiarity with someone who is ill (i.e., contact), mental health treatment experience, high psychosocial coping, and having multiple identities (i.e., rather than only identifying as mentally ill; Corrigan & Watson, 2002; Firmin et al., 2017; Thoits, 2011).

Study 1: Do Self-Compassion and Mental Health Self-Efficacy Moderate Relationships Between Perceived and Self-Stigma/Stigma Resistance?

Various psychosocial variables have been examined alongside mental health self-stigma and stigma resistance (Firmin et al., 2016; Livingston & Boyd, 2010), and some have been found to reduce the impact of perceived stigma on self-stigma (e.g., self-compassion; Heath et al., 2018). One aim of this study was to identify individual characteristics that may lead to a decrease in self-stigma and move an individual toward stigma resistance. Another aim was to examine protective factors that might directly impact and moderate the effect of perceived stigma on self-stigma in the realms of mental health and help-seeking.

Stringer and colleagues (2018) proposed a theoretical framework for how an individual moves toward resilience from self-stigmatization. The basis of Stringer and colleagues' (2018) theory is that self-stigmatization occurs when there are concordant views of self with society's negative views, an imbalance of power (i.e., perceived powerlessness, silence, and shame), and greater social distance. On the other hand, there is less self-stigmatization and more resilience when there are realistic positive views of the self, a balance of power, and social connection

(Stringer et al., 2018). This conceptualization of self-stigma is in line with Corrigan et al.'s (2006) definition of self-stigma—occurring when one is aware of, agrees with, and personally incorporates society's negative views, resulting in feelings of shame and incompetence. What is nuanced about Stringer et al.'s (2018) model is the proposition that two intrapersonal factors (i.e., self-compassion and competence) contribute to "turning points" moving away from self-stigmatization (Stringer et al., 2018). This model posits that self-compassion and the development of competence contribute to resilience by allowing the individual to shift to a more balanced, integrated view of the self, rather than a negative self that is distanced from others (Stringer et al., 2018).

For Study 1, I was interested in testing the intrapersonal "turning point" factors of Springer et al.'s (2018) model of the continuum from self-stigma to resilience and stigma resistance by assessing the impact of self-compassion and competence on self-stigma. Self-compassion was studied in this current research as recent literature has flagged self-compassion as an important variable researched alongside various forms of stigma, including mental health treatment stigma (e.g., Heath et al., 2018). Constructs related to competence, such as self-efficacy, mastery, and empowerment, have commonly been studied as correlates with or outcomes of self-stigma (Corrigan et al., 2006; Livingston & Boyd, 2010) and stigma resistance (Firmin et al., 2016) and are also examined in Study 1.

Self-Compassion

Self-compassion is a Buddhist concept depicting when an individual does not avoid or disconnect from one's suffering and is able to forgive oneself for faults or things one does not like about oneself. This construct has been redefined by Neff (2003b) as having the three main components of self-kindness, common humanity, and mindfulness. Self-kindness is when one

gives kindness and understanding to oneself rather than criticizing and judging oneself. Common humanity includes seeing one's experiences as connected to others' experiences and humanity's experiences rather than feeling isolated in one's experiences. Mindfulness involves awareness and acceptance of the thoughts and feelings one is having rather than overidentifying with the internal experiences. According to Stringer and colleagues' (2018) theory, self-compassion is speculated to help individuals see how one is more alike than different from others, share stories of transformation and meaningful interactions, and ultimately extend understanding to themselves and reject negative self-views and ensuing consequences.

Self-compassion has typically been measured with Neff's (2003a) self-compassion scale (SCS) with three positively worded subscales of self-kindness, common humanity, and mindfulness, and three negatively worded subscales of self-judgment, isolation, and overidentification, as theorized by Neff (2003b). The SCS had test-retest reliability of .93, a good model fit for the six-factor model (NNFI = .92; CFI = .93), as well as for a single higher-order factor (NNFI = 90; CFI = 92; Neff, 2003a). In some studies, women reported significantly less self-compassion than men on the self-compassion scale, indicating that women may be more self-judgmental, critical of themselves, and prone to feeling isolated during painful times (Neff, 2003a), while other studies revealed no gender difference in self-compassion (Neff & Pommier, 2012) or did not report on gender differences (Heath et al., 2018).

Self-compassion is distinct from self-esteem (e.g., being reminded of positive characteristics), as Neff's (2003a) scale evidenced discriminant validity between the two constructs. Self-esteem but not self-compassion is positively associated with narcissism, while self-compassion had stronger negative associations with self-rumination and public self-consciousness than self-esteem (Neff & Vonk, 2009). An experimental study revealed that

participants with higher self-compassion had the lowest negative affect after receiving ambivalent feedback compared to participants high in self-esteem (Leary et al., 2007).

Self-compassion shows promise for reducing self-stigma through the processes of transforming negative and painful emotions and thoughts into positive ones (Neff, 2003; Wong et al., 2018). One pilot study of compassionate mind training for people with shame and self-criticism found that compassion training, along with cognitive behavioral therapy, led to a reduction in self-criticism and shame (Gilbert & Procter, 2006). On the other hand, self-compassion is associated with not only decreasing negative affect but also enhancing positive affect by giving more attention to the positives (Hofmann et al., 2015; Neff et al., 2007).

There are several theoretical bases for the benefits of self-compassion and how it may buffer the adverse effects of stigma. Emotional processing (i.e., an active attempt to understand one's emotions; Stanton et al., 2000) is one mechanism through which self-compassion may buffer stigma, as self-compassion allows for stigmatized individuals to be non-judgmental and mindfully observe negative thoughts without suppression (Wong et al., 2018). Mindfulness moderated the relationship between the automatic and repetitive process of self-stigma and life satisfaction among people with mental illness (Yang & Mak, 2017). Self-compassion may target the ruminative and negative thinking component of stigma, as self-compassion has shown promise to reduce shame (Luoma & Platt, 2015), which is considered to be an essential component to stigma (Luoma, Kohlenberg, Hayes, & Fletcher, 2012). Also, self-compassion has the potential to increase self-care and self-regulation, giving an individual the potential to improve the ability to deal with mental health problems (Terry & Leary, 2011).

Self-compassion was found to partially mediate the relationship between weight-related self-stigma and depression, somatic symptoms, and quality of life (Hilbert et al., 2015). Among a

sample of patients with eating disorders, increased self-compassion was associated with lower levels of shame (Kelly & Tasca, 2016). Also, among Chinese parents of children with autism spectrum disorder, stigma by association was associated with psychological distress at low levels of self-compassion, while no significant relationship was found between stigma by association and psychological distress when there were high levels of self-compassion (Wong et al., 2016).

The conceptual model of stigma resistance and self-compassion by Wong and colleagues (2018) delineated cognitive, emotional, and social mechanisms through which self-compassion both mediates and moderates the impact of public stigma on self-stigma and personal health outcomes. The cognitive mechanisms through which self-compassion buffers stigma include intrinsic self-affirmation (reassuring overall sense of self-integrity), stress appraisal (positive reframing), and benefit finding (identifying positive things in stigmatizing situations; Wong et al., 2018). The emotional mechanisms through which self-compassion buffers stigma include emotional processing and emotional regulation through attempts to understand one's emotions and decrease maladaptive emotion regulation strategies such as rumination and worry concerning stigma (Wong et al., 2018). Lastly, the social mechanisms through which self-compassion buffers stigma include social support (and increased likelihood of disclosure and help-seeking) and forgiveness towards others and oneself (Wong et al., 2018).

In short, self-compassion focuses on balanced internal views of oneself in relation to others (Neff, 2003b) and can impact variables related to mental health stigma, particularly shame (Gilbert & Procter, 2006; Kelly & Tasca, 2016; Luoma & Platt, 2015). Also, it makes theoretical sense that self-compassion would reduce self-stigmatization, even if societal stigma is present (Stringer et al., 2018), as self-kindness and mindfulness may allow for one to have more realistic

positive views of oneself despite challenges with stigma; common humanity may move one away from the stigma aspect of social distance and toward more social connection (Neff, 2003b).

Self-Coldness

Self-compassion researchers have recently proposed a two-factor structure within Neff's (2003a) self-compassion scale (e.g., Brenner et al., 2017; Brenner et al., 2018; Falconer et al., 2015). Neff (2003a) originally found that the three main components of self-compassion loaded onto six instead of three factors, although the subscales were highly intercorrelated and found to measure a single overarching construct, the latter of which has generally been used (e.g., Neff et al., 2007; Heath et al., 2018). Recently, the self-compassion scale was identified via factor analysis as containing two constructs: self-compassion and self-criticism (Costa et al., 2015; Falconer et al., 2015; López et al., 2015) or self-compassion and self-coldness (Brenner et al., 2017; Brenner et al., 2018; Kumlander et al., 2018). The self-coldness factor contains the negatively worded items on the SCS (Neff, 2003a), which include the subscales of self-judgment, isolation, and overidentification (e.g., Brenner et al., 2017).

Gilbert (1993, 2005) argued that beyond the defensive and threat systems associated with flight or flight and psychopathology, there is a safety system linked to positive affect, affection, and affiliation. The defense-threat system is designed to decrease internal threats and is associated with anger and anxiety while the safety system allows individuals to engage in eliciting and seeking care and affection-building relationships (Gilbert, 2005). Self-coldness is theorized to tap into the sympathetic system and defense-threat system while self-compassion taps into the parasympathetic system and caregiving system (Brenner et al., 2017; Kumlander et al., 2018).

Longe and colleagues (2010) studied the neurophysiology of two constructs closely resembling self-compassion and self-coldness: self-reassurance and self-criticism following an imaginal personal failure. Longe et al. (2010) found that participants who were instructed to self-reassure had more activity in their insula and left temporal lobe, which are regions associated with compassion and empathy. Participants who were instructed to self-criticize had more activity in the lateral prefrontal cortex regions and dorsal anterior cingulate, which connects self-critical thinking to behavioral inhibition and error processing (Longe et al., 2010). The differences in neural correlates further substantiate the claim that self-compassion and self-coldness are two separate constructs (Kumlander et al., 2018).

Gender differences have been found for both self-compassion and self-coldness. More recent studies that have looked at the bi-factor model of self-compassion revealed that women had both less self-compassion and greater self-coldness than men (Brenner et al., 2018). Brenner and colleagues (2018) discussed the implications of these findings, including potential internalized sexism that could increase women's self-criticism and self-judgment.

Beyond confirming the two-factor structure of Neff's (2003a) self-compassion scale (SCS), the 6-factor model was found not to be replicable (López et al., 2015), further supporting the two-factor model. For undergraduate samples, separate internal consistency for self-compassion ($\alpha = 0.89 - 0.91$) and for self-coldness ($\alpha = 0.91 - 0.94$) show adequate reliability (Brenner et al., 2017; Brenner et al., 2018). Both self-compassion and self-coldness had unique variances in life satisfaction, positive affect, and psychological flourishing, while self-coldness also had unique variances in anxiety and stress (Brenner et al., 2017; Brenner et al., 2018). Due to these recent findings, I planned to look at self-coldness as a second and distinct variable of self-compassion.

Self-Compassion and Help-Seeking Self-Stigma

Self-compassion may provide a form of psychological resilience for treatment stigma, as research has shown that self-compassion moderates the effect of perceived stigma on one's self-stigma of seeking help (Heath et al., 2018). Heath and colleagues (2018) indicated that this was the first analysis of associations between self-compassion and help-seeking stigma, namely revealing that self-compassion predicts lower anticipated self-stigma. Also in this study model, mental health service use negatively predicted self-stigma (Heath et al., 2018). There has been a call for more research to examine the impact of self-compassion on well-being and help-seeking outcomes for clinical populations (Chan et al., 2018; Heath et al., 2017; Heath et al., 2018). Moreover, with the recent addition of self-coldness to the construct of self-compassion, the former findings are questionable and could be replicated with the two-factor measure (Brenner et al., 2017).

Other recent research has examined self-compassion and help-seeking variables along with gender role variables. Research has shown that self-compassion moderates the relationship between masculine norm adherence and help-seeking self-stigma (Heath et al., 2017). In other words, masculinity (i.e., emotional control and self-reliance) is strongly associated with negative attitudes toward help-seeking and stigmatizing beliefs of treatment, yet self-compassion weakens the association (Heath et al., 2017). More recent research looked at the moderating roles of both self-compassion and self-coldness, revealing that levels of self-compassion moderated the association between rigid masculinities and self-stigma of seeking help, while only low self-coldness moderated the relationship between masculine role adherence and stigma (Booth et al., 2019). The researchers found that men with high self-coldness were likely to report stigma of help-seeking regardless of masculine stress (Booth et al., 2019). Implications of this research are

that self-compassion (and sometimes self-coldness) is a critical component to continue researching for men and those who ascribe to masculine scripts, as factors of emotional control and self-reliance have led to a reduction in seeking out mental health care (Booth et al., 2019; Heath et al., 2017). Although gender role scripts are beyond the scope of this study, gender will be controlled for in the data analyses.

Competence/Self-Efficacy

Stringer and colleagues (2018) refer to competence as a construct based on self-determination theory (SDT; Deci & Ryan, 2012). SDT is a theory of human motivation and personality that addresses fundamental universal psychological needs for competence, autonomy, and relatedness (Deci & Ryan, 2012). According to SDT, perceived competence or mastery in developmental skills works alongside relatedness (being close to others and needing to belong) and autonomy (independence and self-direction) to integrate one's self-concept and enhance intrinsic motivation, which is crucial for goal pursuits, performance, and overall functioning and well-being (Deci & Ryan, 2012). Self-determination has been deemed an essential process for empowering mental health consumers (Cook & Jonikas, 2002). One qualitative study of participants with mental illness generated findings that some individuals worked hard on their competencies at work, school, and in friendships to justify themselves, implying that having strong skills in various domains helped raise empowerment and self-esteem (MacKay et al., 2015).

Stringer and colleagues (2018) also referred to competence as perceived power, which would not require a tangible mastery of skills but rather the cognitive perception of competence. Perceived power has been found to moderate the effect of stereotype threat on school performance (Van Loo & Rydell, 2013), indicating a potential buffering effect of perceived

competence or self-efficacy between stigma and real-life outcomes. Competence is also related to the construct of empowerment (Kramer & Schmalenberg, 1993), which has been shown to negatively correlate to self-stigma of mental illness (Livingston & Boyd, 2010) and positively relate to stigma resistance (Firmin et al., 2016). Many studies that measured empowerment alongside stigma adapted the scale by Rogers et al. (1993) empowerment scale for users of mental health services, which includes a subscale of self-efficacy/self-esteem along with power, activism and autonomy, optimism and control over the future, and righteous anger. Perceived empowerment or self-efficacy should reduce the fear of being perceived negatively by others and the concurrence of these negative views and help bolster oneself against societal prejudice and discrimination (Stringer et al., 2018).

For the current research, I planned to measure the cognitive perceptions of competence via a specific measure of self-efficacy (Hughes et al., 2011). Self-efficacy was defined by Bandura (1997) as one's perception of their competencies or confidence in their abilities. As mentioned earlier, self-efficacy is negatively related to stigma (Livingston & Boyd, 2010), and low self-efficacy is related to the "why try" effect of a diminished sense of personal recovery (Corrigan et al., 2009; Corrigan et al., 2016). Additionally, self-efficacy has a positive relationship with self-compassion (Liao et al., 2021), indicating that aspects of both constructs may be at play in stigma resistance. A recent study revealed that self-efficacy moderated the relationship between substance use stigma and depressive symptoms (Wang et al., 2022). As this research focuses on mental health, one form of self-efficacy I planned to focus on is mental health self-efficacy, which includes components of mental health optimism, coping, and advocacy (Carpinello et al., 2002).

Young Adults and Mental Health Stigma

Internalizing mental health problems (e.g., depression, anxiety) have increased for adolescent girls (with some findings supporting an increase in boys as well) in the 21st century (Bor et al., 2014). Mental disorders reach a peak onset around 22 years of age, yet few young adults seek treatment promptly (Vaingankar et al., 2012). Adolescents and young adults experience unfamiliarity with mental health services, stigma, shame, and embarrassment, identifying significant help-seeking barriers for young people with mental health problems (Gulliver et al., 2010; Westberg et al., 2022). Facilitators of help-seeking include the aid of others and past positive experiences with help-seeking (Gulliver et al., 2010; Westberg et al., 2022). Distress may impact a young person's decision to seek help as they "reach of point of no return;" their increase in symptoms or deterioration in function may act as a catalyst to reach out for help (Westberg et al., 2022).

College or university students may be particularly vulnerable to self-stigma of mental illness and help-seeking, as several studies with students have identified self-stigma as strongly linked to a decreased probability of seeking help (reviewed by Guarneri et al., 2019). Ethnic minority students, in particular, have shown higher levels of perceived stigma toward help-seeking compared to White students (Guarneri et al., 2019). Undergraduate students commonly experience anxiety, depression, and moderate to severe levels of distress (Storrie et al., 2010), and this appears to be increasing in prevalence and severity (Hunt & Eisenberg, 2010). The onset of mental health problems may be exacerbated by stressful transitions, academic demands, along with family and work responsibilities (Pedrelli et al., 2015). Prevalence rates for college students in the United States have been found to be around 11.9% for an anxiety disorder and 10.6% for a mood disorder (Blanco et al., 2008).

Beyond diagnosed mental disorders, much larger percentages of students report symptoms of anxiety and depression, with varying severity levels (reviewed by Sharp & Theiler, 2018). For instance, a 1998 study in conjunction with the University of Cambridge Counseling Service estimated that 53% of students met the criteria for Major Depressive Disorder or Generalized Anxiety Disorder (Surtees et al., 1998). Beyond depression and anxiety, there are high levels of psychological distress in university populations, such as one large study found 67% of students reporting subsyndromal symptoms of mental health problems (Stallman, 2010), and another identified 80% of students meeting clinical levels of psychological stress (Vivekananda et al., 2011). Student distress is linked to problematic health behaviors and poor academic outcomes (Sharp & Theiler, 2018). University students are therefore an important population in which to examine mental health stigma. The current research focuses on an undergraduate population that identifies as having mental health problems, which includes those who are undiagnosed but struggling and in need of help.

Current Study

Previous research has shown that perceived stigma of help-seeking precedes self-stigma of help-seeking (Vogel et al., 2013). In parallel to help-seeking stigma, theoretical models indicate that perceived stigma of mental health is a primary (and arguably initial) factor of self-stigma of mental health (Corrigan et al., 2006; Link, 1982). Previous studies have shown that self-compassion buffers the impact of help-seeking stigma (Heath et al., 2018), and self-efficacy buffers the effect of substance abuse stigma (Wang et al., 2022).

As self-compassion and self-efficacy are theorized to reduce stigma in various domains (Stringer et al., 2018), research is needed to explore their unique variance regarding both help-seeking and different forms of mental health stigma. Also, recent research on self-compassion

and self-coldness (Kumlander et al., 2018) reveals a gap in the stigma and self-compassion literature, which has not considered this two-factor structure. In addition, more studies are needed on stigma resistance, which has great potential to reduce self-stigma and increase quality of life and recovery (Firmin et al., 2016). More research is also imperative to examine factors that can reduce stigma for young adults who may not have a more pronounced or serious mental illness yet are still in need of help (Grant et al., 2016).

For the current study, I first aimed to examine the potential predicting and moderating relationships of self-compassion, self-coldness, and self-efficacy on the assumed relationship between perceived and self-stigma of help-seeking (Heath et al., 2018; Vogel et al., 2013). Second, in parallel, I also planned to explore the potential predicting and moderating relationships between perceived and self-stigma of depression and anxiety. Third, I investigated the relationship between self-compassion/self-coldness and self-efficacy on mental health stigma resistance based on Stringer et al.'s (2018) proposed continuum of self-stigmatization to resilience; this was explored from both a quantitative and qualitative perspective. I recruited undergraduate participants who identified as having mental health problems. Examining not only the self-stigma of help-seeking but also the self-stigma of mental health in a university population allows for further exploration of the range of impacts that mental health and related stigmas have on young adults (Guarneri et al., 2019). The research simultaneously allows me to explore how to enhance stigma resistance among this vulnerable population.

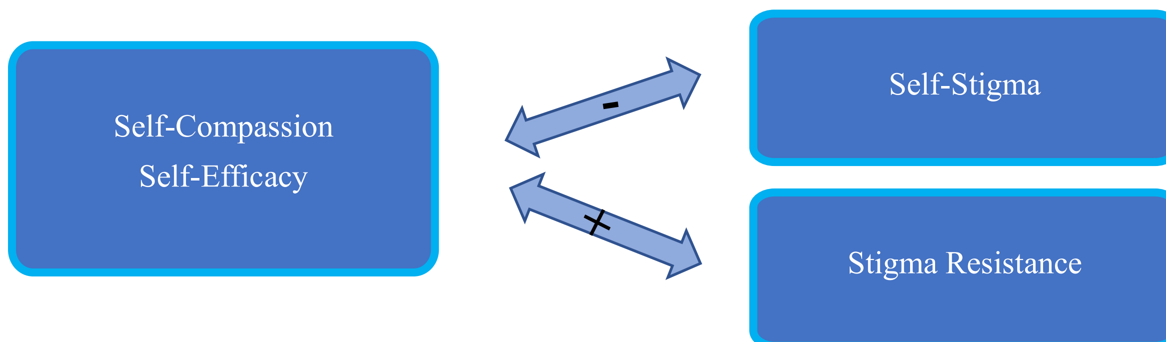
Research Objective 1

Investigate the association between self-compassion and mental health self-efficacy with self-stigma and stigma resistance in an undergraduate population that identifies as having a mental health problem.

Hypothesis 1: Self-compassion and self-efficacy will negatively correlate with self-stigma (i.e., self-stigma of help-seeking, depression and anxiety self-stigma) and positively correlate with stigma resistance.

Figure 1

Hypotheses of Expected Correlations



Note. Hypotheses 1: Self-compassion (and less self-coldness) and self-efficacy will negatively correlate with self-stigma and positively correlate with stigma resistance.

Research Objective 2

Investigate the direct and moderating role of self-compassion/coldness and self-efficacy on the relationship between perceived stigma and self-stigma in an undergraduate population that identifies as having a mental health problem. Investigate the direct and moderating role of self-compassion/coldness and self-efficacy on the relationship between self-stigma and stigma resistance.

Hypothesis 2*:* After controlling for gender, psychological distress, past help-seeking, and perceived stigma of help-seeking, self-compassion/coldness and self-efficacy will (a) uniquely negatively predict self-stigma of help-seeking and (b) will reduce the strength of the relationship between perceived stigma of help-seeking and self-stigma of help-seeking.

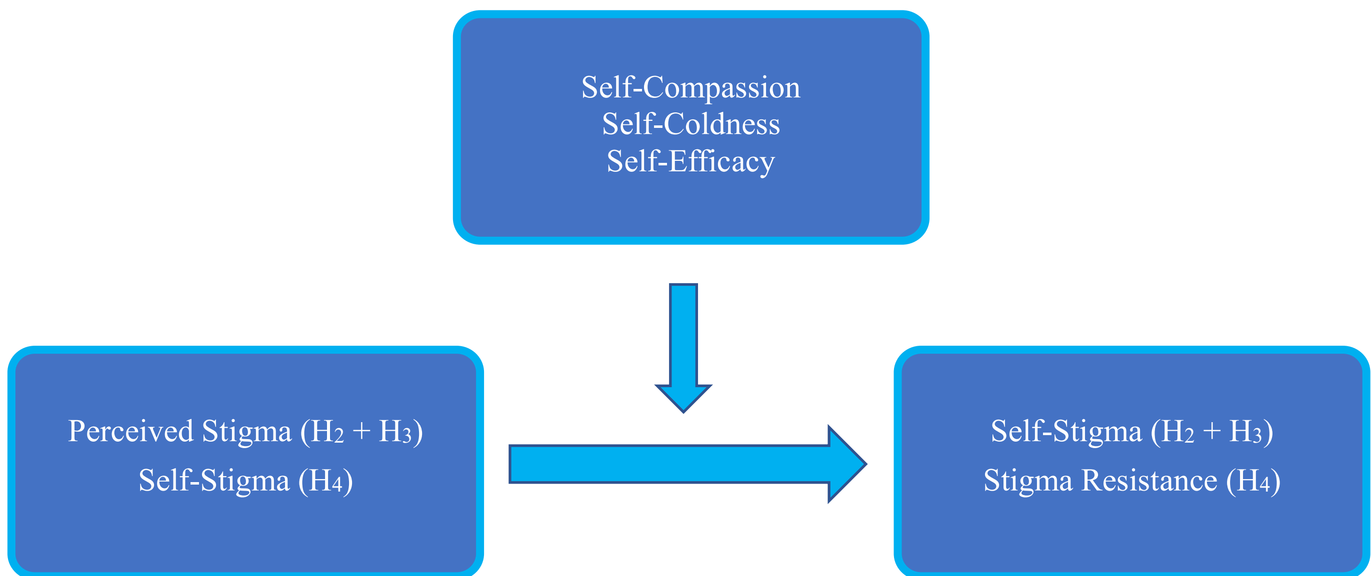
Hypothesis 3*:* After controlling for gender, psychological distress, diagnosis, and perceived stigma of depression and anxiety, self-compassion/coldness and self-efficacy will (a)

uniquely negatively predict self-stigma of depression and anxiety and (b) reduce the strength of the relationship between perceived stigma of depression and anxiety and self-stigma of depression and anxiety.

Hypothesis 4: After controlling for gender, psychological distress, diagnosis, and perceived stigma of depression and anxiety, self-compassion/coldness and self-efficacy will (a) uniquely positively predict stigma resistance and (b) buffer the relationship between increased self-stigma of depression and anxiety and lesser stigma resistance.

Figure 2

Hypotheses of Self-compassion, Self-Coldness, and Self-Efficacy as Moderators



Note. Hypotheses 2b and 3b: Self-compassion/self-coldness and self-efficacy will reduce the strength of the relationship between perceived stigma of self-stigma. Hypothesis 4b: Self-compassion/self-coldness and self-efficacy will buffer the relationship between self-stigma and stigma resistance.

Research Objective 3

Gather written qualitative responses and conduct thematic analysis on participants' experience resisting stigma of mental health and having self-compassion and competence/skills may have helped with stigma resistance.

Methods

This current study employed a mixed-methods cross-sectional research design. Part A consisted of a quantitative design wherein participants completed a series of online questionnaires. For Part B, brief qualitative questions were utilized to target the emerging themes in life course narratives of the self-stigmatized students that contribute to the development of resilience (Stringer et al., 2018).

Participants

Demographics

Participants were recruited from undergraduate psychology courses at a university in northwestern Ontario via the online portal SONA™. SONA™ provided a link to the online study if the individual indicated they would like to participate for extra credit for an eligible course. In the advertisement, the study explicitly called for students who identify as having experienced mental health problems (e.g., depression, anxiety). The first question of the survey confirmed that all included participants identified with a mental health problem. This criterion was set because I hoped to include any participants who had mental health problems, whether it be diagnosed or undiagnosed, past or current, and minimal or severe levels of distress.

Table 1 delineates the demographics for the primary quantitative study (Part A) and those who chose to answer the qualitative questions (Part B). Part A comprised 366 participants and Part B comprised 220 participants (both from the same pool of participants). Participants

reported gender with the terminology of female, male, and other to refer to how the individual psychologically, behaviorally, socially, and culturally identifies (American Psychological Association, 2015); biological sex was not inquired in the questionnaire. Participants also reported ethnic identity (all that apply), university year, university major, and age. Most participants were female (84-85%), Caucasian (84-85%), and in Year 1 or Year 2 of university (63-64%). The mean age for Part A was 28.1 and for Part B was 22.7.

Table 1

Study 1 Participant Demographics

	Study 1A		**Study 1B**	
Participants	Number	%	Number	%
Gender				
Female	313	85.5	185	84.1
Male	50	13.7	32	14.5
Non-Binary	3	0.8	3	1.4
Ethnic Identity (all that apply)				
African	10	2.7	3	1.4
Caucasian/White	314	85.8	186	84.5
East Asian	5	1.4	2	0.9
Indigenous	25	6.8	18	8.2
Jamaican	4	1.1	1	0.5
South Asian	13	3.6	12	5.5
South East Asian -	10	2.7	3	1.4
West Asian/Arab	4	1.1	4	1.8
Other	9	2.5	5	2.3
University Year				
Year 1	128	35.0	74	33.6
Year 2	107	29.2	65	29.5
Year 3	68	18.6	42	19.1
Year 4	58	15.8	34	15.5
Other	12	2.4	7	3.2
University Major				
Psychology	132	36.1	78	35.5
Nursing	54	14.8	31	14.1
Education	38	10.4	22	10.0

Social Work	29	7.9	19	8.6
Kinesiology	21	5.7	8	3.6
Criminology	20	5.5	10	4.5
Engineering	12	3.3	8	3.6
Biology	12	3.3	9	4.1
Political Science	12	3.3	8	3.6
Interdisciplinary Studies	9	2.5	8	3.6
Undeclared	8	2.2	6	2.7
Outdoor Recreation	6	1.6	3	1.4
Other	31	8.5	24	10.9
Mental Health Factors				
Previously Sought Help	235	64.2	148	67.3
Any Mental Health Diagnosis	187	51.1	126	57.3
Anxiety Disorder	138	37.7	98	44.5
Depressive Disorder	114	31.1	79	35.9
Posttraumatic Stress Disorder	29	7.9	20	9.1
Eating Disorder	28	7.7	23	10.5
Obsessive Compulsive Disorder	21	5.7	17	7.7
Attention-Deficit/Hyperactivity Disorder	21	5.7	14	6.4
Substance Use Disorder	9	2.5	7	3.2
Borderline Personality Disorder	8	2.2	2	0.9
Bipolar Disorder	7	1.9	5	2.3
Schizophrenia Spectrum Disorder or Psychosis	1	0.3	1	0.5
Other	4	1.8	4	3.6
	Mean (SD)	Range	Mean (SD)	Range
Age in years	28.1 (5.3)	15-50	22.7 (6.2)	16-50

Preliminary Mental Health Status and Use of Psychological Services Items

Along with the eligibility criteria and demographics, participants were asked if they had received a diagnosis from a mental health professional. They were also asked if they have sought help from a mental health professional (Appendix C). For Part A, 64% of the participants had sought help and 51% had a diagnosis. For Part B, 67% had sought help and 57% had a diagnosis. The most common diagnoses were anxiety and depression (see Table 1).

Study Measures

Depression Anxiety Stress Scale (DASS-21). The DASS-21 (Appendix D) was used to assess symptoms of depression, anxiety, and stress (Henry & Crawford, 2005). The DASS-21 is a 21-item self-report measure that asks respondents to indicate how much the statements apply to them over the past week, from 0 ("Did not apply to me at all") to 3 ("Applied to me very much or most of the time"). All items are summed to result in a final score, with higher scores indicating greater severity levels. The mean scale score found by Henry and Crawford (2005) was 9.43 (range from 0-61). Examples from the three subscales Depression, Anxiety, and Stress subscales, respectively, are as follows: 1) "I couldn't seem to experience any positive feeling at all," 2) "I was worried about situations in which I might panic and make a fool of myself" and 3) "I tended to over-react to situations."

Initial assessment of the scale (Lovibond & Lovibond, 1995) showed adequate construct validity, as the original 42 item DASS Depression scale correlated with the Beck Depression Inventory (0.74), and the Anxiety scale correlated with the Beck Anxiety Inventory (0.81), while the DASS-21 has also shown variance specific to each construct (Henry & Crawford, 2005). Also, the DASS-21 has correlated with mixed measures of depression and anxiety (e.g., The Mood and Anxiety Symptom Questionnaire-90; Osman et al., 2012) and has been used as a general measure of distress (Henry & Crawford, 2005). The DASS-21 has adequate internal consistency overall ($\alpha = 0.93$) as well as for the separate subscales of Depression ($\alpha = 0.88$), Anxiety ($\alpha = 0.82$), and Stress ($\alpha = 0.90$; Henry & Crawford, 2005). The Cronbach's Alpha for the DASS-21 in my sample was .92.

Self-Compassion Scale. The Self-Compassion Scale (Appendix E) was used to assess self-compassion, as a measure of a trait of being kind, nonjudgmental, and understanding toward

oneself (Neff, 2003a). The Self-Compassion Scale is a 26-item self-report measure that asks respondents how often they behave in a stated manner ranging from 1 (“Almost never”) to 5 (“Almost always.”) All items were summed for a total score, with higher scores indicating greater self-compassion. The mean scale score found by Neff (2003a) was 18.25 (range from 0-30). The original Self-Compassion Scale contains three subscales of self-kindness, common humanity, and mindfulness (Neff, 2003a). This total scale correlates with less depression and anxiety and higher life satisfaction (Neff, 2003a).

The self-compassion scale can also be broken down into two separate subscales of self-compassion and self-coldness (Brenner et al., 2017). An example item from the self-compassion subscale is “I try to be loving towards myself when I feel emotional pain.” An example item from the self-coldness subscale is “I’m disapproving and judgmental about my own flaws and inadequacies.” With the bifactor model, there are subscales of self-kindness, common humanity, and mindfulness comprising the self-compassion factor while there are three subscales comprising the self-coldness factor: self-judgment, isolation, and overidentification (Brenner et al., 2017). In my study the Cronbach’s Alpha was .91 for the self-compassion subscale and .90 for the self-coldness subscale.

Self-Perceived Overall Competence. The Self-Perceived Overall Competence scale (Appendix F) is a 14-item measure of self-perceived overall competence of university students (Liu et al., 2015), originally created as an adapted measure of the competence subscale of the Positive Youth Development Inventory (PYDI; Arnold et al., 2012). The scale measures one’s views of their actions in social, academic, cognitive, and vocational areas. Example items include, “I am a good student” and “I make friends easily.” Participants rate items on a 4-point Likert scale, ranging from 1 (“Strongly disagree”) to 4 (“Strongly agree”). Total scores are

derived as an average of all items, with higher scores indicating higher degrees of self-perceived competence. The mean scale score found by Liu et al., (2015) was 2.97 (range from 0 to 4).

The reliability, as researched by Liu et al., (2015), was $\alpha = .80$. The Cronbach's Alpha for the current study was .77. Upon further analysis, several inter-item correlations were below .30 (going as low as < .003), indicating poor construct validity (DeVon et al., 2007).

Mental Health Confidence Scale. The Mental Health Confidence Scale (Appendix G) is a 16-item measure of self-efficacy for individuals dealing with mental disorders (Carpinello et al., 2000). The scale comprises three factors of mental health optimism, coping, and advocacy. Example items are rating how confident one is in their ability to "be happy," "get support when you need it," "deal with nervous feelings," and "use your right to accept or reject mental health treatment." Participants rate items on a 6-point Likert scale, ranging from 1 ("Very nonconfident") to 6 ("Very confident"). All items were summed for a total score, with higher scores indicating greater degrees of mental health confidence. The mean scale scores found by Carpinello et al., 2000 were 65.3 and 68 (range from 16 to 96). Mental health confidence correlated positively with participation in self-help groups (Carpinello et al., 2000).

The reliability for the full scale was .94 (Carpinello et al., 2000). Two items were removed from the scale for the current study: confidence to "stay out of the hospital" was removed due to irrelevance, and confidence to "deal with symptoms related to your mental illness diagnosis" was removed as only half of the participants endorsed a diagnosis. The Cronbach's Alpha for the current study's 14-item scale was .88.

Stigma Scale for Receiving Psychological Health (SSRPH). The SSRPH (Appendix H) is a measure of perceptions of treatment stigma (Komiya et al., 2000) that was adapted as a measure of perceived public stigma of help-seeking. The SSRPH contains five items that are

rated from 0 (“Strongly disagree”) to 3 (“Strongly agree”). All items were summed for a total score, with higher scores indicating a greater perceived public stigma of help-seeking. The mean scale score found by Komiya et al. (2000) was 14.66 (range from 0-30).

The items were modified to say “most people…” prior to each statement in order to measure perceived public stigma of help-seeking, similar to the perceived subscale on the Depression Stigma Scale (Griffiths et al., 2004). An example item is “most people believe seeing a psychologist for emotional or interpersonal problems carries social stigma.” The SSRPH showed adequate internal consistency ($\alpha = .72 - .73$; Komiya et al., 2000; Vogel et al., 2013). The Cronbach’s Alpha for the SSRPH in the current study was .83.

The Self-Stigma of Seeking Psychological Help Scale (SSOSH). The SSOSH scale (Appendix I) is a measure of self-stigma and attitudes toward and intent to seek psychological help (Vogel et al., 2006) and was used as a measure of help-seeking self-stigma. It is a 10-item self-report measure that asks respondents to rate the degree to which various responses to seeking help for problems would describe how they would react in the situation, ranging from 1 (“Strongly disagree”) to 5 (“Strongly agree”). An item example is "I would feel inadequate if I went to a therapist for psychological help. Half of the items are reverse-coded. All items were summed for a total score, with higher scores indicating increased levels of self-stigma of seeking help. The mean scale score found by Vogel et al. (2006) was 27.1 (range from 10-50).

Among an undergraduate sample, the SSOSH had good reliability ($\alpha = .91$) and was identified as a unidimensional construct (Vogel et al., 2006). The SSOSH has been able to differentiate individuals who sought help versus those who did not across a two-month period (Vogel et al., 2006). The Cronbach’s Alpha for the SSOSH in the current study was .85.

Perceived Stigma of Depression and Anxiety Scale (PSDAS). The PSDAS (Appendix J) is a ten-item scale that comes from the Generalized Anxiety Stigma Scale (GASS) subscale of perceived stigma (Griffiths et al., 2011). The Perceived GASS subscale was adapted for use with both depression and anxiety. A sample item is "Most people think that depression and anxiety are not real medical illnesses." The items are rated on a five-point Likert scale from 0 ("Strongly disagree") to 4 ("Strongly agree."). Items are summed for a total score, with higher scores indicating higher levels of perceived stigma. The mean scale score on the Perceived GASS subscale found by Griffiths et al., (2011) was 21.51 (range from 0-40).

Internal consistency of the original measure of the Perceived GASS subscale was good (Cronbach's Alpha = .91). Test-retest reliability over a four-month period for the Perceived GASS subscale was .55 (Griffiths et al., 2011). The Cronbach's Alpha for the PSDAS in the current study was .92.

Self-Stigma of Depression and Anxiety Scale (SSDAS). The Self-Stigma of Depression Scale (SSDS; Barney et al., 2010) was adapted for use with both depression and anxiety, with permission from the corresponding author (personal correspondence, June 2019). The SSDAS (Appendix K) is a 16-item self-report measure that asks respondents how they would feel if they were depressed and/or anxious. A sample item is "I would feel embarrassed." The items are rated on a five-point Likert scale from 1 ("Strongly disagree") to 5 ("Strongly agree"). Subscales include Shame, Self-Blame, Social Inadequacy, and Help-Seeking Inhibition. One item is reverse-coded: "I would feel like I was good company." All items were summed for a total score, with higher scores indicating higher levels of self-stigma. The mean scale scores of the Self-Stigma of Depression Scale found by Barney et al. (2010) were 57.40 for males and 59.17 for females (range from 16 to 80).

For the psychometrics of the original SSDS, internal consistency ($\alpha = 0.87$), test-retest reliability, and construct validity were adequate (Barney et al., 2010). Also, females reported higher on all scales except for Help-Seeking Inhibition (Barney et al., 2010). The scale has also been previously adapted to measure anxiety self-stigma, which had high internal consistency (α = of 0.90; Grant et al., 2016). The Cronbach's Alpha for the SSDAS in the current study was .87.

Stigma Resistance Scale (SRS). The SRS (Appendix L) was used as a measure of stigma resistance (Firmin, Lysaker, et al., 2017). The SRS is a 20-item scale broken down into 5-factors of self-other differentiation, personal identity, personal cognitions, peer stigma resistance, and public stigma resistance (Firmin, Lysaker, et al., 2017). The SRS was originally directed towards individuals with a mental health diagnosis, so it was adapted for the population of this study by changing the term "mental illness" when it occurs to "mental health problems." Example items are "I can have a positive view of myself even when others don't have a positive view of me." and "I know there is more to me than my mental health problems." The items are rated on a five-point Likert scale from 1 ("Disagree") to 5 ("Agree"). Total scores are derived as an average of all items, with higher scores indicating greater stigma resistance. The mean scale score found by Firmin, Lysaker, et al. (2017) was 4.1 (range from 1-5).

This SRS has good internal consistency ($\alpha = .93$) and adequate test-retest reliability at three weeks ($r = .74$). The subscales also have acceptable to good reliability, with Cronbach's alphas as follows: self-other differentiation = .71, personal identity = .85, personal cognitions = .82, peer = .75, public = .88. For the current study, one item that referenced not being defined by a diagnosis was removed, as only half of the participants had a diagnosis. The Cronbach's Alpha for the 19-item SRS scale in the current study was .87.

Qualitative Questions on Self-Stigma Resistance. There were optional qualitative items on self-stigma resistance (Appendix M). The questions were introduced with a brief explanation of what self-stigma or internalized stigma of mental health is. Next, participants were asked if they have experiences of resisting the internalization of stigma of mental health. If so, they were asked to describe in detail how they have resisted the internalized stigma of mental health, how they may have used self-compassion and competence to resist stigma, and how their stigma resistance has evolved over time.

Attention Questions. Attention questions (Appendix N) were used to monitor for how much attention the participants gave to the study in order to remove careless responses (Meade & Craig, 2012). Two instructed response items were dispersed throughout the survey telling participants to choose a specific answer in order to monitor for attention. Additionally, at the end of the survey, participants were asked how much effort and attention they invested in the study, and they were asked (yes or no) if their data should be used.

Procedure

All questionnaires for this study were given through SurveyMonkey. SurveyMonkey is an online survey tool hosted by a server in the USA. Participants were presented with a cover letter delineating the nature of the study, which was to “help us assess psychological characteristics and attitudes for individuals who identify as having had mental health problems” (Appendix A). The word “stigma” was not used in the recruitment nor at the beginning of the survey until all of the independent and control variables had been assessed in order to prevent tainting of the other psychosocial variables. Written informed consent was also presented (Appendix B). The participant was then asked if have had mental health problems: if they selected "yes," they continued with the study, and if "no" was selected, they were directed to exit

the survey due to eligibility requirements. Next, the participants proceeded to complete the study measures. At the end of the survey, there were optional qualitative questions, where the participant was asked how they have resisted or defied the stigma of mental health. Lastly, participants were presented with a closing screen thanking them and giving them the researcher's email to be contacted if they would like a summary of the results (Appendix 0). For compensation, they received a bonus mark toward a psychology course where permitted. Additionally, participants were given the contact information for the university's Student Health and Counseling Centre, local and online resources, as well as the Research Ethics Board for any reason including the experience of distress as a result of the study (Appendix O).

Data Screening

All quantitative data were analyzed using SPSS Statistics 26. A total of 503 participants initiated the online study. Several participants did not complete the study due to missing consent or inclusion criteria (n = 26). Participants were then removed if they did not complete the attention and effort questions (n = 15), if their self-rated attention or effort score was below 3/5 (n = 11), or if they selected “no” when asked if their data should be used (n = 16). Additional participants were removed if they incorrectly answered one or both of the instructed response items (n = 61). Lastly, participants were removed if they attempted to complete the survey more than once (n = 7). This left a total of 366 participants’ data to be analyzed.

Missing values within the dataset of 366 participants were replaced via mean replacement, given at least 90% of the items were present. Mean variables missing more than 10% of items were not included in the analysis in order to avoid a biased analysis (Tabachnick & Fidell, 2019). Multiple imputation was considered as a superior form of mean replacement

(Tabachnick & Fidell, 2019), yet it was ultimately not used due to incompatibility with multiple linear regressions.

Next, the data were checked for the range of variables, normal distributions, skewness, and kurtosis, of which no issues were noted; these tests confirmed the normality of the dataset and ensured the assumptions were met for regression analyses (Tabachnick & Fidell, 2019). Additionally, the variance inflation factor (VIF) values for the predictor variables indicated no issues with multicollinearity (Tabachnick & Fidell, 2019), so all remaining variables were used in regression analyses.

Descriptive statistics of mean variable scales are recorded in Table 2. Reliability analyses for the mean variable scales revealed very good Cronbach's alphas (> .80), except for the Self-Perceived Overall Competence scale ($\alpha = .77$), which was not used in further analyses due to low inter-item correlations and poor construct validity.

Data Analysis

Quantitative Analysis

For Research Objective 1, I computed correlations with Pearson's r to assess the relationship between self-compassion, self-coldness, and mental health self-efficacy and self-stigma/stigma resistance. As gender differences in help-seeking self-stigma (e.g., Nam et al., 2013) and self-compassion (Heath et al., 2017) were expected, the regressions were also run separately for females and males. According to an a priori sample size estimate using G*Power, in order to have a moderate effect size (.5) using Pearson's r at a 0.01 significance level, we needed a sample of 42 participants for each gender (84 total).

For Research Objectives 2 and 3, hierarchical multiple regressions were calculated to predict self-stigma/stigma resistance from self-compassion, self-coldness, and mental health self-

efficacy measures. A priori effect sizes were calculated for the hierarchical multiple regressions. For the proposed three models with up to 10-11 predictors each, to have a moderate effect size (.15) using Cohen's F^2, I needed a sample of about 122 participants to give the regressions a power of .80. As 366 participants were included in the analysis, the sample was sufficiently large to allow for increased power in analyses and smaller effect sizes to be detected.

For regressions with interaction terms, all continuous independent variables were standardized in order to avoid highly correlated variables (Tabachnick & Fidell, 2019),

Qualitative Thematic Analysis

Of the 503 participants who initiated the online study, 220 answered at least one of the qualitative questions and were included in the thematic analysis. We used Braun and Clarke's (2006) six-step method of thematic analysis. The primary researcher and research supervisor collaborated for each step. For phase one, we familiarized ourselves with the data and repeatedly read the responses from the participants. For phase two, we generated initial codes to identify features of the data in their most basic meaningful forms. Phase three initiated searching for themes with the different identified codes and creating a thematic map to identify main themes. Phase four involved reviewing and refining the themes depending on the amount of data that supports them in a coherent manner. For phase five, we defined and named themes and wrote a detailed analysis of each theme. Finally, for phase six, we produced the final analysis and write-up. Since the qualitative questions were provided in written format, without the opportunity for follow-up with the participant, the themes were organized under the overarching three questions. We conducted reflexive thematic analysis of all participants' written responses, a method that does not include formal data saturation considerations (Braun & Clarke, 2021). Generated themes did not have to meet a proportion or count threshold to be included, as the researchers'

judgment was used to identify topics that captured something critical relative to the overall research questions (Braun & Clarke, 2006).

Results

Descriptive Statistics for Main Constructs

Table 2 below presents the descriptive statistics for the main constructs.

Table 2

Descriptive Statistics and Cronbach's Alphas for Study Scale

Scale	N	Min	Max	Mean	SD	Cα
Depression Anxiety Stress Scale (DASS)	366	.10	3.00	1.29	.59	.92
Self-Compassion	365	1.00	4.92	2.73	.74	.90
Self-Coldness	365	1.15	5.00	3.65	.74	.90
Mental Health Confidence Scale (MHCS)	366	1.57	6.00	3.93	.77	.88
[Perceived] Stigma Scale for Receiving Psychological Help (SSRPH)	361	.00	3.00	1.62	.65	.83
Self-Stigma of Seeking Psychological Help (SSOSH)	365	1.00	5.00	2.55	.67	.85
Perceived Stigma of Depression and Anxiety Scale (PSDAS)	359	.20	5.00	2.90	.90	.92
Self-Stigma of Depression and Anxiety Scale (SSDAS)	366	1.44	5.00	3.57	.63	.87
Stigma Resistance Scale (SRS)	364	2.60	5.00	4.02	.54	.87

Gender Differences

As there was an unequal number of female (n = 313) and male (n = 50) participants, gender differences were computed with Welch's t-test (Kohr & Games, 1974). No significant

differences were found for the measures of diagnosis, psychological distress level, self-compassion, mental health self-efficacy, perceived stigma of receiving help, or self-stigma of depression and anxiety. There was a significant effect for gender, with females having higher scores than males on the following scales: self-coldness $t(75.04) = 5.34$, $p = .02$, perceived stigma of depression and anxiety $t(60.36) = 4.64$, $p = .04$, and stigma resistance scale $t(63.31) = 4.21$, $p = .04$. For self-stigma of seeking help, males had higher levels than females, $t(62.89) = 4.37$, $p = .04$. Females were more likely than males to have sought help from a mental health professional: $t(63.66) = 11.38$, $p < .01$.

Correlations Between Self-Compassion, Self-Efficacy, Self-Stigma, and Stigma Resistance

To test Hypothesis 1, which predicted that self-compassion and self-efficacy will negatively correlate with self-stigma and positively correlate with stigma resistance, I conducted Pearson correlations (Table 3). Self-compassion negatively correlated with self-stigma of help-seeking and with self-stigma of depression and anxiety and positively correlated with stigma resistance at a significant level. Self-coldness positively correlated with both self-stigma scales and negatively correlated with stigma resistance at significant levels. Mental health self-efficacy negatively correlated with both stigma scales and positively correlated with stigma resistance at significant levels.

Table 3

Correlations of Predictor and Stigma Variables (All Participants)

	Self-stigma of help-seeking	Self-stigma of depression and anxiety	Mental health stigma resistance
Self-compassion	-.29**	-.34**	.50**
Self-coldness	.25**	.41**	-.33**
Mental health self-efficacy	-.32**	-.44**	.58**

Note. $n = 366$. Pearson product-moment correlations significant at ** $p < .01$, two-tailed.

Due to the aforementioned gender differences, correlations for female participants (n = 313) were also conducted separately but illustrated the same significant relationships as the total sample. See Table 4 for results.

Table 4

Correlations of Predictor and Stigma Variables (Females)

	Self-stigma of help-seeking	Self-stigma of depression and anxiety	Stigma resistance
Self-compassion	-.34**	-.35**	.51**
Self-coldness	.30**	.41**	-.35*
Mental health self-efficacy	-.37**	-.48**	.58**

Note. $n = 313$ female participants. Pearson product-moment correlations significant at * $p < .05$ and ** $p < .01$, two-tailed.

Analyzing the correlations for male participants only ($n = 50$), self-compassion did not significantly correlate with self-stigma, yet it positively correlated with stigma resistance. Self-coldness positively correlated with self-stigma of depression and anxiety; self-coldness did not significantly correlate with self-stigma of help-seeking or stigma resistance. Mental health self-efficacy positively correlated with stigma resistance, while it did not significantly correlate with either self-stigma scale. See Table 5 for results.

Table 5

Correlations of Predictor and Stigma Variables (Males)

	Self-stigma of help-seeking	Self-stigma of depression and anxiety	Stigma resistance
Self-compassion	-.03	-.25	.50**
Self-coldness	.03	.36*	-.27
Mental health self-efficacy	.01	-.21	.51**

Note. $n = 50$ male participants. Pearson product-moment correlations significant at * $p < .05$ and ** $p < .01$, two-tailed.

Predicting Self-Stigma of Help-Seeking from Self-Compassion, Self-Coldness and Mental Health Self-Efficacy

We used a hierarchical multiple regression to predict self-stigma of help-seeking from self-compassion/coldness and self-efficacy measures (Hypothesis 2a; Table 6). For the first model of the regression, the control variables were accounted for: male gender, higher psychological distress, no previous use of mental health services, and perceived stigma of help-seeking were significant predictors of self-stigma of help-seeking.

For the second model, the predictors of self-compassion, self-coldness, and mental health self-efficacy were added to the model. The following emerged as significant predictors of self-stigma of help-seeking: male gender, no mental health service use, perceived stigma of help-seeking, lower self-compassion, and lower mental health self-efficacy; psychological distress and self-coldness were not significant predictors.

To test Hypothesis 2(b), which asserted that self-compassion/coldness and mental health self-efficacy would reduce the strength of the relationship between perceived and self-stigma of help-seeking, the third model included the addition of the three moderators (self-compassion, self-coldness, and mental health self-efficacy times perceived stigma of help-seeking). The predictors of male gender, no previous mental health service use, perceived stigma of help-seeking, less self-compassion, and less mental health self-efficacy remained significant predictors. None of the moderators were statistically significant, although self-compassion times perceived stigma of help-seeking neared significance ($b = -.07$, $p = .07$). This moderation effect was further examined for self-compassion one standard deviation above and below the mean

with PROCESS macro (Hayes, 2022): when self-compassion was low, perceived stigma and self-stigma had a significant relationship in a positive direction ($b = .20$, $p < .01$); when self-compassion was high, the relationship was not significant ($b = .06$, $p = .20$; see Figure 3). In other words, self-compassion somewhat buffered the relationship between perceived stigma and self-stigma of help-seeking; when self-compassion was lower, perceived stigma had a stronger relationship with self-stigma, and when self-compassion was higher, perceived stigma did not predict self-stigma as strongly.

Table 6

Hypothesis 2: Regression onto Self-Stigma of Help-Seeking

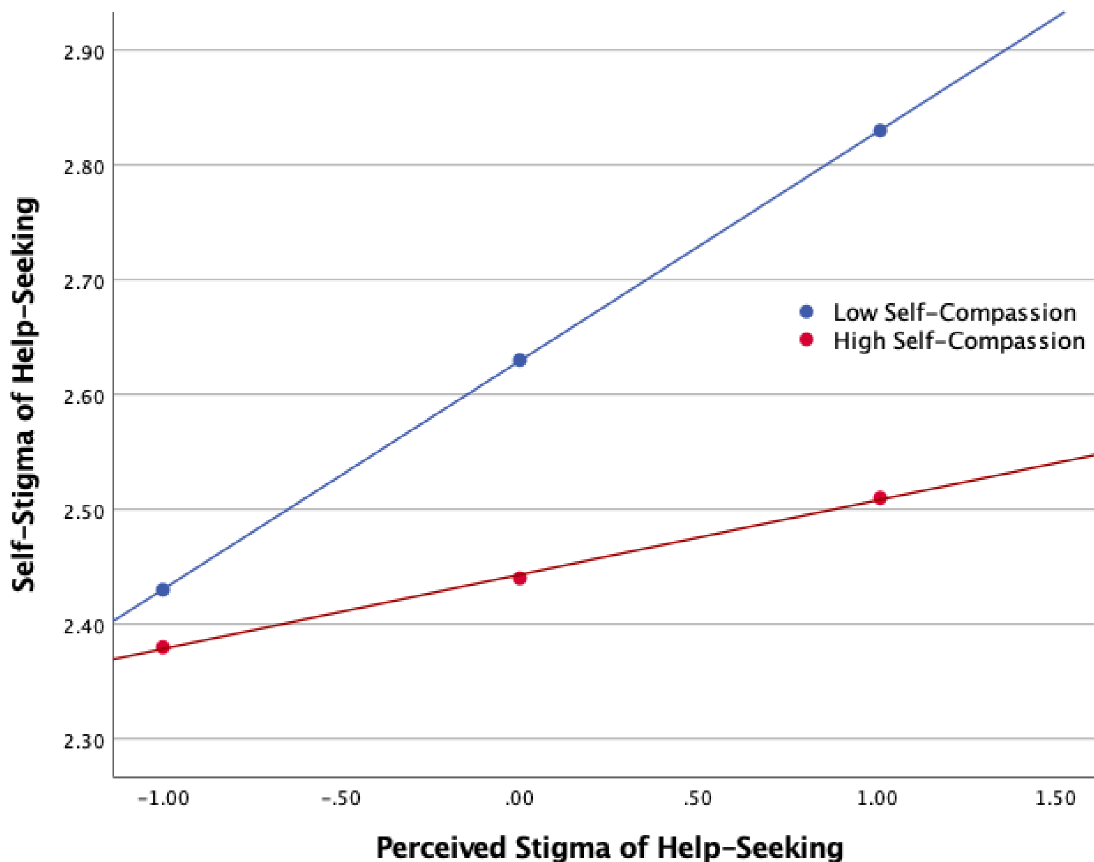
Predictor	R^2	R^2adj	ΔR^2	*B*	*SE B*	β
Model 1: Controls	.16***	.15	---			
Female gender				-.22	.10	-.11*
Psychological distress				.13	.03	.20***
Use of services				-.33	.07	-.24***
Perceived stigma of help-seeking (PSHS)				.15	.03	.22***
Model 2: All predictor variables	.23	.21	.07***			
Female gender				-.20	.09	-.10*
Psychological distress				.03	.04	.04
Use of services				-.33	.07	-.24***
PSHS				.13	.03	.19***
Self-compassion				-.09	.04	-.13*
Self-coldness				.05	.05	.07
Mental health self-efficacy				-.11	.04	-.16*
Model 3: Moderation added	.24	.22	.02			
Female gender				-.21	.10	-.11*
Psychological distress				.02	.04	-.03
Use of services				-.33	.07	-.23***
PSHS				.13	.03	.19***
Self-compassion				-.09	.04	-.13*
Self-coldness				.06	.05	.08
Mental health self-efficacy				-.11	.04	-.16*
PSHS x self-compassion				-.07	.04	-.10
PSHS x self-coldness				.04	.04	.07
PSHS x mental health self-efficacy				.02	.04	.03

Note. * $p < .05$, *** $p < .001$. Overall model: $F(10, 346) = 11.22$, $p < .001$. All continuous predictor variables scores were standardized before analyses conducted. Psychological distress =

Depression Anxiety Depression Scale; Perceived Stigma of Help-Seeking (PSHS) = Social Stigma of Receiving Psychological Help Scale; Self-compassion = Self-compassion subscale of the Self-Compassion Scale; Self-coldness = Self-coldness subscale of the Self-Compassion Scale; Mental health self-efficacy = Mental Health Confidence Scale.

Figure 3

Moderation of Self-Compassion between Help-Seeking Stigmas



Note. Moderation of the relationship of self-compassion between perceived stigma and self-stigma of help-seeking. All continuous predictor variables scores were standardized before analyses conducted.

Predicting Self-Stigma of Depression and Anxiety from Self-Compassion, Self-Coldness and Mental Health Self-Efficacy

To test Hypothesis 3(a), which asserted that self-compassion/coldness and mental health self-efficacy would uniquely negatively predict self-stigma of depression and anxiety, another hierarchical linear regression was calculated (Table 7). For the first model of the regression, the controls were accounted for: gender was not significant, but higher psychological distress, lack of a mental health diagnosis, and perceived stigma of depression and anxiety significantly predicted higher self-stigma of depression and anxiety.

For the second model, the predictors of self-compassion, self-coldness, and mental health self-efficacy were added to the model. In this model, the following emerged as significant predictors: not having a diagnosis, perceived stigma of depression and anxiety, higher self-coldness, and lower mental health self-efficacy; psychological distress was no longer significant and self-compassion was not a significant predictor.

The final regression step included the addition of the three moderators (self-compassion, self-coldness, and mental health self-efficacy times perceived stigma of depression and anxiety) in a test of Hypothesis 3(b). In the final model, not having a diagnosis, perceived stigma, self-coldness, and less mental health self-efficacy remained significant predictors. The moderators of perceived stigma times self-compassion and perceived stigma times self-coldness were not significant, while mental health self-efficacy times perceived stigma emerged as a significant moderator. This moderation effect was further examined for mental health self-efficacy one standard deviation above and below the mean with PROCESS macro (Hayes, 2022): when mental health self-efficacy was low, perceived stigma and self-stigma of depression and anxiety had a significant relationship in a positive direction ($b = .19$, $p < .01$); when mental health self-

efficacy was high, the relationship was not significant (*b* = .00, *p* = .93; see Figure 4). In other words, mental health self-efficacy buffered the relationship between perceived stigma and self-stigma of help-seeking; when self-efficacy was lower, perceived stigma had a stronger relationship with self-stigma, and when self-efficacy was higher, perceived stigma did not predict self-stigma as strongly.

Table 7

Hypothesis 3: Regression onto Self-stigma of Depression and Anxiety

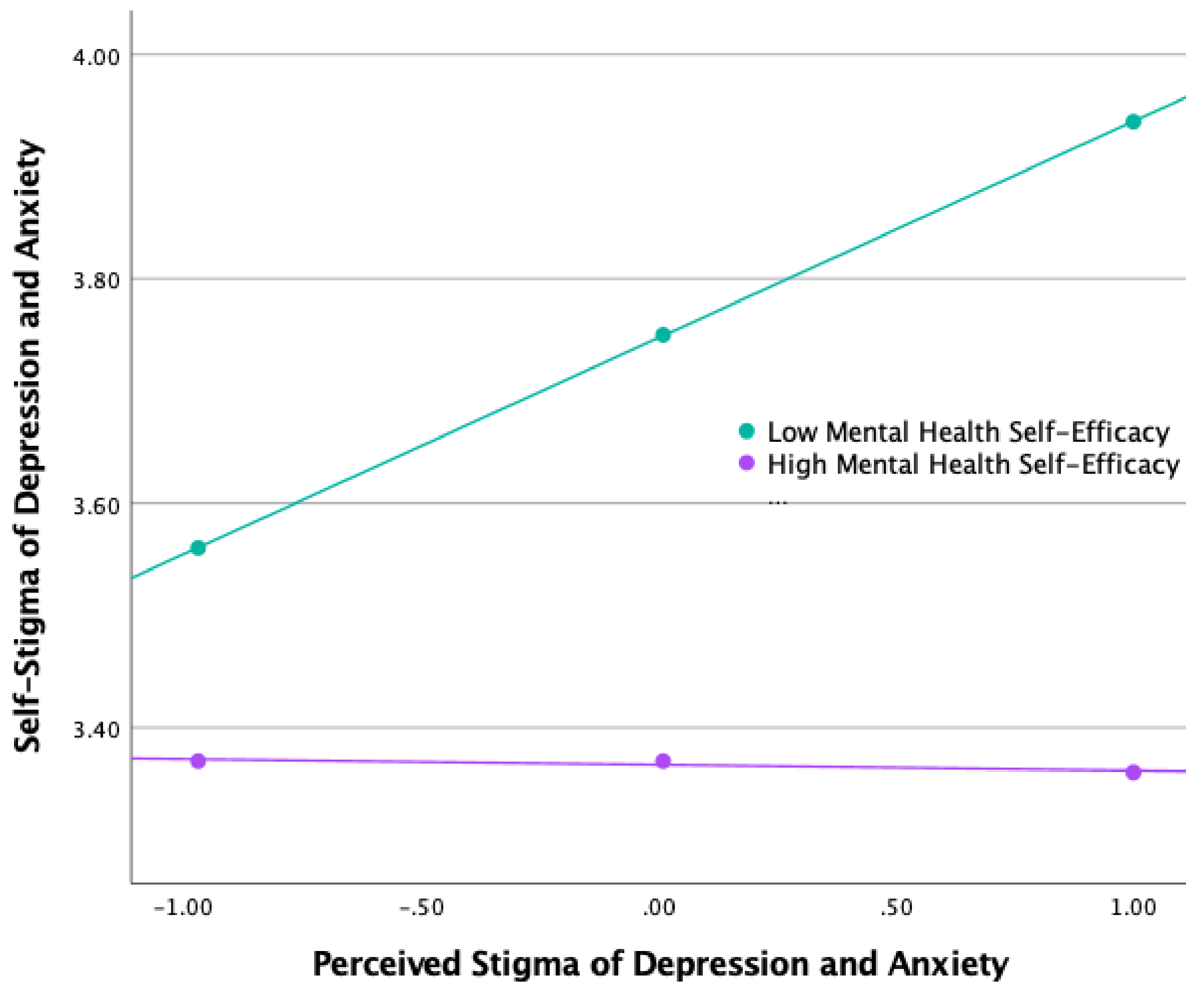
Predictor	R^2	R^2adj	ΔR^2	*B*	*SE B*	β
Model 1: Controls	.10***	.09	---			
Female gender				.01	.09	.00
Psychological distress				.17	.03	.26***
Diagnosis present				-.14	.07	-.11*
Perceived stigma of depression and anxiety (PSDA)				.09	.03	.14**
Model 2: All predictor variables	.27	.25	.17***			
Female gender				.03	.09	.02
Psychological distress				-.02	.04	-.04
Diagnosis present				-.15	.06	-.12*
PSDA				.09	.03	.14**
Self-compassion				-.05	.04	-.08
Self-coldness				.14	.04	.22**
Mental health self-efficacy				-.18	.04	-.29***
Model 3: Moderation added	.28	.26	.02			
Female gender				.04	.09	.02
Psychological distress				-.03	.04	-.05
Diagnosis				-.15	.06	-.12*
PSDA				.10	.03	.16**
Self-compassion				-.05	.04	-.08
Self-coldness				.14	.04	.23***
Mental health self-efficacy				-.18	.04	-.29***
PSDA x self-compassion				.04	.04	.06
PSDA x self-coldness				-.01	.03	-.03
PSDA x mental health self-efficacy				-.10	.04	-.16**

Note. * $p < .05$, ** $p < .01$, *** $p < .001$. Overall model: $F(10, 343) = 13.64$, $p < .001$. All continuous predictor variables scores were standardized before analyses conducted. Psychological distress = Depression Anxiety Depression Scale; Perceived stigma of depression

and anxiety (PSDA) = Perceived Stigma of Depression and Anxiety Scale; Self-compassion = Self-compassion subscale of the Self-Compassion Scale; Self-coldness = Self-coldness subscale of the Self-Compassion Scale; Mental health self-efficacy = Mental Health Confidence Scale.

Figure 4

Moderation of Mental Health Self-Efficacy between Depression and Anxiety Stigmas



Note. Moderation of the relationship of mental health self-efficacy between perceived stigma and self-stigma of depression and anxiety. All continuous predictor variables scores were standardized before analyses conducted.

Predicting Stigma Resistance from Self-Compassion, Self-Coldness and Mental Health Self-Efficacy

Hypothesis 4, that self-compassion and self-efficacy would positively predict, and self-coldness would negatively predict stigma resistance, was tested with a hierarchical regression (Table 7). For the first model of the regression, the control variables were accounted for: female gender and lower psychological distress were significant predictors of stigma resistance; having a mental health diagnosis was not significant. Perceived stigma correlated with stigma resistance in a positive direction in the first model; yet the variables did not significantly relate when analyzed in a bivariate correlation (r = .01). Self-stigma of depression and anxiety correlated with stigma resistance in a negative direction.

For the second model, the predictors of self-compassion, self-coldness, and mental health self-efficacy were added. With these additions, some controls (female gender, less self-stigma) remained significant predictors of stigma resistance, psychological distress and perceived stigma became insignificant, and the presence of a diagnosis remained insignificant. The predictors of self-compassion and mental health self-efficacy were significant in a positive direction; self-coldness was not significant.

The third model included the addition of the three moderators (self-compassion, self-coldness, and mental health self-efficacy times self-stigma of depression and anxiety). None of the three moderators were significant.

Table 8

Hypothesis 4: Regression onto Stigma Resistance

Predictor	R^2	R^2adj	ΔR^2	*B*	*SE B*	β
Model 1: Controls	.21***	.20	---			
Female gender				.20	.07	.13**
Psychological distress				-.11	.03	-.21***

Diagnosis present				.06	.05	.05
Perceived stigma of depression and anxiety (PSDA)				.06	.03	.10*
Self-stigma of depression and anxiety (SSDA)				-.19	.03	-.36***
Model 2: All predictor variables	.43	.41	.21***			
Female gender				.14	.06	.09*
Psychological distress				-.02	.03	-.03
Diagnosis present				.08	.05	.07
PSDA				.03	.02	.06
SSDA				-.09	.03	-.16***
Self-compassion				.15	.03	.29***
Self-coldness				.06	.03	.11
Mental health self-efficacy				.22	.03	.40***
Model 3: Moderation added	.43	.41	.00			
Female gender				.14	.07	.09*
Psychological distress				-.01	.03	-.03
Diagnosis				.08	.05	.07
PSDA				.03	.02	.06
SSDA				-.09	.03	-.16**
Self-compassion				.16	.03	.29***
Self-coldness				.06	.03	.10
Mental health self-efficacy				.22	.03	.40***
PSDA x self-compassion				.03	.03	.06
PSDA x self-coldness				.01	.03	.02
PSDA x mental health self-efficacy				-.01	.03	-.02

Note. * $p < .05$, ** $p < .01$, *** $p < .001$. Overall model: $F(11, 343) = 23.21$, $p < .001$. All continuous predictor variables scores were standardized before analyses conducted. Psychological distress = Depression Anxiety Depression Scale; Perceived stigma of depression and anxiety (PSDA) = Perceived Stigma of Depression and Anxiety Scale; Self-stigma of depression and anxiety (SSDA) = Self-Stigma of Depression and Anxiety Scale; Self-compassion = Self-compassion subscale of the Self-Compassion Scale; Self-coldness = Self-coldness subscale of the Self-Compassion Scale; Mental health self-efficacy = Mental Health Confidence Scale.

Thematic Analysis of Qualitative Data

The themes were organized according to the three written questions presented to the participants (See Table 9). The topic of general stigma resistance had seven themes: coming to terms with experiences, opening up about struggles, becoming comfortable with seeking help, receiving social support, sharing experiences with others, education and advocacy, and righteous anger. The topic of resisting with self-compassion had five themes: self-kindness, self-care, normalizing experiences as common, mindful evaluations and detachment, and struggling with practicing self-compassion. The topic of resisting with competence and skills had three themes: feeling capable and empowered, not suffering in all areas of life, and struggling with perceiving and displaying competence.

Table 9

Study 1: Themes Related to Stigma Resistance, Self-Compassion, and Competence

Written Question Topic	Themes
General mental health stigma resistance	Coming to terms with experiences Opening up about struggles Becoming comfortable with seeking help Receiving social support Sharing experiences with others Education and advocacy Righteous anger
Resisting with self-compassion	Self-kindness Self-care Normalizing experiences as common Mindful evaluations and detachment Struggling with practicing self-compassion
Resisting with competence and skills	Feeling capable and empowered Not suffering in all areas of life Struggling with perceiving and displaying competence

General Mental Health Stigma Resistance

Responses to the general topic of mental health stigma resistance highlighted the acknowledgement of one's mental health experiences through the process of beginning to learn about and accept their mental health challenges, starting to open up about these challenges, as well as seeking help and learning to be okay with seeking help. Participants also revealed that they were able to work against stigmatizing beliefs by having empathic and loving support from others. In turn, intraindividual benefits of stigma resistance were often shared back with other people through personal storytelling, advocacy and education, and righteous anger.

Coming to Terms with Experiences. Participants referenced coming to terms with experiences 19 times. Several participants described their stigma resistance as commencing with a realization about their mental health and acknowledging the stigma that has impacted them. The longer individuals experienced difficulties with their mental health, the more likely they were to acknowledge that they had a problem. One man with diagnosed OCD wrote, "Well, whenever I tried to resist it, I realized the more bad my symptoms got the next day. So I accepted my problems…" (Participant #152, male, age 18). Another participant with both depressive and anxiety disorders described how unproductivity in her life helped reveal she had a mental illness:

> I believe for a long time I didn't believe I was mentally ill because I was high functioning and productive. I equated productivity with wellness and as long I was getting things done, I was fine. When I began to become unproductive even with activities I enjoyed, that is when I realized there may be a problem. (Participant #150, female, age 23).

Participants also talked about how education about mental health assisted them in coming to terms with their own experiences. Many stated that knowing mental health issues were real helped reduce the stigma; for instance, realizing that it's not just "regular sad teenage-angst" but

"an actual mental health issue." Others could contest the message that mental illness is a moral weakness or a choice by identifying multiple causes, including genetics, neurology, brain chemistry, and life experiences. Excerpts here demonstrate how learning about the intricacies of mental illness helped them understand and accept their mental health struggles:

> I was told by my family that a person who is depressed is weak within themselves, and that if I was more faithful and stronger that I would not have episodes of depression. After hearing this I refused to accept that this is the reason why I felt down during my episodes, instead I said it must be from factors within my neural chemistry or factors within my life situation. (Participant #195, male, age 23).

> I have often caught myself thinking that my life actions have led me to choose the mental illnesses I live with, but then other people as well as myself have reminded me that mental illnesses are either hereditary or caused by trauma and I did not choose to live this way. (Participant #166, female, age 18).

> And it started with acceptance and understanding, first accepting that when I felt this way it wasn't me, it was chemistry and neurology at play. I would be having a bad day with nothing wrong and accepting that I'm not having a bad day just a bad mind chemistry is what is making me feel that way. Which I figured was some form of bipolar and I did some research, and took time to understand pre-symptoms and symptoms I would experience ... (Participant #65, male, age 25).

Numerous participants studied psychology in school or learned about mental health through other means. This education rendered a powerful and often helpful recognition of mental health; this ultimately assisted with defying the stigma and unhelpful stereotypes concerning mental illness diagnoses. Quotes from two women are as follows:

> I think the more I learn in psychology about mental health, the more comfortable I feel to speak on personal experiences and seek help. Before, I never mentioned anything about good or bad days but now I feel because I have the educational background, I can support my feelings with logic while talking to others. (Participant #136, female, age 19)
>
> As someone studying psychology, I recognize this is a real problem. Not something that people are pretending. And I understand the pain they feel. (Participant #123, female, age 19)

Opening Up about Struggles. Along with personal reflection and education, beginning to open up to others helped individuals further acknowledge their experiences (theme referenced 11 times). Talking about what they were going through contradicted the societal belief that one should keep their struggles to oneself. Participants described talking with family, friends, and significant others after hiding their struggles for a long time in the following:

> I used to not talk about what I struggled with to anyone, and I used to be the only person who knew besides professionals. I learned that talking about it and educating others helps to reduce the stigma, so I opened up to some family and friends about what I deal with. (Participant #23, female, age 20)
>
> I started talking about it. I knew that I needed to talk about it to people, not only to share my story and maybe help someone else but also to help me (Participant #178, female, age 35)
>
> I started being more open to my significant other as to when I was feeling down instead of bottling up my feelings (Participant #17, female, age 19).

Not only did opening up signal to others that help was needed, but it directly challenged the harm that avoidance and silence brought. One person identified the ongoing challenge to be

open but recognized the need to prevent mental health from sinking in silence, while another became more visible with their struggles by no longer covering self-harm scars:

> The main stigma I struggled with was that no one was talking about it. And I felt alone in my battle. With opening up and researching I soon learned that so many other people are experiencing similar battles, not identical to mine, but relatable. I had to resist keeping my struggle to myself for the fear no one else was feeling what I was feeling. I kept my depression to myself for a long time, which only made it worse. I still keep it from some people, but have found the courage to open up to others. (Participant # 122, female, age 18).

> My experience of internalized stigma has been in attempting to hide self-harm scars. I generally resist this by making a conscious decision to wear clothing that does not hide the scars (Participant #24, male, age 21).

Becoming Comfortable with Seeking Help. Many participants (theme referenced 24 times) who chose to answer the open-ended questions wrote about how seeking help for their mental health was a huge turning point in stigma resistance. Participants realized that it was to not have to handle things on one's own and "to seek help or support from others." One woman with diagnosed anxiety and depression wrote, "There is nothing wrong with seeking help when you need it because it helped me and I would not be where I am today or as strong as I am today without help." (Participant #8, female, age 27).

Seeking help and seeing successful results was empowering for many individuals. One woman wrote about taking the steps to talk to a counsellor or go to therapy and feeling bold for seeking help: "Usually, it just takes one badass person to say 'Yeah, I messed up really bad, but I'm fixing it- with help!'" (Participant #185, female, age 34). Another wrote, "I was strong for

seeking help and helping myself allowed me to help others." (Participant #108, female, age 21). Often these positive feelings were in direct contrast to negative internal thoughts regarding seeking help. Other participants reported that they were "glad" and "proud" of themselves for getting the help they needed.

One woman wrote about the journey of coming to terms with her mental health directly led to viewing help-seeking from a more positive light:

> When my depression was bad, I felt as though seeking professional help would make me seem incapable of being independent but once I learned to accept my mental health problems as an aspect of my life, I realized that therapy was actually a great help. (Participant #43, female, age 20)

Participants also acknowledged that using medication and becoming comfortable with using medication were significant components in healing and acceptance. Realizing that antidepressants can be helpful seemed to challenge the stereotypes that medications change someone or that needing medications is shameful. Two participants wrote about struggling with the need for antidepressants and learning to accept that (even though it's still hard):

> Some of my experiences of internalized stigma are coming to terms with the fact that I'll likely need to be on an SSRI for the rest of my life, and being okay with that. It's still a hard thing to deal with, and it's still incredibly frustrating that I need to take a medication in order to function at a normal level. (Participant #112, non-binary, age 28)
>
> I had to finally choose whether to continue to suffer or swallow my pride and feel better. I ultimately chose to take antidepressants and it's the best decision I've ever made. I now tell people that antidepressants don't change your personality, they help you become "you" again. (Participant #157, female, age 23)

Lastly, finding services with relevant cultural awareness facilitated an Indigenous woman's seeking treatment. She illustrated how having a good cultural fit with a service allowed for them to seek help comfortably:

> I have seen counsellors in agencies that do not understand spirituality and culture for Indigenous clients. I have found a private practice [that] is Indigenous led by an Indigenous man and I have not felt the need to hide or feel bad about accessing counselling services for the betterment of my mental health. (Participant #111, female, age 26)

Receiving Social Support. Many participants (theme referenced 14 times) mentioned how having a great support system allowed for a safe environment to open up about struggles, work on healing, and feel empowered in the process. People "realized how important it is to talk to the people around you about how you are doing mentally" because social support was "crucial." One non-binary/transmasculine person identified how they believed it was best to heal independently, only to learn that isolation exacerbates mental illness; they wrote the following excerpt:

> I had an internalized stigma that accepting help for mental health meant that I was weak and couldn't figure out my problems myself (that I had allegedly caused in the first place). I have learned through therapy that it's impossible to pull one's life together by themselves if they are struggling. They need community and support in ways of therapy and supportive friends and family. Mental illness thrives in isolation, and all one needs is another person there to help carry that weight. (Participant #138, non-binary, age 28).

Sometimes, other people first helped an individual identify that they were mentally struggling. One woman without a mental health diagnosis noted, "It took a strong support group

of friends to notice that I wasn't doing as well as usual, and walk alongside me, to learn that it's okay not to be okay." (Participant #159, female, age 21). Along with friends, "understanding and supportive parents" were a great source of support in letting their child know seeking help is okay. Being raised with a positive outlook on mental health was a strong influence regarding current mental health journeys. One woman with a diagnosed anxiety disorder recognized: "I am very lucky to have a mom that worked in mental health who told me since I was young that getting help was nothing to be ashamed of." (Participant #149, female, age 19).

Instead of internalizing the harmful stereotypes about mental illness from society, those with a support system could internalize positive messages of compassion and love. Receiving compassion from friends allowed for self-compassion to make way, as seen in the following quote: "As my friends around me have had compassion for me, I have learned to have compassion for myself." (Participant #159, female, age 21). Social support could also work alongside an intrinsic or internal support to ensure more than one form of coping help during difficult times:

> I feel like if you believe in yourself and you have others who believe and care for you too it's easier to overcome. When you know you're okay and you can handle your mental illness the compassion and love you share for yourself spreads throughout the body. At that point, you are able to help determine how to get through a specific dark time in your life. (Participant #37, female, age 20)

Sharing Experiences with Others. Several study participants noted accounts of resisting stigma by telling their mental health stories (theme referenced 23 times). One woman acknowledged how she chose to share after initial reluctance, writing "When I was in the hospital, I didn't want anyone to know because I saw it as weakness until I realized how many

people I could help by speaking about what I went through." (Participant #165, female, age 18). Another woman saw the strength in her mental health experiences because it meant she could help others; she wrote, "I consider my journey as a story that I can share with others to help others who face similar mental and emotional problems as I do." (Participant #111, female, age 26).

Comfortability in sharing with others was reciprocated wherein friends became comfortable in opening up and receiving advice to seek help if needed. One woman with diagnosed anxiety and ADHD wrote, "I am open with telling people about my struggles, and my friends feel comfortable coming to me with theirs, and I now encourage them to see a professional for themselves." (Participant #1, female, age 21). Another woman with diagnosed trauma, mood, and anxiety disorders agreed that others modeling openness allowed for further encouraging others to be open to seeking help:

> I tell people I see a mental health professional and I encourage others to do the same. I have friends that ask me about my experiences and if I can share them with people who are struggling. I also let people know if they have people struggling to let them know that I seek counsel and have done so for years and that it is beneficial to see a mental health counsellor regularly equally as is seeing a medical doctor. (Participant #218, female, age 43)

While some people may share general struggles, others presented personal and relatable stories that might speak to a certain population. For example, a substance abuse survivor who now works in a facility where they were treated as well as a successfully employed mother with mental health issues shared the following two quotes:

> I once lived in a recovery home, while I placed focus completely on healing the darkness of my past. I met amazing people, and two years later I started working in that facility as a spiritual advisor- as I am clean and sober through the teachings of my culture. I began sharing my story, making it more relatable and powerful throughout the last two years, and I am now being paid by companies and organizations to tell countless people struggling (with circumstances that were similar to my own) my story- and I have always stood up as the person who says, "It is OKAY to say you're [not] okay, and to reach out for help!" I'm alive today because one day I decided I was worth helping. (Participant #185, female, age 34).

> I am generally very open about my mental health issue with most people as I feel it does come with stigma that generally implies lack of ability to be a working member of society, and I am reputable employed, a secondary education student and a mother; so it allows people to build a different narrative. (Participant #137, female, age 30).

Some participants were able to reap the rewards of sharing their stories. One woman acknowledged how the open conversations helped affirm that harmful stigmas were not true: "The more I talk about these issues with like-minded people, the more confident I feel in my beliefs about the false stigmas around mental health." (Participant #192, female, age 20). Another woman found that being open in the workplace transformed the entire work environment:

> I began to be more open with my co-workers in general, and through this confidence, was more effective at my work, leading to advancements and new opportunities. The culture in the workplace also shifted, and while some people continued to hold their stigmatized

views about mental health, in general, everyone became more open and understanding, not just to me but to each other. (Participant #78, female, age 31)

Education and Advocacy. The theme of education and advocacy was referenced by participants 39 times. Support against stigma arose from being able to learn from others. One woman detailed how she had the opportunity to learn about the topic of stigma specifically, which was empowering for her; she wrote, “Over the years I’ve sat through many stigma online videos and in-person presentations and I believe they’ve all made me more competent in understanding stigma and what needs to be done to stop it.” (Participant #50, female, age 18).

Participants also cultivated skills in stigma resistance via informal and formal education on mental health:

> After becoming more educated on mental health, I learned how to be more supportive of myself and others. Hearing about others’ personal battles with mental health as well as learning about mental illness in school are definitely two things that helped shape my positive outlook on mental health. (Participant #189, female, age 20).
>
> Taking psychology courses, doing my own research and seeing different life experiences like my sister and my dad has helped me have a much better understanding of mental health. It makes me feel more confident to speak against stigma resistance. (Participant #109, female, age 18).

Many participants marked how they will correct other people, including friends, who are perpetuating stigma and stereotypes: “I always speak up when I hear people react with why someone shouldn’t be depressed based on what they have in their life.” (Participant #88, female, age 33), “In a civilized conversation about mental health I often bring up mental health stigmas and argue against them.” (Participant #127, female, age 17), and “When I hear people make

comments related to mental health stigma, I try to politely correct them or offer alternative ways of thinking." (Participant #150, female, age 23). One woman recounted how she calls out family members in particular for their stigmatizing views on mental health:

> I come from a family who believes addiction is a choice, anxiety is a choice and so is depression. That if you just put your big girl pants (or big boy) on and get a job and pay your bills that you won't even have time to be depressed or anxious. And every time my family announces these views, I always make sure I show them how wrong it is to think that way. It is important to call out someone who is stigmatizing these illnesses because they wouldn't stigmatize someone with diabetes so why to someone with depression or anxiety? (Participant #48, female, age 28).

Another woman with diagnosed anxiety and depressive disorders wrote how her self-acceptance and first-hand knowledge of proving stereotypes wrong allows her to advocate for mental health:

> I was diagnosed with anxiety and depression three years ago and since then I have learned how to accept my myself and what my mental illness makes me do/feel… My awareness has impacted my experience. I am able to see when stigmas are wrong and advocate for anxiety/depression because I know first-hand what it can do at its worst and how you can live a semi-normal life with it, without second guessing everything as well. (Participant #38, female, age 21).

Advocacy was also seen in more extensive interpersonal engagements, including in school settings as well as within mental health-based organizations. One woman explained a school project she did about bringing awareness "about how mental health in students is very hard to recognize with definitions for each of the mental health disorders along with what the

actual common feelings are like." (Participant #71, female, age 23). Another woman mentioned she runs an organization that focuses on "Black women's mental health and empowerment" (Participant #207, female, age 20), and another wrote about her role as "an advocate for mental health with a Canadian organization, jack.org," which includes engagement across the country "to break the stigma." (Participant #210, female, age 18).

Righteous Anger. A few study participants (referenced four times, by four participants total) documented experiences of learning to stand up against harmful mental health stigma with justified and righteous anger. Sometimes this indignation was reflected in a self-compassionate defence or rightful rebukes of those in authority who should know better. One woman passionately wrote about how she stands up for herself against ignorance:

> I always stand up for myself. I believe I am worthy of compassion-- by God and by my peers and that anyone who thinks otherwise, is suffering worst of all with their own ignorance, they are afraid to be abnormal. To me, they are blind to their own intellectual mental illness. Ignorance. (Participant #121, female, age 38)

Another participant recounted a time in high school when she was dealing with anxiety, and although she was receiving support from a guidance counselor, she had to reproach a misinformed teacher:

> I do vividly remember some teachers who did not understand why I needed to be at home during that time, and one even confronting me in the hallway about it when they saw me picking up homework. Since they had their own misconceptions about mental health and personally felt like I should be in class, I emotionally explained to the one teacher on my own, in the middle of the hallway, that I was struggling with an anxiety disorder, and that the guidance office should have explained this. That was one of the first times I really

stood up for myself and told someone it was inappropriate to assume things about people and chastise them when they do not understand a situation or condition properly. (Participant #68, female, age 26)

Righteous anger was also extended on the behalf of other people. A few people described disbelief regarding witnessing ignorance and negativity toward other people with mental illness. They felt for the people who were struggling and detested the judgment, as seen in the following citations:

> When hearing those speak upon people with mental health problems in a negative light, I don't stand for it. I understand what it is like to feel such ways for basically no reason and I wouldn't want people talking like that about me. (Participant #60, female, age 20)
>
> A coworker started telling me his friend was pretending to be suicidal so I explained that his friend was most likely trying to reach out for help and the coworker just laughed it off ... got me very upset! (Participant #172, female, age 20)

Resisting with Self-Compassion

Themes on resisting stigma with self-compassion comprised self-kindness and self-care, normalizing experiences as common, and mindfulness evaluations and detachment. One woman with diagnosed anxiety and ADHD eloquently described her experience of the various facets of self-compassion in a single response:

> Self-compassion and self-love is the only 'treatment' worth having. Nothing has helped more than reshaping my thoughts and internal dialogue and moving it towards something that is kinder, gentler, and more loving. We cannot succeed if we are constantly yelling at ourselves, crushing ourselves, and hurting ourselves. Being our own worst nightmares. Self-compassion has helped me find peace with myself, resist the negative and

> overwhelming feelings that swamp me, it has helped me accept myself and make realistic and supporting decisions about my life. I struggle with it still but every time I offer myself kindness things get better. Self-compassion and mindfulness are some of the best tools we could possibly have for healing anxiety, depression, and mental health struggles. (Participant #187, female, age 24).

Self-Kindness. Self-kindness was seen in positive self-talk and being gentle with oneself (referenced by participants 57 times). This was referred to this as a kind internal monologue “to try to remind myself to speak to me the way in which I would speak to someone else struggling with mental health.” (Participant #196, female, age 33). Affirmations shared by participants related to self-accept when things aren’t perfect, such as telling oneself, “I am trying my best.” They also told themselves it was okay-- “okay to be sad sometimes,” “okay to not be functioning at my best 100% of the time,” and “okay to struggle and that it’s not always possible to just ‘pull my socks up’ or ‘pull myself together’ all of the time and that I need to take time to face and work with these experiences.” One woman documented how she explicitly thinks of five positive things about herself daily; this activity not only increased her happiness but also directly opposed the stereotype that those with depression or anxiety cannot be happy:

> Having compassion and kindness for myself has impacted my experience with stigma resistance, because I feel that when someone looks at a person with depression or anxiety or both, their initial thought may be that “they’re never happy with themselves,” however this is untrue and I can attest to break-in this stigma because I try to think of at least 5 positive things I like about myself, or things I’m proud of that I’ve done each day. To me, this breaks that stigma, and having this self-compassion and kindness for myself

> ultimately breaks the stigma that because I have anxiety, "I'm never happy with myself." (Participant #213, female, age 18).

Self-kindness also came with an intentional resistance to negative self-talk (referenced 34 times). This included therapy work to stop negative thinking patterns and "retrain [their] brain." They challenged feelings of inferiority: that they are "no less of a person" because they have depression and anxiety and "not inferior just because [they] struggle with mental health issues," but rather they are "stronger" for overcoming the hardships. They also challenged stigmatizing thoughts that they are blameworthy for struggling with their mental health. Participants worked on their own or with therapists to know that their mental illness was not their fault. They delineated the process of "trying to internalize that thought to replace the old [self-blaming] one." Learning that they cannot control the origin of their illness gave them a self-compassionate stance to hold onto, as seen in the quotes from two women:

> Getting up the strength to be compassionate to me was extremely difficult because I had made myself believe that my life meant nothing, but I was able to fight the internalized stigma and stopped blaming myself for something I had no control over. (Participant #171, female, age 17)
>
> My mother, who also suffers from mental illness, taught me to be kind to myself. She always said there was nothing wrong with me, my brain was just wired incorrectly. I always remind myself of her words and I feel more confident knowing that I couldn't stop or control the development of my mental illnesses. I now believe a mental illness can be considered similar to a physical illness. (Participant #157, female, age 23)

Self-Care. Another aspect of self-compassion was actionable self-care (referenced 13 times), which included reminders to put oneself first, taking care of oneself via seeking

professional help, nourishing one's body with food, and engaging in fun activities. Many participants illustrated intentional actions to put aside time to meet their own various needs. Some excerpts are as follows:

> Self-compassion has impacted my experience with stigma resistance because taking care of myself has become really important. Putting myself first has always been difficult for me, but once I started taking the time to it has helped me overcome stigma resistance. (Participant #80, female, age 21)

> Starting [university], I read all the materials about wellness and mental health and now every day I check with myself with questions like: Did I eat well? Did I move? Did I talk to a friend? Did I deal with important things to do? Did I pray? And that helps me to be on the top of my issues and I don't want to let them overwhelm me. (Participant #139, female, age 24)

> I also started carving out time in my day for activities that help my mental well-being (ex: crocheting, yoga) instead of only doing schoolwork, getting exhausted, and then getting down on myself when I did not accomplish as much as I had planned. It is all about balance in your life. (Participant #17, female, age 19)

Self-care was also seen as intentionally taking breaks or days off when needed. This was identified as an act of self-love and a step that allows one time to cope with mental health struggles as well as instances to slow down and have time to resist societal stigma and become more accepting of oneself intentionally. Several women engaged in self-compassion by physically and metaphysically taking care of themselves:

> By allowing myself physical and mental breaks and just taking care of myself it gives me the power to know that just because some people struggle with things does not mean you

> cannot love yourself. Loving yourself means giving yourself time to rest but also maintaining your day-to-day life. (Participant #42, female, age 18)
>
> Self-compassion has impacted my experience with stigma resistance because taking care of myself has become really important. Putting myself first has always been difficult for me, but once I started taking the time to it has helped me overcome stigma resistance. (Participant #80, female, age 21)
>
> Now being older and on my own, experiencing more people's journeys, and learning more [about] health, I am learning to let myself take care of myself before helping others. I allow myself to take days for myself and think things through. Slowly I am becoming more accepting of taking time for myself to cope. (Participant #136, female, age 19)

One mother wrote how her self-care was justified as the same care she would give to a loved one; her actions were also kindled by the idea that she needs to her best self in order to take care of her daughter. She wrote the following:

> Though counselling and self-love routines I work on caring for myself as if I were a close friend or family member. I'm learning to take care of myself so I can be the best parent I can for my daughter. if that means counseling or medication then so be it. (Participant #176, female, age 34)

Normalizing Experiences as Common. Closely tied to other aspects of self-compassion, participants were able to resist stigma by realizing they were not alone in their struggles as human beings (theme referenced 29 times). Many realized how common it is for "thousands of people" to have similar experiences with mental health difficulties. Some methods that were helpful in normalizing mental health included researching online and seeing individual stories on social media. One woman explained, "Seeing others share their stories on socials make me feel

not so alone and especially when girlfriends of mine come out as struggling I feel way less alone or like an outsider." (Participant #163, female, age 19). Another recalled, "With opening up and researching I soon learned that so many other people are experiencing similar battles, not identical to mine, but relatable." (Participant #122, female, age 18).

A couple of participants with anxiety wrote about how they overcame embarrassment and self-consciousness by realizing they were not alone in their anxious experiences. Relief did not have to come from the absence of anxiety, but rather from the understanding that others have experienced this before. Two participants depicted this:

> Often times when I start to feel anxious, feel a panic episode coming on, or fully experience that panic attack I find myself getting into my own head about how embarrassed I am that I had to leave a social event, or could not bring myself to attend the most basic of social events in the first place, and I get overwhelmed thinking that I could be doing better to maintain those feelings. However, I then remind myself that other people experience the same feelings I do, that I am not alone, and that there is no need for me to feel embarrassment or any other negative feeling associated with my mental health. (Participant #105, female, age 21).
>
> I often feel embarrassed about being socially anxious, but I resist the stigma that other people do not feel this way and realize a lot of people do which helps me not be so self-conscious about my own appearance and behavior. (Participant #22, female, age 21).

Defiance from stigmatizing beliefs was upheld by acknowledging that mental health difficulties are an inevitable experience. This normalizing of struggles allowed individuals to put their own experiences in perspective. One participant wrote, "It's always difficult to remind myself that everything in life is not an upwards road. There are always going to be ups and

downs regardless of where one is." (Participant #75, female, age 21). Another wrote how she learned to have self-compassion for her own "battle," as others have their own to deal with: "I learned it is okay to have compassion for yourself and what you're going through. Everyone goes through something or multiple things, and I learned to remind myself that this is my battle." (Participant #220, female, age 22). Furthermore, participants identified how their university education contributed to their understanding of human mental health in general, which rendered leeway when it came to their family and personal mental health:

> I think now that I am in psychology and have learned more about depression, anxiety, and eating disorders, I am better able to understand the issues my dad, who has clinical depression. This in turn has made me a little more understanding towards myself when I am feeling depressed or anxious, and I try to tell myself that it is okay to feel this way. (Participant #130, female, age 27)

> Once I got into university, I learned a lot. Something that really stuck though was when my professor said we are only human and through studies I learned more and more what that means…It asks you to see that you are only human and humans are far from perfect so allow yourself to be imperfect as well it's okay. It allows me to be okay with myself. (Participant #178, female, age 35)

Mindful Evaluations and Detachment. Self-compassion was also revealed in people being able to take a step back to evaluate all they are thinking and feeling and to experience and accept the truth of their struggles (referenced 35 times). The need to suppress negative feelings was absent for one woman who resisted stigma; she said, "I don't tend to stigmatize myself. I let myself feel what I am feeling and deal with it accordingly." (Participant 11, female, age 19). Another woman identified they can accept their feelings as temporary, as she said, "I find that

accepting how I feel and knowing it will pass is a big help." (Participant 116, female, age 40). Sometimes, this acceptance was balanced by a discrete time in their feelings followed by moving on; as one person wrote, "I'm able to let myself live in my feelings for a bit as long as I set a specific time where I have to get up, shower, and move on with my life no matter how badly I may still feel." (Participant #29, female, age 19). Another delineated how she was able to mindfully evaluate by examining their experiences in the form of words or art:

> Externalizing my internal experience helps to step back and witness what is really happening for me, and where I'm at. Once it is out in the form of words or art, I can work with it more tangibly and concretely. (Participant #103, female, age 28)

While mindful evaluation let the individual experience the fullness of their thoughts and struggles, it sometimes comprised detachment from harmful outside beliefs and stereotypes. They stated that they "do not care what people think," "forget about the misinformation that people spread," "stopped believing popular stigma about mental health issues," and "basically turned off any judgments and tossed any preconceived notions about mental health out the window." They chose to ignore what "uneducated people might say about mental health," those "who haven't experienced it" or those "who do not understand it." One man was able to achieve detachment by telling himself, "Those who propagate stigma are unaware or rather cannot comprehend the other side of the field. It's their view and has nothing to do with me. My reality is my own." (Participant #104, male, age 25).

Participants chose not to overidentify with what society says regarding mental health struggles. Many participants explicitly wrote that they chose not to be "defined" by the diagnosis, the mental illness, or the bad days. Despite many participants having diagnoses, they stated that their mental illness did not define their value as a person, and even more so, they were

much more than their mental health. One woman wrote, “I am a strong believer that an individual has so many more defining qualities than just their mental health state and that no illness should ever define anyone.” (Participant #120, female, age 21). This detachment from social views allowed for a reduction in the shame of mental illness, as evidenced in the following excerpt:

> [Self-compassion] helped me not attach such a strong sense of shame to my mental illnesses. It has a more neutral feel to it now, if that makes sense. It is what it is. I don’t love them, but I’m also not ashamed of them. (Participant #138, non-binary, age 28)

Struggling with Practicing Self-Compassion. Self-compassion was a strong component of stigma-resistance. At the same time, many participants struggled with being kind to themselves (theme referenced 50 times). Some participants stated that they simply lack self-compassion. Several participants wrote that they tend to be “very hard on [themselves],” can be their own “harshest critics,” and are guilty of “not giving [oneself] much of a break as fair as [one’s] own failures and struggles.” In fact, several participants identified that they have less compassion toward themselves than toward others. One woman wrote, “I judged myself for what I was going through but I never judged others” (Participant #144, female, age 18), and another wrote, “I am very supportive of other people taking care of their mental health in any way they see fit, but I have difficulties extending that compassion to myself.” (Participant #97, female, age 23). On the other hand, one woman reflected on how she does not perceive compassion from society and how that impacts her ability to turn any compassion inward. She wrote, “I find it hard to have self-compassion when around people who strongly believe in the stigma around mental health, making self-compassion have little impact on my experience with stigma resistance.” (Participant #61, female, age 20).

Another battle with self-compassion was the amount of practice and time it takes. Participants stated that self-compassion "is a behavior that needs to be learned," that it is something "to work on every single day," and "it isn't as easy as everyone makes it sound." Even when one puts in the effort to practice, there may be "slow progress." Part of why it is hard to practice may be due to a continued internal conflict, that of wanting to be kind to oneself versus the reality that one still has a mental illness. Two women with diagnosed depressive disorders wrote, "It's kind of hard when the mental disorder hasn't gone away" (Participant #71, female, age 23), and "…at most times when I feel very down and depressed, having self-compassion is extremely difficult to uphold." (Participant #190, female, age 18). Another woman wrote about her gradual journey of self-compassion and how that was interrupted at times by overbearing anxiety:

> By slowly learning to love myself and accept my flaws, I somewhat managed to create a barrier between me and the thoughts of self-harming. Though at times I do go through moments of relapse where I have episodes of anxiety attacks and it becomes overbearing for me to even try and live. Self-compassion, treating oneself kindly in response to failure, looks, etc., may seem easy at times but it's more difficult than it sounds. (Participant #175, female, age 22)

Resisting with Competence and Skills

Several participants were able to write about experiences of how their perceived competence and skills helped them resist internalized stigma of mental health. They wrote of feeling empowered and confident in their schooling, work, hobbies, sports, and general life skills. They also reminded themselves that even though they had struggles, they were not

suffering in all areas of life; in fact, they could go to therapy, work toward mental health recovery, and have healthy coping skills.

One woman with multiple mental health diagnoses delineated how competence helped her realize what she was capable of despite struggling with mental illness:

> I would say that competence has had a beneficial effect on my internalized stigma resistance because sometimes when I am at my lowest if I'm able to, I'll try to think about the accomplishments I've made. I particularly prefer to think about my successes in horseback riding as I have multiple, and the sport helped me to create an outlet to clear my mind and realize that I do in fact have potential and am capable of doing something, regardless of what my intrusive thoughts try to say. I also attempt to consider how far I've come academically, understanding that I managed to keep my grades up whilst struggling with my mental illnesses, which was always incredibly difficult. (Participant #126, female, age 18).

Feeling Capable and Empowered. The theme of feeling capable and empowered was referenced by participants 29 times. Participants who felt personally capable of different skills were detached from the stereotypes and prejudices against those with mental illness. Small and large successes reassured them that their "mental problems don't hold [them] back." For instance, one woman emphasized how those with mental illness can perform above the average person despite having a mental illness:

> I was/have been a high-functioning mentally ill person for quite some time, which I think shows that people with mental illnesses can be just as competent – and sometimes more – than the average person. This can help reduce the stigma that mentally ill people are lazy, etc. (Participant #26, female, age 21).

Participants wrote that competence came from being "capable in any hobby or sport," "being successful in university classes," "obtaining a diploma/degree," and "hold[ing] a steady job." Capability was experienced by a student in the sports community by "seeing younger athletes look up to" them. Likewise, many had successful work and academic experiences that confirmed they could perform well, despite stereotypes about those with mental illness. A few excerpts are presented here:

> Working in retail has helped to see the potential I hold for working with the public. It helped me to see that I am capable of working with individuals and that I can rise to the occasion when I am needed. I may struggle with mental health, but it does not mean it will keep me from getting my job done. (Participant #51, female, age 19)

> I am a fairly intelligent person and have been praised for this my entire life. When I think about my academic successes and all that I have accomplished despite my mental illnesses, I am able to rationalize. (Participant #29, female, age 19)

> As I get older each year and gain more wisdom, I realize that my mental health problems don't hold me back. Applying for a new job, transferring from college to university and going out with new friends have shown me that I can function like a normal person. (Participant #157, female, age 23)

Another way that self-perceived competence helped participants resist stigma was by feeling empowered. Participants reminded themselves they were "competent," and that even when they struggled, they felt as if they put their "best effort into things," doing "nothing but the next right thing." Competence came from meeting one's own personal goals and feeling rewarded by successfully completing a task and "learning how to be self-sufficient." One person

with a diagnosed anxiety disorder wrote that her competence helped her self-worth when she stayed busy working on her goals:

> Competence has definitely improved my own sense of self-worth. When you are busier, you have less time to be stuck in your own mind and you have more of an ability to help those around you. You can have more confidence in not being entirely dependent on other people, to progress with your goals. (Participant #184, female, age 20)

Not Suffering in All Areas of Life/Mental Health Coping Skills. Favourable aspects of perceived competence were portrayed in a mindful and balanced perspective that they were not suffering in all areas of life (referenced 65 times). Similar to experiences of self-compassion, competence in various areas taught them to say, “I am more than my mental illness” and “My mental health issues do not define me and they do not cripple me socially.” Two people explained how they saw the complexities of their identity and abilities:

> The more skills and knowledge I acquire on various topics, whether that be in school or outside of school, challenges conceptions I have of myself as “anxious.” The more I get out in the world and participate in life, the better equipped I am to tackle challenges. Who I was several years ago is hardly comparable to who I am now, largely due to taking initiative and developing skills in different domains. (Participant #62, female, age 21)

> Competence has impacted my experience in the sense that these mental health problems that I had went through do not confine in any way what I am capable of doing. Intelligence itself is so broad in that everyone has their own sense of it. Being competent certainly helps me to understand that I can succeed like everyone else. (Participant #155, male, age 21).

While participants had a past or current mental health struggle, many had gained adaptive coping skills. One wrote she became more competent "in assessing a situation and managing [her] emotions," allowing her to more quickly "move on to other things." (Participant #219, female, age 49). Another noted, "Having multiple skills has allowed me to find relaxing or calm down activities for almost any environment that I am in (ex. at home - colour, at the store - walk the tiles etc.)." (Participant #191, male, age 18).

Mental health treatment progress was one form of competence. One woman with an anxiety diagnosis wrote, "I have resisted internalizing stigma by continuing to seek methods of treatment while acknowledging the progress I have made thus far." (Participant #62, female, age 21). Another with both a depressive and anxiety disorder wrote, "Showing that I can live a fulfilling life with therapy and the independence that therapy gives me helps with my stigma resistance." (Participant #43, female, age 20). Treatment was cited as helpful in the forms including CBT and DBT programs that helped people gain "tangible skills." A woman with an eating disorder wrote about gaining cognitive strategies that helped reduce her sense of shame: "I stopped thinking negatively about my eating disorder when I started making improvements and learned that weight is healthy, not something to be ashamed of having." (Participant #158, female, age 19).

Recovery from mental illness also spoke directly against the societal stigma. One woman with depression and anxiety noted "seeking help" and "eventually leaving that chapter of [her] life behind." (Participant #173, female, age 24). Another woman who identified as a recovering alcoholic described the positives of her sobriety journey:

> I am a recovering alcoholic. Treatment taught me many skills to help with my sobriety. Most importantly it taught me self-worth. To be kind to myself. In my journey I have

> learned I am not less because of my addiction. I am stronger because of it. (Participant #117, female, age 50)

One male participant said that he was initially upset at himself for not being able to cope with his depression, but once he gained positive coping tools, the stigma was less relevant:

> I have developed healthier coping methods that work for me. I am a naturally happy person and once I figured out how to cope with my issues, I was able to overcome the stigma in my life and my own issues. (Participant #110, male, age 20)

Struggling with Perceiving and Displaying Competence. Perceived competence and skills were an inconsistent form of stigma resistance (theme referenced 14 times). While perceived competence rendered people to feel empowered in some ways, it also undermined the mental health struggles that still impacted them. Participants described how competence in different areas could hide mental illness, as they had the “perfect student persona” and appeared to others to be “doing well” or “high functioning.” Unfortunately, having the appearance of competence led people to have to keep up the persona and work even harder, often contributing to higher levels of depression and anxiety (rather than lowering it). This is exemplified in the following excerpt:

> I overwork myself to make it seem like I am more "functioning.” With going to school full time and having 3 jobs outside of school it appears that there is no way I can be depressed because I don't fit the stigma of being "lazy.” However, the balancing of school and all of the work contributes more to depression and anxiety for me. (Participant #216, female, age 19)

Displaying competence often signaled to both oneself as well as outside observers that nothing was wrong. One person had difficulty identifying their own mental illness due to being

"high functioning and productive," only to later learn that "someone who is hardworking and diligent isn't always doing well, despite what societal norms express." (Participant #150, female, age 23). Even if the individual was aware of their struggles, outward competence made it hard for family and friends to understand their loved one's mental health struggles. Participants were left to feel "very alone" with "no one to turn to" because others didn't associate them with mental illness. In these cases, having successes and skills directly added to mental health stigma, rather than detracting from it. For instance, two women who appeared to do well in life were held accountable to stereotypes that mental health is not serious or real:

> I think since my parents think I am very smart and doing a good job in school it is hard for them to acknowledge or accept the fact that I have anxiety. They don't seem to completely understand that it's not easy to deal with. They think because I am doing well in my education I should be able to overcome the anxiety. (Participant 180, female, age 19)
>
> I was a smart athletic kid with no impactful traumas in my life. I was popular; I was captain of many teams; I got good grades. Everyone expected me to be perfect and looked up to me. No one expected me to go home and be a completely different person than I was at school. The skills in my life have only added to the stigma in my experience. (Participant #122, female, age 18)

Some participants delineated how the coupling of competence with stigma resistance was unhelpful when they found themselves incompetent in some areas. For instance, one non-binary person felt as if they were proving the stereotypes true when they failed in certain domains: 'I find myself to be somewhat incompetent in certain domains, such as social situations and learning certain new material, which I think have negatively impacted my own stigma resistance.

I feel like I'm just a stereotype when this happens." (Participant #128, non-binary, age 21). Two other participants wrote about how an unmet expectation of competence hurt their view of their mental health:

> Competence has impacted my experience with stigma resistance because, at times, I felt like I was not competent enough to get a proper grasp on my mental health alone. It made me compare myself to other people who did not need to seek help by professionals and caused me to see myself as inferior. (Participant 118, female, age 22)
>
> I have felt that feelings of incompetence (for example, entering and completing university at a certain time, and expectations I have of myself as a student) have deeply and still deeply affect how I deal with resisting stigma both internally and externally. (Participant #68, female, age 26)

Lastly, even when competence was perceived as helpful overall, it still could not be enough to positively impact one's mental health journey. One woman simply wrote, "I feel like I am competent overall, however, I wish I was able to help my mental health issues alone." (Participant #160, female, age 19). Another wrote,

> Even though I am quite capable and get a lot done, it is still a daily struggle to do things that tend to give me more anxiety. My anxiety takes over almost anything I do and undermines my confidence at every turn of my life. I am consistently thinking people are judging me or I am saying the wrong thing. (Participant #116, female, age 40).

Summary

Overall in Study 1, quantitative analyses revealed that self-compassion had a moderating effect (approaching significance) between perceived and self-stigma of help-seeking, while mental health self-efficacy had a significant moderating effect between perceived and self-stigma

of depression and anxiety. Self-compassion also had a main effect on help-seeking self-stigma and mental health stigma resistance, while self-coldness had a main effect on depression and anxiety self-stigma. Mental health self-efficacy had a main effect on all three dependent variables (e.g., help-seeking self-stigma, depression and anxiety self-stigma, stigma resistance).

Thematic analysis was utilized to explore the experience of resisting mental health stigma for individuals who identified as either having a mental health problem or having sought professional mental health before. Seven main themes of stigma resistance evolved, while five themes of resisting with self-compassion and four themes of resisting with competence and skills were also generated. While most participants who chose to respond to the written questions had positive experiences of resistance, many also described experiences of internalizing stigma, struggling to practice self-compassion, and witnessing the downsides of displaying competence and skills.

Discussion

This study examined how self-compassion/self-coldness and mental health self-efficacy might associate with and moderate the relationship between perceived stigma and self-stigma. The results partially supported the study hypotheses regarding help-seeking stigma, depression and anxiety stigma, and mental health stigma resistance. Qualitative written responses elaborated on mental health stigma resistance, self-compassion, and self-efficacy in the form of perceived competence/skills.

Help-Seeking Stigma

The regression onto help-seeking self-stigma revealed several significant main effect variables and one nearing significant moderating variable (i.e., self-compassion). Qualitative data

expanded on some of the findings, particularly within the themes of "becoming comfortable with seeking help" and "receiving social support."

Gender

In the final model predicting self-stigma of help-seeking, being male increased the likelihood one would experience self-stigma of help-seeking. Male participants also had higher levels of self-stigma of help-seeking and a lower chance of having sought help than female participants. This is consistent with overall findings that men are less likely than women to have positive attitudes toward help-seeking and to engage in help-seeking behaviors (Nam et al., 2010). This implies a strong need to reach out to men who may need to overcome personal feelings of shame before being comfortable seeking help. Notably, gender was measured as a binary variable (the subsample of other genders was too small to analyze), so other factors, such as masculinity, may be necessary for future research on help-seeking and gender and further clinical implications (Booth et al., 2019; Heath et al., 2017).

Self-Compassion

As expected, self-compassion had a significant main effect on help-seeking self-stigma. Self-compassion also had a moderating effect that approached significance, revealing that higher self-compassion buffered the relationship between perceived and self-stigma (i.e., the relationship was no longer significantly correlated as it was with low levels of self-compassion). This was supported by previous research by Heath and colleagues (2018), who looked at the complete self-compassion scale; yet the current analyses split the subscales of self-compassion and self-coldness, revealing that only the positive subscale of self-compassion was significantly related to help-seeking self-stigma. The nature of the interaction effect between perceived stigma of help-seeking and self-compassion was also consistent with Heath et al. (2018), who found that

the slope between perceived and self-stigma was weaker with high self-compassion. Overall, this moderation means that self-compassion has somewhat of a buffering impact on the adverse effects of stigma and may disrupt the process of perceived stigma being internalized at a personal level.

Qualitative data identified how participants gave themselves kind affirmations to be okay with seeking help and knowing there is nothing wrong with getting help. Receiving social support was also a reminder that they were worthy of getting help. Other aspects of self-compassion surfaced as participants delineated a mindful awareness of not ignoring their distress and need for support while reducing self-judgment of the shame often associated with seeking help. Mindful deflection of stereotypes about professional treatment could also be a way of ignoring perceived stigma and resolving conflicting external and internal views of the self (Stringer et al., 2018), which may explain the buffering effect found in the quantitative analyses.

Self-Coldness and Distress

Self-coldness did not have an effect at any level on help-seeking self-stigma beyond the bivariate correlation; this was unexpected, as I predicted that lower levels of self-coldness would be similar to higher levels of self-compassion (Neff et al., 2018) and that higher self-coldness would associate with adverse outcomes (Brenner et al., 2018), such as self-stigma. In the control model, increased psychological distress (which highly correlated with self-coldness) related to increased self-stigma, yet this was not a significant predictor of help-seeking stigma in the final regression model. The basic correlations and control model hint at a potential relationship between increased self-coldness or distress and increased self-stigma. Yet, looking at the overall insignificance of both self-coldness and distress, these results are consistent with meta-analytic findings of an insignificant relationship between attitudes toward help-seeking and levels of

psychological distress (Nam et al., 2013). Although distress or self-coldness may make one vulnerable to more self-judgment and shame, higher levels of mental stress may also indicate a greater need for help (Vogel & Wei, 2005). Other variables may be at play, confounding any potential relationship between distress or self-coldness and help-seeking stigma. For instance, having increased symptomatology or a greater need for help may relate to increased help-seeking. In contrast, the level of shame associated with help-seeking may depend on past experiences, positive social support, or the level of self-compassion.

Mental Health Self-Efficacy

Lastly, mental health self-efficacy had a direct effect on self-stigma but did not significantly buffer the relationship between perceived and self-stigma. In other words, no matter the level of mental health self-efficacy, perceived stigma still predicted self-stigma; yet mental health self-efficacy was negatively related to self-stigma. Individuals who, despite psychologically struggling, have a sense of control and empowerment over their mental health may inherently feel more comfortable and safer to risk disclosure by seeking help (Nam et al., 2013). In the qualitative responses, participants described how growing in their mental health understanding and awareness (i.e., one aspect of self-efficacy) led to becoming comfortable seeking help. Along with help-seeking, being able to see progress toward recovery appeared to make help-seeking less daunting and stigmatizing. The relationship can be seen the other way: reducing stigma around help-seeking allowed for gathering more skills (e.g., such as learned in therapy), which could enhance a sense of self-efficacy. Similar to self-compassion, these findings on self-efficacy may support Stringer et al.'s (2018) theory that competence and mastery of coping skills can be a defense against negative concordant views.

Mental Health Stigma and Stigma Resistance

The second and third regressions were predicting forms of mental health stigma, the former in terms of depression and anxiety self-stigma and the latter for mental health stigma resistance. Several variables were associated with self-stigma and stigma resistance in opposing directions, yet this was not always the case. Most qualitative data was specific to mental health stigma, which can help clarify some of the quantitative relationships observed.

Gender

Gender was not a significant predictor of depression and anxiety self-stigma, but female gender was a significant predictor of stigma resistance. While men may be targets to decrease help-seeking stigma, women may be prime research targets to examine unique experiences of resilience and empowerment in the face of mental health stigma.

Diagnosis

Not having a diagnosis predicted more self-stigma. Considering the positive impact of self-disclosure (Corrigan et al., 2010), having a diagnosis may indicate that an individual has been through the process of sharing their problems and seeking support (Corrigan et al., 2015), which can be empowering and reduce internalized stigma. In the current study, all participants either identified as having a mental health problem or having sought help, but only about half of the participants had a diagnosis. The other half of the participants may be struggling in some capacity, and it is possible that the lack of a diagnosis or label for their struggles could signal concealment and shame (Pachankis, 2007), which could further exacerbate psychological distress and increase subsequent stigma. It is also possible that not having a diagnosis could signal something else, such as a lack of access to professional health services.

Interestingly, the presence of a diagnosis did not significantly relate to stigma resistance. This may be due to the more interpersonal nature of the stigma resistance scale or could simply indicate the lack of a diagnosis. For instance, some items on the Stigma Resistance Scale (Firmin, Lysaker, et al., 2017) comprised helping others resist, advocating for others, and encouraging others with mental health problems. Considering this, it is possible that many participants, with or without a diagnosis related to mental health difficulties and also extended their resistance beyond themselves.

Perceived Stigma

As expected, perceived stigma of depression and anxiety had a positive relationship with self-stigma of depression and anxiety (Link, 1982). This paralleled the expected and confirmed relationship between perceived and self-stigma of help-seeking (Heath et al., 2018; Vogel et al., 2013). However, perceived stigma did significantly correlate with or predict stigma resistance in the final regression model. This differed from previous studies that found a significant negative association between perceived stigma (as measured with the Perceived Devaluation Discrimination Questionnaire; Link, 1987) and the Stigma Resistance Scale (Firmin et al., 2017) as well as varying measures of perceived stigma and stigma resistance (see review by Firmin et al., 2016). Perceived stigma measures what “most people” think rather than what they agree with, so it is possible that an individual can believe that other people are prejudiced while nevertheless understanding that the beliefs are unfair and subsequently use that information to fight against the stereotypes.

Distress

In the control model, increased psychological distress (i.e., depression, anxiety, stress) related to increased self-stigma of depression and anxiety. This aligns with the literature

suggesting that symptom severity will signal whether stereotypes ring true and lead to either self-esteem decrement or empowerment (Livingston & Boyd, 2010). Similarly, lower psychological distress (i.e., depression, anxiety, and stress) was associated with lower stigma resistance in the control model; this is consistent with mood and other psychological symptoms negatively relating to stigma resistance (Firmin et al., 2016). These findings demonstrate an example of the double-edged sword of disease and stigma (Corrigan & Wassel, 2008). On the other hand, psychological distress was not a significant predictor in the final regression models, indicating that other factors may better account for self-stigma and stigma resistance. Implications for psychological distress may also be extrapolated based on findings of self-coldness below (due to the high correlation between the two variables).

Self-Compassion and Self-Coldness

In the hierarchical regressions, self-coldness (but not self-compassion) significantly predicted increased depression and anxiety self-stigma, while self-compassion (but not self-coldness) significantly predicted stigma resistance. This revealed that negative or positive psychosocial variables were more closely tied to each other. The different results strongly support the separation of the constructs of self-compassion and self-coldness, as high levels of one are not necessarily low levels of the other (Muris & Otgaar, 2020). For instance, qualitative responses disclosed that positive self-compassion was one of the most ubiquitous experiences of stigma resistance (i.e., self-kindness, self-care, normalizing experiences as common, mindful evaluations and detachment); yet many simultaneously described experiences of being critical and struggling at times. Although self-compassion helped resist stigma and increase empowerment, self-stigma did not disappear, perhaps explaining why self-compassion only had a significant variance for stigma resistance but not self-stigma.

Qualitative findings also constructed key reasons self-compassion was a struggle for many participants. Sometimes the practice of self-compassion made less sense when their mental health symptoms were more impairing (i.e., psychological distress, self-coldness). Struggles with self-compassion toward having mental health problems may be conflated by the robust association between self-coldness and psychopathology (Muris et al., 2018). Self-compassion may be easier to practice during symptom reprieve, yet more self-compassion effort may be needed when symptoms are higher. Unfortunately, this may put individuals in a Catch-22 of not engaging in stigma resistance until there is some improvement in mental health. They may perceive they do not have the strength to work on their mental health because they are bogged down by self-criticism, feeling isolated, and overidentifying with their suffering. With that said, other variables beyond self-compassion, such as self-efficacy, may be vital factors in defying stigma.

Mental Health Self-Efficacy

Mental health self-efficacy had a main effect on self-stigma of depression and anxiety and stigma resistance and a moderating effect between perceived and self-stigma of depression and anxiety. The relationship between mental health self-efficacy and perceived stigma remained significant at all levels of mental health self-efficacy; the moderation accounted for a small but potentially consequential effect. These findings extended previous research on the relationship between perceived and self-stigma of help-seeking (e.g., Booth et al., 2019; Heath et al., 2018; Vogel et al., 2013) by applying psychosocial variable moderators to perceived and self-stigma of mental health. While self-compassion was a nearing significant moderator for help-seeking stigma, mental health self-efficacy may have been more relevant for depression and anxiety self-stigma, given that the stigma was specific to mental health. Despite diagnosis and distress,

perceiving a sense of control and self-determination over one's mental health was decisive in fighting against internalizing stigma. My findings also expanded on prior findings on the association between self-efficacy and stigma (Corrigan et al., 2016; Livingston & Boyd, 2010) by revealing that a personal sense of confidence and control over one's mental health can help protect against the negative impact of self-stigma even with an acute awareness of societal stigma surrounding mental health.

Qualitative responses somewhat helped clarify the buffering effect of mental health self-efficacy. Participants who described a positive view of competence in skills in the mental health domain were more likely to resist stigma. For instance, participants referenced gaining coping skills for their mental health, which meant that despite having a diagnosis or identified mental health difficulty, they perceived a strength in their overall well-being. It makes sense that having cognitive skills and a sense of emotional self-control would make stereotypes about mental health less valid, contributing to stigma resistance (Stringer et al., 2018).

Conclusion

Study 1 explored mental health and help-seeking stigma from quantitative and qualitative approaches. Quantitative analyses revealed several significant psychosocial predictors of help-seeking self-stigma, mental health self-stigma, and mental health stigma resistance. Qualitative responses revealed circumstances under which stigma resistance was empowering or a struggle. The mixed-methods approach of Study 1 was beneficial in allowing for the generalizations of a sizeable quantitative sample and in going further in-depth concerning the participants' subjective experiences (Rahman, 2016).

For Study 1, the qualitative data was embedded in the quantitative data, yet further insights could be gained from a complete qualitative sequential study (Halcomb & Hickman,

2015). About half of Study 1 participants completed brief, written qualitative questions. All participants identified with a past or current mental health struggle, yet there was a wide variation in diagnoses, past mental health service use, and applicability of mental health stigma resistance. This research could be complimented by a qualitative study exploring stigma resistance among individuals with similar mental health experiences from an idiographic approach. For Study 2, I planned to recruit a small group of individuals with depression or anxiety to explore their stories of stigma resistance through in-depth interviews using interpretative phenomenology analysis (IPA).

Study 2: The Lived Experiences of Resisting Self-Stigma of Depression and Anxiety

In Study 1, I examined the continuum of self-stigma and stigma resistance quantitatively, along with various psychosocial and demographic variables. Knowledge gaps concerning stigma resistance remain in the qualitative domain (e.g., experiences that contribute to or hinder the development of resistance to internalized stigma; Stringer et al., 2018). The majority of qualitative studies on mental health or treatment stigma have explored the adverse side of stigma while only briefly touching on stigma resistance (e.g., Alvidrez et al., 2008; Kranke et al., 2011; MacKay et al., 2015; Villagrana et al., 2018; Ware et al., 2015). Exploration of the inverse of stigma (i.e., stigma resistance) is needed to understand the processes working against stigma. The qualitative experience of mental health stigma, internalizing stigma, and resisting stigma can document essential targets for future stigma reduction strategies and interventions (e.g., Clement et al., 2015).

Study 2 further delved into the construct of stigma resistance by analyzing the experience of personally resisting the stigma of mental health. The goal was to appraise what contexts or situations typically influence resisting stigma rather than internalizing it (i.e., resisting self-

stigmatization). One previous qualitative study by Firmin, Luther, and colleagues (2017) explicitly examined stigma resistance for individuals with serious mental illness with a grounded theory approach. For the current study, I was also interested in delving into the experience of stigma resistance but focusing specifically on individuals with depression and anxiety (in comparison to serious mental illness). The objective of this subsequent study was also to conduct qualitative analyses through an interpretative phenomenology analysis (IPA) approach to explore the subjective experiences of a handful of participants from an idiographic approach.

Methods

Study Design

This research was implemented with an interpretive phenomenological approach (IPA). IPA is based on phenomenology and symbolic interactionism, with ties to both social cognition (i.e., attitudes and behavior) and discourse analysis (i.e., how people use language; Smith, 1996). Phenomenology is a method of qualitative human science inquiry that is the scientific, systematic, and explicit study of essences (van Manen, 1990; Moustakas, 1994). Phenomenology answers research questions about what is at the essence that all persons experience about a phenomenon (Creswell et al., 2007). Symbolic interactionism in social science claims that the meanings of an event or phenomenon come from both the individual's subjective experience as well as from the interpretation of the researcher (Smith, 1996). IPA answers questions about what is at the essence of experiences, while the researcher and individual work to make sense of and reflect (i.e., interpretation) on the experience (Smith et al., 2009).

A review of studies using IPA between 1996 and 2008 found that illness experience (e.g., chronic pain, neurology) was the main research area of interest that employed this method (Smith, 2011). Relevant to the stigma literature, IPA has been used to better understand stigma in

schizophrenia (Knight et al., 2003), problem gambling stigma (Hing et al., 2016), and art therapists' understanding of working with self-stigmatization (Papagiannaki & Shinebourne, 2016). IPA can help examine the experience of mental illness and mental illness stigma as well as the counter experiences of resilience and resisting self-stigmatization. For this study, the IPA approach showed promise for understanding mental health self-stigma resistance through detailed examinations of a handful of university students' experiences.

In order to explore the lived experiences of resisting internalizing stigma of depression and anxiety, participants were first asked about their experiences seeing and internalizing stigma, after which they were asked to describe their experience challenging the stigma of mental health and how they have pushed back and fought against the stigma. Additionally, participants were asked how their resistance to self-stigmatization has changed over time, due to the recent call to investigate the personal evolution of resilience concerning stigma (Stringer et al., 2018). As this is a qualitative study analyzing the unique experiences of a few individuals, no a priori hypotheses were proposed.

Participants

We recruited undergraduate student participants who have experienced depression or anxiety or both and who believe they resist internalizing mental health stigma. There is a large population of undergraduate students at-risk for depression, anxiety, and psychological distress (Hunt & Eisenberg, 2010; Stallman, 2010), and these mental health problems may create a different experience for individuals resisting stigma compared to information about individuals with serious mental illness (Firmin, Luther, et al., 2017). This university population was intended to help fill the gap in literature exploring the personal experience of mental health stigma outside of non-statutory and mainstream mental health services (Huggett et al., 2018). Participants were

recruited via the SONA portal at Lakehead University where undergraduate students who are enrolled in a psychology class can partake in research. Additionally, participants were recruited via university mental health peer support and stigma resistance clubs. Inclusion criteria were undergraduate students who self-select as experiencing depression or anxiety as well as having experiences of resisting the stigma of mental health.

Five participants were recruited per the suggestion of Smith and Osborn (2003) and in order to fit the ideographic, case-study approach of IPA which gathers an in-depth understanding of a few individuals' experience with resisting stigma (Smith et al., 1999). For IPA, a small homogeneous sample was needed in order to examine the similarities and differences in detail, resulting in comprehensive narrative accounts of the phenomenon of resisting stigma for university students with depression and anxiety (Smith et al., 2009). Participant demographic information is presented in Table 10.

Table 10

Participant Demographic Information

Name*	**Gender**	**Age**	**Univ. Year**	**Race/Ethnicity**	**Mental Health History**
Ava	Female	21	3	Caucasian	Obsessive-compulsive disorder, anxiety, and depression
Cami	Female	22	3	Caucasian	Anxiety and potential mood disorder
Heather	Female	20	2	Caucasian	Anxiety, depression, and eating disorder
Jordan	Non-binary	21	4	Caucasian	Anxiety, depression, and attention-deficit/ hyperactivity disorder
Nicholas	Male	21	4	Caucasian	Anxiety

Note. Pseudonyms are used for names of the participants to protect their identity and privacy. Participants were given the option of creating their own pseudonym, or having one created by the researcher.

Participant #1 – Ava

Ava is a 21-year-old female and a year 3 student. She described her race as White/Caucasian. She has had a diagnosis of obsessive-compulsive disorder (OCD) for about three years. She described "germophobic tendencies" and cleaning behaviors that impacted her interactions with other people. Ava also shared that she was diagnosed with Generalized Anxiety Disorder (GAD) and depression following a breakup about two years ago. Ava talked about going to therapy and taking medication for her mental health.

Participant #2 – Cami

Cami is a 22-year-old female and year 3 student. She described her race as Caucasian/White. Cami reported that she had not received a diagnosis yet but had experienced anxiety for the past four years, since the start of university. She also suspected that she may have depression and bipolar disorder. Cami sought help from her family doctor and takes medication for her anxiety.

Participant #3 – Heather

Heather is a 20-year-old female and year 2 student. She described her race as Caucasian. She reported lifelong experiences with mental health issues, including anxiety, anxiety attacks, and depressive episodes. She reported past suicidal ideation that led to hospitalization in early adolescence. She also described having and recovering from an eating disorder in adolescence. Heather was diagnosed with anxiety in adolescence, and she has been treated by a psychiatrist since then. She also shared that she takes medication for her anxiety.

Participant #4 – Jordan

Jordan is a 21-year-old non-binary and year 4 student. They described their race as White. They shared that they were an anxious child when younger. They received diagnoses of

anxiety and depression in adolescence. Additionally, they were diagnosed with attention deficit hyperactivity disorder (ADHD) in early adulthood. They have sought and attended therapy for mental health and have taken medication for ADHD.

Participant #5 – Nicholas

Nicholas is a 21-year-old male and year 4 student. He described his race as Caucasian/Italian. He reported having mental health issues for about four years. He was diagnosed with GAD recently. He shared about his significant involvement in university peer support and advocacy clubs for mental health.

Procedure

In advance of their participation, participants were sent a cover letter (Appendix Q) and informed consent form (Appendix R). Participants also received the basic interview questions ahead of time (Appendix S) in order to allow participants to prepare and to collect thoughtful responses. Interviews were conducted by the first author and primary researcher of this study, a Ph.D. Clinical Psychology student with a Master's degree in Clinical Psychology. Interviews were held for about 40-60 minutes on the Zoom platform following an interview schedule (Appendix T). The interviews were digitally recorded (Smith & Osborn, 2003) and later transcribed (Richards, 1999) via Nvivo and directly listening to the transcript for quotes not picked up by Nvivo. All names on the transcript were replaced with pseudonyms and personal identifying information was removed in order to maintain the participants' anonymity. Following the interview, participants were emailed a debriefing letter, thanking them for their participation, and giving them the contact information for the university's Student Health and Counseling Centre, local and online resources, as well as the Research Ethics Board for any reason including

the experience of distress as a result of the study (Appendix U). They were also sent a digital $15 gift card as compensation for their study participation.

Semi-Structured Interview

We used a semi-structured interview, which is traditionally used with IPA (Smith & Osborn, 2003). The semi-structured interview followed a set of identical open-ended questions on an interview schedule. The interviewer initially established rapport with the participants and throughout the interview. There was flexibility to ask questions out of order and probe interesting areas that arose. Initial inquiries were broad, followed by more explicit prompts, allowing for more opportunities to respond to the complexities of the question and fit the needs of each participant (Smith & Osborn, 2003).

Interview Schedule

The interview schedule contained four sections, which were enhanced with probing questions (Appendix T). The primary sections were as follows:

1) Demographics and mental health history or diagnosis (official or unofficial)
2) Experience of internalizing (being aware of and applying to oneself) mental health stigma
3) Resisting mental health stigma at a personal level/ resisting internalizing mental health stigma
4) Evolution of resisting stigma over time

Analysis

The data were analyzed using IPA for an idiographic, case-study approach, employing the steps outlined by Smith and colleagues (1999), using Nvivo. Three coders were involved in analyzing the data: the first author, who held an M.A. in Clinical Psychology; the first

supervisor, who held a Ph.D. in Clinical Psychology; and a research assistant, who was an undergraduate research assistant.

The first step involved looking for themes in the first case by reading and re-reading the transcripts of the interviews closely: we wrote summaries and intriguing ideas that arose from the transcript; alongside these, initial interpretations of the quotes were recorded. The second step comprised looking for connections among the ideas for the first case: on a separate document, we organized emerging themes and links between the themes, creating clusters while perpetually going back to the transcript to check what had been said. The third step was generating a table of themes that captured the most salient concerns of the first case: at this step, we began a master list of the encompassing themes, identifying sub-themes with each superordinate theme. The fourth step was continuing the analysis with the other cases: we replicated the first three steps with each of the cases, and as new themes were constructed, the list of themes were modified. While a formal measure of data saturation is not generally utilized for IPA (Brocki & Wearden, 2006), the researchers determined that no new themes were emerging with the fifth participant, and we were comfortable finalizing our participant group with five individuals in total. The fifth step involved the production of a master list of themes for the group of participants: we constructed this list according to how rich and illuminating the themes were, as well as how the themes explained other aspects of the participants' stories. Additionally, subordinate themes were only selected if they were identified in at least three of the five transcripts (meeting the suggested threshold by Smith [2011] of being supported by at least half of the participants). The sixth and final step was writing up the analysis: the themes as the main results were backed up with verbatim extracts from the participants along with strong interpretation beyond the descriptive component.

Quality, Reflexivity, and Rigor

To uphold standards of qualitative research, the analytic procedures were transparent among the three researchers. We employed validity procedures, including triangulation, member checking, and collaboration (Creswell & Miller, 2000). Triangulation (i.e., the systematic process of analyzing the data across participants and finding common themes to report on rather than a single data point) was done throughout the analyses. Member checking (i.e., taking the data, quotes, and interpretations back to the participants in the study so that they can check the information and comment on their accuracy) was offered to all participants at two separate times. One participant responded to the check-in: they said they felt as if the qualitative results write-up and themes were accurate and no changes were needed.

The three researchers remained aware of our subjective experiences and style that may draw out certain meanings from participants. In considering the first author's/primary researchers' own personal characteristics that may have impacted the interview and research process, the researcher is trained in the area of Clinical Psychology, which may have influenced the posing of questions and manners in which follow-up questions and summaries were stated back to the participants. The researcher also has personal beliefs regarding the importance of stigma resistance, which might have influenced the tone of the interviews.

Two of the researchers have a background in mental health stigma research. To ensure that the themes that were identified came from the participants and not solely from the literature, a second reviewer less familiar with the literature worked to code the raw data and participate in all steps of the analysis. This outside second reviewer also provided an opportunity for the researcher's assumptions and perspectives to be challenged and other points of view considered.

Results

Common Previous and Ongoing Experiences of Stigma

Participants were first asked about their experiences with stigma before they shared their experiences of stigma resistance. Although not the focus of the study, a brief description is provided here to provide context to the discussion of stigma resistance. Instances of both public stigma and internalized stigma were common for participants as obstacles to overcome and eventually work toward stigma resistance. Additionally, experiences of stigma also came up simultaneously alongside experiences of resistance, as stigma continued to be an ongoing struggle in certain circumstances.

External Invalidation

Experiences of external invalidation mainly focused on not being taken seriously by others because of one's mental illness. Participants felt invalidated by friends and family who called them "crazy" or "lazy" and dismissed their mental health symptoms as unwarranted or exaggerated. The reality of their mental health was often discredited by people they knew. This was often connected to feeling not understood, as if other people did not have an understanding of their mental health. Sometimes participants (i.e., Ava and Cami) believed they were not taken seriously because they had a high-functioning appearance; this created a dissonance with their internal struggles.

Societal avoidance and fear of mental illness also impacted participants. Many were aware of a sense of shame in society that rendered it taboo to talk about mental health. Due to this, they anticipated judgment and feared negative consequences if they were to reveal their mental health difficulties.

Internalizing Stigma

Participants' experiences of stigma comprised feelings of alienation. They noticed that they were feeling different than other people around them, and this led to embarrassment and shame. These feelings led to both reluctance to open up about their struggles and avoidance of seeking help when it was needed. Stigma was also revealed in the form of self-criticism when participants internalized negative labels that others had given them (e.g., lazy, crazy). They began to question their worth as well as the validity and reality of their mental health experiences. Some participants (i.e., Ava, Cami, and Jordan) experienced some confusion about their symptoms and the cause of their mental illness before they sought help, which was also tied to internalized stigma. Lastly, most participants (i.e., Ava, Heather, Jordan, and Nicholas) had times when stigma exacerbated their mental illness symptoms, as judgments would cause them to spiral further.

Themes of Stigma Resistance

Six superordinate themes were generated from the interpretative analysis, and these were shared by all five participants. The six themes and fifteen related subordinate themes are presented in Table 11. The following section includes a detailed depiction of the themes with in-depth analysis and interpretations. Direct excerpts from at least three participants for each subordinate theme were included to support the claims made (Smith, 2011).

Table 11

Study 2: Superordinate and Subordinate Themes Related to Stigma Resistance

Superordinate Theme	Subordinate Theme
Accepting one's mental health experiences	Coming to terms with experiences Validating and normalizing experiences
Transparency about mental health experiences	Opening up Becoming comfortable with disclosure

Blocking public stigma	Not being defined by the illness Believing you are sick not weak Separating self from others' opinions
Taking actions to better oneself	Self-compassion Seeking help Working toward recovery of mental health
Receiving social support	Receiving compassion and validation from others Having a network of similar others Increased societal awareness and understanding
Extending stigma resistance to others	Having compassion and helping others Spreading awareness and education

Accepting One's Mental Health Experiences

The theme 'accepting one's mental health experiences' describes the process of beginning to acknowledge one's mental health or mental illness and then learning to be okay with one's experiences. The theme emphasizes the importance of intrapersonal awareness, validation, and acceptance of oneself.

Coming to Terms with Experiences. Four of the participants shared their journey of coming to terms with their mental health difficulties. Seeking out and acknowledging a mental health diagnosis was often a first step in validating their symptoms and experiences. Ava described receiving diagnoses in the past two to three years and how she was able to recognize that her behaviors were pathological. She also described the validation that she experienced with having a root cause to help explain her difficulties:

> So, I think it was about three years ago I got diagnosed with OCD… And then about two years ago, following a breakup, I was diagnosed with anxiety and depression, and it had come forth kind of that these anxious symptoms were presented for a longer time. But I was coping really well with them. So, I kind of had acknowledged, I guess, the burden and the weight that that was holding on me… So, I guess it was validating to kind of have

> that: there is nothing wrong, it's this is kind of the root cause. And then it gave a more straightforward path as to how we were going to deal with it. (Ava)

Similarly, Nicholas had received a recent diagnosis of GAD about a year ago because he sought out an assessment when his anxiety started to get problematic for him. He received comfort from a label that informed him about what was wrong with him and why it was happening. At the same time, it appeared to be easier for him to come to terms with his diagnosis because he categorized it as a "relatively minor" mental illness:

> It was like a bit like I guess relieving just to know, like okay, like it is what I thought it was. It's not like two or three different things. It's just like this one thing that's like relatively minor, as mental illnesses go and such. So, I'm like, at least now it is labeled, and I'm done with that. So, like I know what it is and I don't have to just keep, like, hypothesizing, like what's mentally wrong with me. I actually can kind of be like, this is what it is, these are like treatments for it, this is what people have done. And it's a little bit—Yeah, it's kind of nice to have a bit more, almost physicality to it. Like, I can actually, I can label it now. So, it's not just a bunch of thoughts and feelings. It's actually like, okay, I know what this is, and I know why this is happening. So, it just makes it a little bit easier. (Nicholas)

The process of receiving a diagnosis brought about recognition of a mental illness label. Some participants acknowledged their mental health after receiving a formal diagnosis, while others had to first engage in inner reflection and admit to themselves that their symptoms were problematic. Cami, similarly to Nicholas, described how her mental health was getting worse, and she had to work on it. She needed to recognize and admit her difficulties before she could

take further steps in addressing her mental health. Cami also received comfort in having an explanation for what she was going through:

> It's like once you like say it out loud to yourself and finally come to terms with it yourself. I think that's kind of what it's like, "Okay, I'm not just like going crazy, like there's something kind of more going on." (Cami)

Jordan referred to coming to terms with their mental health as an acceptance of both the good and the bad with the mental health journey. Even when they felt as if their mental health was getting worse at times, they were able to accept their own reality. They explicitly stated that this helped with stigma resistance:

> Well, I think the first thing that made me have to actually try to resist [mental health stigma] is like: this is how it is. I can try to improve it, but for the most part, this is how it is, this is going to be how it is for better or worse. (Jordan)

Validating and Normalizing Experiences. Three of the participants highlighted the experience of validating and normalizing their mental health experiences as a form of stigma resistance. Previous and ongoing experiences of mental health stigma often came with invalidation and alienation. As a counter, a few of the participants were able to have positive self-talk to remind themselves that their reality is valid. Ava heavily spoke to her practice of self-validation to directly target internalized stigma. She was able to view her behaviors as normal for someone with a mental illness, and by doing so she was able to be kind to herself and show self-compassion:

> So, having that validation, that it is normal for people with anxiety to be feeling this way, and to be sensitive about this, or it is normal for people with depression to be really internalizing these sad feelings and to be kind of, you know, it's okay to be upset even

> though things are going really well. And so, I think it was kind of validating to remove that conflicting mindset of, "Okay, everyone else is feeling this way, I'm feeling this *this* way." (Ava)

Validating that difficult experiences are normal for many people to go through helped bring some peace. Nicholas talked about resisting internalized stigmatizing thoughts by reminding himself that other people go through similar struggles:

> So there still are like a lot of … incompetent thoughts and worries, but it's definitely less than what it was like years ago… I understand that I'm not like the only person that's struggling academically or mentally, right. So, it's a lot like, it's not just my fault. It's literally, like every--, like a lot of people go through similar things. So, it's just knowing you're a part of that bigger picture, almost not stressing so much about my circumstance. (Nicholas)

Cami also was able to validate her own feelings, "And part of that was just like reminding myself, like "It's okay to feel like this. It's okay for people to like—even if people think I'm crazy." This helped her to be able to resist some of the societal stigma that of which she was aware had invalidated mental health issues in general. Beyond that, she was able to reduce her sense of shame surrounding mental health and take a sense of pride in who she is. She said,

> I think it was more so before that I was…worried about the stigma and if I'm crazy. Cause now I'm kind of like, "I am crazy." I just kind of embrace it, like it's part of me now. (Cami)

Transparency about Mental Health Experiences

The theme 'transparency about mental health experiences' was emphasized by the participants as they discussed various courses for becoming transparent. Transparency often started with opening up to a few safe people about one's mental health. The more one opened up and received positive feedback, the more they grew comfortable with disclosure, even leading to empowerment.

Opening Up. All of the participants shared the process of how beginning to open up to others about their mental health facilitated stigma resistance. Ava, Jordan, and Cami spoke about opening up to family and friends about their challenges and their needs. Ava first recalled that therapy gave her skills of honesty with others: "I think [therapy] gave me the skills to be able to have more honest conversations with people and that I could let them know what my expectations and my emotionality around things were." She discussed one high point of being able to have a transparent conversation about her needs going into a new romantic relationship:

> I guess like one of the points that I was really proud of myself was entering into a new relationship with a romantic partner, I was able to sit them down and have a very transparent conversation about my mental illness and also, I guess, kind of the behaviors that are associated with that, the emotions I commonly experience, and then expressing kind of what I need out of a relationship in order to feel like there isn't that stigma. (Ava)

Another particular area Ava opened up about was her medication for depression and anxiety; she was able to combat the stigma by openly talking about it without shame:

> I think I've definitely had a lot of open conversations. And I know especially when I started medication… that that was something quite stigmatizing, just in society in general, because that kind of implies that there needs to be a pharmacological

> intervention and that something needs to be rectified. So, I try to kind of combat that by just being very open and honest with my friends and the people around me. (Ava)

Jordan talked about how they had trouble reading social cues due to ADHD and how they would bluntly tell other people what they needed to understand what was going on and self-advocate. This is a shift from when they were younger and less open and direct in saying what they needed. She said,

> When I was a lot younger before I had a diagnosis, I would just be like, "Wow, why the hell?" I just was like, "I'm really awkward. I can't read social cues. I don't understand what's going on." But now I'm like, "Oh yeah. I don't know what the fuck you're saying. Like, tell me. Just tell me." (Jordan)

Cami hesitated to talk to her parents about her mental health, even though she normally tells them everything. She recalled the first time she opened up to her parents: "I was finally like, "Oh, by the way, I've been going to counseling. I have this and that." And then it just kind of opened the conversation further to be like what else is going on." Once she started to open up, she was able to talk even more and remove the barrier of silence and shame.

Other participants spoke about opening up more publicly and how that empowered them to resist stigma. Heather shared how she presented about her recovered eating disorder while she was in high school with Grade 9 students. Similarly, Nicholas was empowered by having the chance to openly share his struggles in public settings. He also described chances to open up with his friends and by being a part of mental health clubs. Excerpts from the two are as follows:

> I was proud of myself. I wasn't, I wasn't worrying about what anybody else was thinking, like how I normally would … I was thinking if saying my symptoms can help other

> people, like if I say this and maybe somebody notices something with their friend, then that's good, then that means I'm helping. (Heather)
>
> Now I have a bit more of an open friends' group, and as I've mentioned with the whole, you know, mental health clubs, kind of if it comes up during a meeting or something, I openly share that with my peers, as well as I did a presentation with the [Indigenous organization] in town months ago … And just a bunch of strangers, like we were doing stories about our experience, and I just openly shared my struggles with my mental health and illness in that context. So, it's definitely getting better at being more open to it, which is more of the [stigma] resistance … (Nicholas)

Becoming Comfortable with Disclosure. Four participants highlighted comfort with disclosure as an aid to stigma resistance. The more they opened up, the easier it was to be transparent. Cami, who opened up to her parents about her mental health, said, "I can always tell my parents anything, but like it took me a while to open up about that specifically. But once I did that, I was able to talk about it more." Similarly, Ava's ability to be honest led to comfort in expressing her needs. She recalled having a supportive group of people who helped her gain comfort in expressing how she was feeling:

> I think being able to have a really upfront conversation and to not feel shame in expressing my needs was really empowering for me. And I was able to realize that that was something I was never able to do in past relationships. And it's led to a stronger and better and more communicative relationship. So I think that was a big step for me. (Ava)

Nicholas also was able to gain more comfort the more he opened up and shared in mental health clubs. He recognized that acquiring this level of comfort was a strength in resisting stigma as it empowered him to break out of concealment:

> I've pretty much busted through that [stigma] resistance. Like come second year when I started that, when I joined that club and I wanted to actually talk to random students about it, because not a lot of people would be comfortable talking to strangers … definitely takes quite a lot of stigma resistance just to even step foot in the door. (Nicholas)

Jordan and Heather were on a slightly different trajectory, as they had fluctuating levels of comfortability with disclosure. Jordan mentioned that they are still working on becoming comfortable with becoming open about their needs and advocating for themselves. When asked how their resistance to mental health stigma has changed over time, Jordan referenced their journey of disclosure and self-advocacy for when they had mental health needs:

> Well, I'm still actually pretty like—I don't like asking for help still, really. I usually only do it when I absolutely have to. So, I'm still working on that, but I am definitely more open than I have been about things that I probably should be open about to people close to me, to people who need to know it. (Jordan)

Blocking Public Stigma

The theme 'blocking public stigma' comprised examples of participants not being defined by mental illness and not agreeing with the stereotypes that mental illness is a weakness. Additionally, participants had to set a boundary between their own beliefs and others' opinions.

Not Being Defined by the Illness. One way that participants blocked mental health stigma was by not being defined by what society says it means to have a mental illness. All five participants referenced internal thought processes of not overidentifying with the stereotypes of mental illness and not ruminating on their mental health struggles. Nicholas spoke of ignoring

mental health stigma by keeping things in perspective. He also credited his blocking methods to his generally unbiased demeanor. He said,

> It's just knowing you're part of that bigger picture, almost not stressing so much about my circumstance (Nicholas)
>
> I'm not normally one to stigmatize people because I just I don't much like care to follow trends of stigmatization or whatever. So, I'm kind of like a very unbiased person. (Nicholas)

Similarly, Ava, Jordan, and Heather expressed their desire to view challenges as normal for someone with a mental illness, but also that the challenges should not define the person as a whole. Excerpts are as follows:

> It's normal to be stressed for them and it's normal for them to internalize that … it's normal to have these experiences, we can talk about how to progress through that, I guess, and how to see the difficulty of those experiences as separate from the validation of them as a person. (Ava)
>
> Okay, just because I'm dysfunctional for like even like a few days, a few weeks, doesn't mean that my existence is worthless because why does capitalism define my worth? (Jordan)
>
> It would just be like saying that I have a chemical imbalance that doesn't define who I am as a person, or like just because I used to have a problem with eating that doesn't mean that I'm any less of a person or any more of a person. That doesn't change anything. That's not my character. That's not anything to do with who I am. That's just circumstantial. It's just what I've gone through. (Heather)

Moreover, Cami and Heather discussed how they prevented rumination about their mental health as a way to keep things in perspective and show resilience. Cami believed that distractions, such as music, helped her cope with her struggles and the impending stigma, while Heather explained that she did not give much thought to the negative stereotypes surrounding mental illness, despite a long history of mental health challenges. They said the following:

> [Distractions from stigma] were definitely helpful because they put me into a more positive headspace and allowed me to actually think things through more clearly. (Cami)
>
> I don't have too, too much experience [with internalizing stigma]. It wasn't like a constant, like every day, like—It was just like, "Oh, I'm crazy." There wasn't really anything else really to it. (Heather)

Believing you are Sick not Weak. Akin to the journey of coming to terms with their mental health experiences, all of the participants were able to challenge stigma by believing there was a "root cause" (Ava) or reason as to "why people with a mental illness might be acting a certain way" (Cami). They shot down harmful assumptions about who they are by referring to the mental illness as a cause of a "chemical imbalance" (Heather & Jordan) or "neurotransmitter imbalance" (Nicholas). When asked if he believed that mental health stigma stereotypes applied to him, Nicholas replied,

> A lot of people don't believe in mental health and mental illness, that they don't think it's real. They just think, "Oh, it's like you're just faking it. You're just pretending, whatever." But they are actual, like diagnosable and treatable conditions, some of which actually do show up due to physiological problems like schizophrenia. You can actually image someone's brain that has schizophrenia and you can literally see structural and activity changes. So it is actually like a physiological thing, might be due to like

neurotransmitter imbalances or even hormonal imbalances, and it's not just in their head as everyone says it is. It does affect your brain. Technically, it is in your head, but you're not making it up. (Nicholas)

Using their psychology background, Jordan shared that they directly resist external stigma by asserting that they do not have full control over their illness due to the biological component at play:

> I think especially having, like, a background in psychology now I'm just like: No! No, it's a chemical imbalance in my brain. It's not something that I have control over, to an extent and, it's just wrong, like, it's just that's not the reality of it, and it's just kind of shitty to assume that. (Jordan)

Furthermore, Nicholas and Heather likened mental illness to a medical or physical illness such as a broken leg or diabetes. This implied that they believe that a mental illness is an actual and valid sickness rather than a personal weakness:

> And they are real so you should be not only validating what you're going through, but making sure people also validate that. And obviously seeking whatever help you might actually need to essentially treat your ailment as you would treat like, you know, a broken leg. Like it's something that needs to be fixed, it's a problem that should be acknowledged and you should treat it somehow … Obviously counseling might help for some people, so you don't necessarily need medical treatments. But some individuals do. Like you can have anti-depressants, you have anti-anxiety medications that do work, so it actually is medically relevant. (Nicholas)

> Yeah, I mean, at first, I definitely struggled with that [internalizing stigma]. Over time, I was just like, "Okay, when, I take these it fixes like what's in my brain." And I would

> just kind of convince myself; it's just like if you need insulin, you take insulin. It's like the same thing. People who have diabetes aren't crazy. They need something—like, that's kind of how I started seeing it. (Heather)

Separating Self from Others' Opinions. All participants talked about how they were able to separate their feelings about themselves from other people's opinions. This involved the process of not taking what other people say personally and reducing self-judgment by setting boundaries between self and others. This subordinate theme was substantial for Ava. Ava described skills learned in therapy of problem-solving to separate what she perceives from others and what she chooses to believe about herself. She appeared to mindfully examine potentially stigmatizing situations and actively work to minimize internalizing the stigma. She also practiced self-compassion in her thoughtful self-evaluations:

> I think in therapy, my personal experience was mainly CBT [cognitive behavioral therapy]-focused. So, a lot of it was being able to kind of go through that thought process of: "I've done this behavior. What does it mean for the situation and how does it reflect upon myself?" And a lot of times it was, "Okay, that doesn't necessarily mean that I'm a dramatic person for feeling this way or that I'm a sensitive person for internalizing these factors intensely." (Ava)

Ava also discredited others when she noticed that they were being unkind to those with a mental illness. She accredited the harmful stigma to a limitation that the person has. She said,

> And I think if it was from others, giving that validation of how people treat others and if people treat others unkindly, that's a limitation of themselves. And that's a lack of kindness that they're showing. And it's not reflective of you, but instead it's reflective of their personality. And especially nowadays with all this information about mental illness

> coming out and more and more resources for people, if people still are treating mental illness as a taboo topic or something to be shameful of, that's reflective of their own ignorance and their own desire to be unkind as opposed to something wrong with you. That's a limitation that they have. (Ava)

> So, I think a lot of it was being able to resist mental illness stigma by just reducing everything down to kind of the bare bones, and understanding that people's intentions and perceptions didn't reflect on me, but instead just reflected on their own knowledge and their own limitations. And that's just as valid as mine. (Ava)

Cami also worked intentionally to learn to not care what other people think, as those external perceptions were an oppressive force of stigma:

> I'm slowly starting to learn like, "I don't know those people, like, who cares about their opinions?" But that took me so, so long to get to that point. And I think that's the biggest thing that helped was to push away, like, as many negative thoughts as I could, anyways. (Cami)

As for Nicholas and Heather, they seemed to have a more innate attitude of dismissing others and not letting it get to them. Nicholas mentioned that he "wasn't too concerned" with what other people were thinking and called out stigma for the harm that it is while Heather elaborated on how she avoids paying attention to others and not letting it get to her:

> Stigmatizing any group is not really useful, anyway, if people don't like a group for whatever reason. It's pretty much like it could be as harmful as being racist or sexist towards a particular group. It's just those people are, they're getting ridiculed or verbally, emotionally harassed for like literally no reason. (Nicholas)

> It's like people are going to joke about everything. People are not going to understand, like people aren't going to understand everything. And so, if somebody is making a joke about something they don't understand, they just don't understand it. That's not anything. There's no point of getting offended. You are just going to get upset for no reason. Because who cares what that one person thinks anyways? (Heather)

Lastly, Jordan challenged public stigma by discrediting the people who were perpetuating stigma. Jordan passionately spoke about how they were able to resist internalizing misinformed stereotypes with righteous anger:

> And a lot of things that people are saying and like that wildly are [perpetuated] have no idea what the hell they're talking about. And I was just mainly more so just discrediting people, because I was just like, you don't know, what the hell are you talking about? Who are you? You're just some rando, I don't care. (Jordan)

Taking Actions to Improve Mental Health

The theme 'taking actions to better self' comprised both focusing inward and giving oneself intentional self-compassion, using external resources and seeking help from professionals and peer support. Also, this theme targeted the overall journey of recovery from mental health.

Self-compassion. Three of the participants noted how they engaged in different forms of self-compassion, which helped minimize the impact that stigma could have on them. Cami was often helping her friends during their struggles. She had to learn to take her own advice: "I'm becoming more aware of it myself. So, it's like I kind of like, okay, you can't just say that or not do it yourself. And I try to do it then." She also had the realization that she had to first take care of herself:

If I can help all these people and help them love themselves a bit more, why can't I do it for myself? And then it's like finally learning to put myself first a bit more in helping myself first before others … I'm just like putting myself first and it's like, "Okay, like I want to help you. But right now, I need to focus on myself because if I can't even focus on myself, how the heck am I supposed to work on you and help you?" (Cami)

Ava revealed self-compassion she attentively gave herself. When contemplating on whether stigmatizing judgments applied to her, she was able to reflect with self-kindness:

So, let's kind of focus on: yeah, those aren't ideal demonstrations of how I'm feeling, but they're not uncommon. So how can I work on these things that are definitely going to pop up again to make sure that I have an easier time next time? And so, I think having that understanding for me allowed me to be a bit more patient with myself. So, I was able to give myself some more compassion, and I was able to kind of process things a little bit more kindly to myself without taking them as personal failings. So, I always say it was giving myself the patience to get through a situation and then to kind of evaluate what to do next time without immediately internalizing all of the issues and the problems as a self-failing or something I did wrong and therefore like a limitation of myself. (Ava)

Nicholas mentioned that he was working on self-compassion but that it did not come naturally to him. When asked what his goals were as he continued to work on internally resisting stigma, he replied that he wants to figure out how to take the compassion he receives from others and independently apply it to himself:

I just need to pretty much figure out a way how to almost do it myself. So, like if I am inaccessible to use supports, that I don't start going down a slope again. (Nicholas)

> Pretty much almost like internalizing all this external validation, just to kind of boost the overall self-esteem … I am working on that. (Nicholas)

Seeking Help. All of the participants noted seeking some form of help for their mental health. Cami and Heather did not elaborate on their experiences with counseling, but Jordan and Ava spoke about how seeking professional therapy helped them on their journey to stigma resistance and Nicholas recalled the importance of seeking help from peer support. Jordan noticed that their biggest moment in starting to resist stigma was their experience of finding a good therapist who validated them. They said the turning point was the following:

> Probably when I actually started, like with a therapist in late high school, I think it was, because she was the one who, she was actually really nice. I really liked her … it was like just CBT therapy, and I would like talk to her about these things and she'd be like, "Well no, because you like you're not, that because you do this, you do this, you do this, you have this." And I'm like, "Oh, I guess you're right." So that really helped me be able to like not internalize resistance. (Jordan)

Ava spoke about her experiences with therapy in a positive manner, without any evident sense of shame or internalized stigma. Ava appreciated the skills she learned in therapy that helped with not only her mental health symptoms but also her resistance to mental health stigma. She said,

> So going to therapy that started just after my generalized anxiety and depressive diagnosis. So I found that was really helpful for me in that I could have open conversations and have my experiences and feelings validated. And I found seeing my therapist gave me a strong skill set of being able to distance myself and my feelings from other people's perceptions of how I was feeling and other people's applied reasoning and

> negativity…I guess it gave me a better place to have certain conversations with a medical health professional instead of kind of heaving everything into the people around me, and then giving them that role of having to help me with how I was feeling. (Ava)

As for Nicholas seeking help via peer support, he reported feeling initially scared, then feeling subsequent emotional comfort and social connection with others that ultimately supported him on his journey to stigma resistance. Here he recalls the thoughts that went through his head when went to his first peer support meeting:

> Definitely a bit scared because, you know, talking to strangers about mental health and struggles and such, is definitely pretty weird. But I do also remember at the end of that meeting, this is only me and [one other person], like, she was just so happy that someone showed up [she ended up] giving me a hug at the end of the meeting. So I also remember that. And that was like super comforting. So getting a little bit of a physical, as well as, like emotional support during that meeting was definitely very beneficial. Plus, there was worksheets, so I had something to take home, and there were snacks. It was very welcoming, it wasn't just like going to see a counselor and them just telling you, telling you, "Oh, work on these skills," but not like really, they can't connect to you as well as like another student with mental illness can, so it's definitely like that was like a big impact, I think, on this whole journey. (Nicholas)

Working Toward Recovery of Mental Health. Four of the participants indicated that working toward or achieving recovery of some aspect of their mental health was an empowering form of stigma resistance. Cami noticed things were getting worse and that she had to work on her mental health:

> And once I figured out what I was going to do with myself and what to focus on, and then just like knowing that school's almost done and knowing that life is going to progress more, it just kind of made me, kind of helped bring me out of that deep, dark thing. And then just—and then I was able to myself, like, work on the other things to improve. (Cami)

Heather spoke about achieving recovery for an eating disorder. She said it was a coincidence that the day she presented about eating disorders in high school she was declared "eating disorder-free." She was able to say, "I overcame it." Although she continued to seek treatment for anxiety and depression, it was soon after this recovery feat that she was less bothered by stigma. When Heather asked how her resistance to stigma has changed over time, she replied, "Well, beforehand, like I said, it was—like I let things get to me more, I would get mad about it. And then as I graduated high school, I just didn't worry about that anymore."

Likewise, Jordan noted that they had shown a lot of improvement since they started seeking therapy. These aspects of recovery significantly helped them to have more clear thought processes that in turn helped challenge stigmatizing beliefs:

> When my anxiety doesn't manifest like that like I used to in high school, I think it was worse because I used to have, like, panic attacks on the daily, almost. Now it's a lot better. (Jordan)

> I think mainly—recovery really did help with being able to resist certain stigma things, because once you have a clue, because when I started treatment in high school, and it was like, "Okay, I have a bit of a clear head now, and I can rationalize." (Jordan)

Although Ava did not directly reference recovery, she noted she had a lot of resources that helped her improve in some areas. She felt as if this made stigma less applicable to her:

> I'm privileged enough to have the resources of therapy and medication, sometimes I feel like I have a lot of the resources to succeed that aren't available for other people. And therefore, a lot of mental health stigma might not be applicable to me because through these resources, I've been able to have certain skills that allow me to kind of blend in more and allow a lot of my—a lot of my self-demonstrations of my illness to not be as visible. So in some ways I don't know if a lot of the stigma applies to me because I've been able to have a lot of skills to monitor how I'm demonstrating my illness. (Ava)

Receiving Social Support

Social support from family, friends, as well as the larger public sphere were imperative influences to accept themselves as they are and gain motivation to fight against stigma, knowing they are not alone. This theme comprised receiving compassion and validation from others, having a network of similar others, and increased societal awareness and understanding.

Receiving Compassion and Validation from Others. All participants recalled the compassion, validation, and other forms of help they received from family and friends. Cami reported that after the urgings from a friend, she went to see her family doctor to discuss her options to treat her anxiety. Cami said that while talking to one of her friends, "She was like, 'Cami, I think you need to go talk to someone or do something.' So once I finally was like, 'Okay, I'll do it.'" Likewise, Ava accredited the commencement of her stigma resistance journey to her mother, who talked about mental health openly with her. Her mother encouraged her to seek therapy, which was another important step in her story of stigma resistance. Also, Ava felt validated by her mother, which connected to her own self-acceptance and self-compassion:

> I think the biggest start to that [stigma resistance] probably for me was having some conversations with my mom, who's always been really, really open about my struggles.

> And she was a good communicator for me. And for her, she recommended going to therapy, which I think kind of started a lot of my stigma resistance … So I found that was really helpful for me in that I could have open conversations and have my experiences and feelings validated. (Ava)

> I think a lot of it was like through my mom's validation and consideration to what I was going through and how patient she was with me, I was able to kind of see that that was the behavior that I deserved from other people and then also from myself to myself. (Ava)

Heather noted that one of the biggest turning points in her journey of stigma resistance was when she had the opportunity to publicly present on eating disorders. She was able to sense immediate validation in this context:

> I did this presentation for the Grade 9's, and it was about eating disorders. And so, I went into depth about that, and the warning signs, and like to watch out for your peers … And so they just thought, "Oh, she was just forced to do this assignment," like they were just all laughing at it. And then after I told my story, everyone was just like—the complete tone changed ... because once I talked about it, like people seem to take it more seriously. (Heather)

Nicholas, who also had experiences of sharing about his mental health publicly, talked about how he gets validated by others in his mental health clubs when he openly shares. It was helpful to receive compassion from others, especially as he mentioned self-compassion is harder for him to practice:

> Their validation, definitely, it helps me, I guess validate myself a bit more. So, it's definitely boosting, like the more the self-confidence and lowering that stereotype, like

externally, because it's not coming from internal means. Like I'm not like naturally boosting it. It's almost like being fed from the outside. But the experience is definitely helping. (Nicholas)

Ava and Jordan both spoke to how compassion from others originated from more understanding that people were gaining about mental health. Ava initially felt a lack of compassion from others who did not have a great understanding of what she was going through, yet when others started to learn more about her mental illness diagnoses, she noticed they reacted more positively to her. Jordan reported that their romantic relationship was very supportive because the partner also struggled with mental health difficulties; this contrasted with a past relationship in which their partner showed annoyance instead of support. Ava and Jordan said the following:

> I think it was easier for people to know how to approach the situation and to know that it wasn't just overthinking and kind of a sensitivity towards everything. And so, I think that allowed people to feel a bit more, in my experience, to feel a bit more comfortable with helping me because they knew a little bit more about what was causing these reactions … I think the compassion kind of stemmed from a clearer understanding. (Ava)

> So, and I think just having someone who is able to work with me and just understand how I work, is a lot more validating than like a person who is pushing me to do things, because then it makes me feel like I'm not doing things right. (Jordan)

Having a Network of Similar Others. Four of the participants referred to having a network of similar others that helped along the process of stigma resistance. Jordan was able to receive compassion and validation from their partner because they both had ADHD, and they both did "the exact same thing basically, or similar things." As for Nicholas, attending a mental

health peer support club provided a significant amount of support and mutual understanding from others:

> I was meeting more people with similar experiences. And just, yeah, I got like a lot more, like you could relate to the people more, you are like, "Okay, other people are going through this. It's not just me. It's not as big of a deal." You can kind of, yeah, you get support and then you also can provide support … (Nicholas)

Ava's openness and transparency were deeply connected to her network of peers that had similar mental health experiences. She expressed the importance of having support outside of family and friends who could not relate to mental illness. She believed that it was this support group that enabled her to resist internalizing stigma by using her critical evaluation skills and instilling a sense of self-confidence:

> I've been able to invite a lot of helpful and promoting conversations from like-minded people and people with similar experiences that I wouldn't have had if I wasn't open and I wasn't kind of searching for that similarity and experiences. And so, I think for me, being able to develop kind of a support group, not only of my friends and family who don't have mental illness but who appreciate and understand and support me, but specifically through a support group of people who have similar diagnoses or experiences or difficulties with that internalizing self-shame, has really provided me with a network to kind of critically evaluate how I'm feeling and ensure that I feel confident and comfortable in expressing how I'm feeling, because other people that I'm close to are feeling the same way. (Ava)

Social media also helped create a network of similar others. Cami was drawn to an Instagram page that was created by a friend of hers where people can share their stories about

mental health. She described her inspiration from other people's stories on the page that have helped her feel less alone and also assisted her in understanding more about herself and her mental health:

> You don't realize how many people have something going on or even like, I'm bad for being like, "Oh, my God, I wouldn't have expected that person to have that because it's just how well you hide it." But it's definitely, I've definitely kind of got over the stigma thing. But especially that has helped me realize and put it more into perspective. (Cami)
>
> I've definitely seen people that I'm like, "Okay, that's kind of like me," like a lot of anxiety, like I said, some depression and it's like a lot of their symptoms of have made me, kind of like, this helped me understand me more and like what I have going on more. Because like certain things I was able to pinpoint, but others I'm like, "Okay, why am I doing this?" And now I'm kind of like, "Oh, okay, that kind of makes a bit more sense now." So it's like they're helping me in a way, too, without even realizing it. (Cami)

Increased Societal Awareness and Understanding. While social shame and silence led to an intensification in stigma, social awareness and understanding assisted the defiance of stigma. Three of the participants brought up how validation from society can help those with mental health difficulties. When asked about her experience of mental health awareness growing up, Cami replied, "Well, I think it's definitely gotten better since the beginning because I feel like more people are starting to become aware of how big of a problem it is." On the other hand, Jordan recalled always having exposure to mental health from a young age and how that contributed to more understanding about their own mental health:

> I was always kind of like, I always tried to make myself kind of aware of it because I did have a decent amount of exposure to like different types of mental illnesses and mental

> health like education when I was younger. So I think I was pretty lucky in avoiding like being completely unaware of what was going on with me. (Jordan)

Cami, Jordan, and Heather spoke about how the media spread more awareness concerning depression and anxiety. They emphasized the importance of people giving information about depression and anxiety and correcting stereotypes or myths surrounding mental health:

> I've seen people, more people speak up about it online. And I'm like, "That's good"… it's mainly with depression and anxiety I've seen. (Jordan)

> There's been a lot lately about like opening up to talk about mental health. Like I see it all over the Internet, like depression, and it talks about, like for example, there's a whole bunch of posts on Instagram that I'm talking about, like: "Depression isn't just this—it's this, this, this—" And like "Anxiety isn't just this—" And just there's it's like there's a whole bunch of, like, awareness now for mental health that there wasn't before. (Heather)

Additionally, Heather believed that education about the biological components of mental health could further increase societal awareness, and in turn, help those with mental illnesses feel less alienated. She said,

> I would like to see a little bit more about talking about—because it's not really mentioned too much—about how like most cases are chemical imbalances. Like it's [the media] not talking about how it's just as regular as like some people need to take melatonin to go to sleep. Like it's a chemical imbalance. And having more discussion about that would make it seem less novel and more relatable.

Extending Stigma Resistance to Others

Part of the passage of resisting stigma personally included the extension of stigma resistance to other people. Participants extended the resistance by having compassion and showing empathy for others; this also included tangible goals of working in the mental health profession to help others. Also, disseminating knowledge and empowerment to others simultaneously facilitated their personal and others' stigma defiance.

Having Compassion and Helping Others. All of the participants described goals of helping others process having a mental illness. Having their own experiences with mental health and learning self-compassion led to empathy for other people. Here Jordan talks about how they stop friends in negative self-talk and instill confidence in them:

> I know, like some people, like I've talked to some people who have like this really like carved image of themselves, basically, that they've kind of just made out of this and it's like, "Dude, you're not! Like it's not, that's not the truth." And it's kind of just letting people who have no idea who you are dictate how you are. (Jordan)

Nicholas emphasized how receiving compassion from others in his peer support clubs enabled him to give others compassion. He was able to support and validate peers even when their struggles differed from his own, as he explained:

> But definitely receiving the compassion in that context has definitely related to me like giving compassion in the context. Yeah, if I receive more, it's not I'm not saying like I only give compassion if I'm receiving it, but definitely like just understanding the impact of that, and how you can do that to even people you don't know. (Nicholas)
>
> Like potentially they're having family trouble, relationship trouble, like I don't have much experience with that because my anxiety and troubles are more academic in nature,

> but just like being compassionate when they are pretty much opening up to us and trying to support them or relate as best as possible. (Nicholas)

Ava and Cami described goals of helping others in the future in the field of mental health. They believed in the importance of serving other people with mental illness just as they themselves have transformative journeys with their mental health:

> Yeah, I think for me, being in psychology, I really want to have a career eventually in like the mental health profession. And so I think for me, it would be really meaningful to continue my journey as more of an educator and to be the support for other people going through similar experiences in a more professional capacity. I think that would be really validating for me to kind of be able to develop those skills not only to help myself, but also to help people with similar problems. (Ava)

> I think I'm leaning more towards kind of like the counselling angle. So that way it's like—I could give them a voice, but that way I know too, like you said, like I have my own experiences too. So using those. Even if I can help like one person, even educate them, I feel like then they could go and help people, too. So it's like just getting the ball rolling in a sense. (Cami)

Heather did not have any specific future goals but laid out a scenario in which she would help out someone in need. She said, "It depends on the situation I'm in, I guess. Like if there's a time where I feel like it could benefit people, definitely."

Spreading Awareness and Education. While sometimes participants resisted stigma by ignoring or shutting down others, they all also had times of actively correcting and educating others. For instance, Jordan would correct people on their assumptions about depression, anxiety, and ADHD. Heather recalled that when she presented on eating disorders and shared her

personal story during high school, she was proud of her disclosure because she knew had the potential to help other people. Similarly, Cami took opportunities to continue her own journey of stigma resistance by also talking to people about mental health:

> Just like just trying to remind myself, I guess like to keep trying to resist and keep trying to work towards it. And not just with myself, but with other people, like just trying to point out little things to them about like why someone might be acting a certain way or trying to get them to understand a bit more, too. (Cami)

With his heavy involvement in mental health peer clubs, Nicholas was actively working to help other people resist stigma:

> Not only was I like the person that initially went to go seek out this help to kind of fight the whole stigma of not wanting to go talk about it, but now I actually like promote other people to come talk to us and come to our events … it is an opportunity to encourage other students … and just to kind of help them fight the stigma, resist it themselves by actually being able to talk to pretty much strangers and form connections based on this shared battle that we're all having. (Nicholas)

> So it's now, it's not just like me personally resisting stigma, it's me trying to also, like, not push but like encourage other people to also resist, as well as to kind of, yeah resist the stigma not just on the receiving end, but also on the dishing out end. Because if I can educate people that might view this as a stigma, like people without mental illness might be like stigmatizing other people, if I can educate them, then I can potentially lower their stigma. (Nicholas)

Ava preferred to take a step back and not directly challenge others, however she did engage in casual conversations that could help educate others. Some of these conversations were met with validation from others, which in turn encouraged her stigma resistance:

> Well, I know in my experience, no one's ever necessarily asked me, like, "Can you explain what this is and what this is?" But I guess just more casual conversations of like, "Okay, why are you doing that, though? Like, that doesn't seem warranted to the situation." And then kind of providing a blanket statement of, "Well, from my anxiety, personally, it feels a lot better if I'm able to clear out this task and do it all at once so that I know that burden's gone and then I can progress." And then sometimes I guess my explanation of the casual conversation was met with understanding and appreciation and kind of validation. (Ava)

Both Cami and Nicholas expressed future goals to continue to assist other people in resisting mental health stigma. Cami was so inspired by her friend's heartening Instagram page that she stated she would like to do something similar, as she said: "I would like to do something like that Instagram page almost too, just to allow people the platform to share." As for Nicholas, he shared his plans to continue to become a speaker and to advocate and educate others on mental health. He believed this would help him personally to continue to resist stigma while also aiding others in stigma resistance:

> I mean as future work towards anti-stigmatization and such, I am potentially looking into becoming not only just a mental health advocate, but actually a more of a, I guess, contract speaker about said things, so like actually like educating students and different academic or community groups based on mental health, the spectrum, the stigmatization, as well as some resources and actually ways that you can help others that are going

through mental health crises … that would be the next actionable step that I would take towards this whole pretty much helping myself and also trying to reduce the stigma of more people. (Nicholas)

Summary

A semi-structured interview was utilized to explore the experience of resisting mental health stigma. Comprehensive IPA analysis revealed six main themes for stigma resistance: accepting one's mental health experiences, transparency about mental health experiences, blocking public stigma, taking actions to better oneself, receiving social support, and extending stigma resistance to others. There were strong connections and a few juxtapositions among the six main themes and 15 subordinate themes.

The connection among the first two themes of 'accepting one's mental health experiences' and 'transparency about mental health experiences' was robust, particularly for the foundation of stigma resistance. The former likened to a way of opening up to oneself and becoming comfortable in one's own skin, while the latter resembled a literal opening up to other people and becoming comfortable with transparency. On the other hand, although acceptance and transparency were noteworthy, individuals had to balance this personal acknowledgment with blocking or ignoring societal messages that were less validating (i.e., 'blocking public stigma'). Furthermore, while receiving and acknowledging a label or diagnosis was an important validation of people's experiences, strong personal validation also came via self-compassion and subsequent efforts to seek help and work toward recovery (i.e., 'taking actions to better oneself'). Lastly, 'receiving social support' and 'extending stigma resistance to others' were closely tied together. The two participants who were explicitly part of a mental health peer group, Nicholas and Ava, emphasized the support they had from others and how that was a considerable factor

for personal resistance. The more support they had, the stronger their enthusiasm appeared to be about giving back support to other people.

Discussion

Six superordinate and 15 subordinate themes were constructed from the interpretative analysis of the experience of stigma resistance. The findings are discussed in relation to the current literature review. Also, each theme is discussed in further detail and interpretations regarding its role in stigma resistance, implications for clinical practice, and future research recommendations.

Connection to Literature Review Defining Stigma and Stigma Resistance

The results show that stigma resistance comprises multiple components at both an intrapersonal and interpersonal level. Stigma resistance generally is experienced after identifying with having a mental illness and first having times of being exposed to societal stigma and then applying some of those stereotypes internally (Corrigan et al., 2006). Just as it takes others to perpetuate social and public stigma, it takes compassion and acceptance from others to help do away with many of those stigmatizing and demoralizing beliefs. On the same line, internalizing stigma can happen at a deeply personal level that may feel completely separate from other peoples' opinions. In that case, it takes an intrapersonal, inward reflection to undo those stigmatizing beliefs one has. These findings support previous literature on perceived public stigma and self-stigma as separate constructs (e.g., Corrigan et al., 2006; Vogel et al., 2013).

First off, participants had experiences of self-stigma before and during their journey of stigma resistance. Corrigan and colleagues' (2006) noted that awareness of stereotypes precedes self-stigma, which is the ensuing agreement, self-concurrence, and self-esteem decrement due to internalization of society's attitudes and reactions. Many aspects of this definition were well

described by and relatable to the five participants. The awareness of stigma was seen in external invalidation of not being taken seriously, societal avoidance, and judgments about mental illness. Public awareness was a part of growing and learning about mental illness and how others treat those with mental health difficulties. Before most participants began to resist the stigma, they had times of acknowledging the stigma with which they were socialized. This familiarity with harmful social views inevitably led to applying the stereotypes to themselves and internalizing the stigma, such as questioning their own mental health experiences and believing they were lazy or crazy because other people had said so. Link's Modified Labeling Theory (1982, 1987) was less relevant, as participants didn't explicitly talk about fear of being devalued and discriminated against for having a label; this might be less relevant as participants generally had anxiety and depressive disorders that could be perceived as less severe than a serious mental illness for which one might be hospitalized or less likely to function in society. For several of the participants, receiving a diagnostic label was instead empowering as it began their journey of self-awareness and self-acceptance.

Beyond self-stigma, experiences of stigma resistance generally converged with the recent literature. Similar to the qualitative results of Study 1, stigma resistance was observed at intrapersonal and interpersonal levels, coinciding with Firmin, Luther, and colleagues' (2017) Stigma Resistance Model at the Personal, Peer, and Public Levels, based on 24 individuals with serious mental illness. For the current study, the five participants experienced stigma resistance on a personal level by blocking public stigma (e.g., not being defined by mental illness, separating self from others' opinions); stigma resistance was seen on a peer level through receiving social support and validation from others as well as extending stigma resistance by

having compassion for and helping others; stigma resistance was rendered at the public level via spreading awareness and education.

Theme One: Accepting One's Mental Health Experiences

Personal acceptance of one's mental health experiences and often diagnostic labels were central premises for stigma resistance. Denying mental illness may have avoided stigma in a sense, as they were less aware of the relevance of the stigma personally, yet this was avoidance, not resistance. The participants described an explanation via diagnosis as helpful in identifying what was happening. Following the recognition, a more profound acknowledgment could take place. Furthermore, rather than just accepting a diagnosis as defeat, they could receive validation for their experiences. It was validating to realize that other people have mental health struggles, and for those with the struggles, it was normal to experience the highs and the lows of mental illness. This validation helped challenge the societal stereotype that one was "crazy" if one had a mental illness. First, it is not accurate to believe the stereotypes, as they are reductionistic, but second of all, so what if one is "crazy"? as Cami questioned.

Components of acceptance coincide with the mindfulness aspect of Neff's (2003b) self-compassion, as awareness and acceptance of thoughts and feelings one is having (vs. overidentification). This theme of acceptance also concurs with Pachankis's (2007) model delineating the harmful effects of concealing a stigma and how both self-acceptance and disclosure can break the cycle of concealment. Self-acceptance naturally comes before disclosure, which is the general first step in stigma resistance. For instance, individuals unaware of signs of mental illness will likely not seek out or accept a diagnosis; without recognizing what is going on, no further steps can be taken, such as disclosure or seeking treatment.

Clinical implications may be tied in via success in therapy treatments that include acceptance components (i.e., acceptance and commitment therapy [ACT]; Hayes et al., 1999; Hayes et al., 2012). As noted in the literature review, ACT has successfully reduced self-stigma for substance abuse (Luoma et al., 2008, Luoma et al., 2012) and weight self-stigma (Palmeira et al., 2017; Potts et al., 2022). While ACT is efficacious for treating anxiety and depression (e.g., Twohig & Levin, 2017), no known literature was found on ACT treating self-stigma for anxiety and depression specifically (Stynes et al., 2022). However, there is theoretical support for ACT increasing acceptance, mindfulness, and self-compassion and decreasing shame and fear (Krafft et al., 2018; Luoma and Platt, 2015; Stynes et al., 2022). Perhaps if the acceptance component targets negative thoughts related to stigma specifically, treatment could target anxiety and depression and the stigma associated with them simultaneously. For instance, a treatment for depression and anxiety may target self-stigmatizing thoughts around having depression and anxiety and teach individuals to respond more flexibly to the self-stigma, such as simply acknowledging that they have self-stigmatizing thoughts and being self-compassionate and accepting of those thoughts. Moreso, this time and reflection could have the potential for individuals to stop and realize that the thoughts may stem from the societal stigma that does not ring true or have a hold on them.

Theme Two: Transparency about Mental Health Experiences

Following acknowledgment of and some level of acceptance of depression or anxiety, most participants could safely disclose with others when appropriate, coinciding with the two theorized aspects of breaking the cycle of concealment (Pachankis, 2007). What often started with reticence and shame transformed into empowerment in honesty and sharing of mental

health stories. While concealment of their mental health was linked to lower self-esteem, transparency triggered an increase in self-worth, self-efficacy, and self-confidence.

Disclosure aided in stigma resistance, similar to the findings in the literature of "coming out proud" to reduce shame and fear associated with a mental health diagnosis (Corrigan et al., 2010; Corrigan et al., 2013; Corrigan et al., 2015); this was seen in the overarching theme of 'transparency about mental health experiences' as well as aspects of 'receiving social support.' According to the Disclosure Process Model (Chaudoir & Fisher, 2010), the individuals believed it was acceptable to open up due to positive social support and signals from others that changes in social information and subsequent interactions. For instance, Cami's first step in opening up to one person led to more comfort in disclosing to others. Empowerment through disclosure is also tied to the theme of 'extending stigma resistance to others,' such as Heather's pride in sharing her eating disorder recovery with younger high school students.

Clinically, there are strong indications for encouraging disclosure of mental health diagnoses when appropriate. Disclosure of mental illness can reduce self-stigma (Corrigan et al., 2010) and help signal a need for support (Corrigan et al., 2015; Weisz et al., 2016). On the other hand, mental health status is personal health information and not owed to other people. Concealability can be a privilege for some people who can pass as "normal" to avoid prejudice and discrimination. Depression or anxiety may be more passable than other mental health conditions (e.g., severe mental illness, psychosis).

It is suggested to weigh the pros and cons of coming out with one's mental illness situation by situation (Corrigan et al., 2010). For instance, there may be fewer potential consequences of revealing a mental health difficulty that is lesser in severity and, therefore, lower in perceived and self-stigma (Livingston & Boyd, 2010). When it is safe to disclose, this

may be received well by others, allow for social support, and empower a sense of authenticity. Disclosure risks include potential discrimination, such as social rejection, not getting a workplace promotion, or poorer insurance coverage. Unfortunately, both disclosure and non-disclosure of mental health issues can lead to job loss (Brouwers, 2020). Personal and societal context may render the decision to disclose in some situations and not others.

Theme Three: Blocking Public Stigma

The theme ‘blocking public stigma’ originated in the participants’ various ways of blocking or not overidentifying with what other people or society, in general, say about mental health. This strongly aligned with Corrigan and Watson’s (2002) reaction to stigma entitled ‘ignoring the public stereotypes and stigma,’ wherein an individual may identify with a mental illness but not perceive the stereotypes as relevant. For the current study, Nicholas and Heather seemed innately unconcerned with societal views, while Ava and Cami appeared intentional in their resistance to others' opinions. As for Jordan, their position may have fit better with Corrigan and Watson’s (2002) ‘righteous anger.’ Both methods of blocking and righteous anger protected them from the encroaching negativity and shame of public stigma.

This theme resembled Thoits’ (2011) theory of resisting stigma as the strategy of “challenging” but not “deflection.” Challenging included pushing back or rejecting stereotypes (e.g., I am sick, not weak). Identity deflection is potentially seen by choosing not to be solely defined by their mental illness; however, while the current participants had experiences of blocking public stigma, the distancing from stereotypes did not include denial of their mental health experiences. This is likely the current case, as participants were sought who explicitly identified with having depression or anxiety. Other people who may deflect mental illness with a “that’s not me” mentality may have less internalized stigma but may also not have much active

stigma resistance. These findings are consistent with Firmin et al.'s (2017) grounded theory study, where the participants stated that deflection was too "passive" to fit with the intentional components of stigma resistance.

Participants in the current study pushed aside stereotypes by taking into account the causes of mental illness for which they are not personally responsible. For example, Heather, Jordan, and Nicholas mentioned chemical or neurotransmitter imbalances. While helpful in reducing blame, one caveat for biogenetic causal beliefs is that they have the potential to increase negative attitudes toward mental illness in the form of prognostic pessimism, perceptions of dangerousness, and less empathy for those with mental illness (Kvaale et al., 2013; Larkings & Brown, 2017). The stigma moderators of perceived controllability and responsibility (Corrigan & Watson, 2002) may play a role in the impact of mental illness stigma. Perceived controllability can vary between mental disorders, such as depression being viewed as controllable, psychosis being considered as uncontrollable, and anxiety being viewed as somewhere in between (Krendl & Freeman, 2019). While depression and anxiety can be perceived as more treatable and less dangerous than the assumed uncontrollability of psychosis (Hasan & Musleh, 2017), they are still stigmatized because the individual with a "controllable" condition is perceived to be responsible for their behaviors (Krendl & Freeman, 2019).

For this study, it was found that participants were empowered with a "sick not weak" mentality within a larger framework of accepting things as they are, taking accountability for one's own mental health journey, and helping others. For most of these participants, having an explanation for the mental illness did not appear to be an excuse but rather an explanation that allowed self-compassion. While the terminology of "sick" or "illness" does not have a positive connotation, it can help diverge from the "weak not sick" stereotype that is associated with

higher prejudice and discrimination (Hanlon & Swords, 2020). For example, a qualitative study with mental health service consumers found that causal beliefs about mental illness increased personal insight into their illness, reduced self-blame, and increased symptom and treatment management (Larkings et al., 2017). Believing and spreading the message that mental illness is in fact an illness and not a personal failing can increase self-stigma resistance, and it may also be that within the appropriate context, the message of "sick not weak" can also improve public stigma resistance.

On top of this, participants delineated their processes of setting boundaries between themselves and others. Sometimes individuals were more likely to take a gentle mindfulness approach in the blocking behaviors, while other times, they actively dismissed hurtful stereotypes. This ties back to the first theme of mindful self-acceptance as an aspect of self-compassion (Neff, 2003b). Sometimes the most self-compassionate action is to ignore any negative external influences to allow for a more neutral or balanced evaluation inward. Clinical implications from this motif encompass the varying methods through which public stigma can be resisted: individuals may distance themselves from the general views to focus inward or draw their attention to the public opinions and challenge them head-on.

Theme Four: Taking Actions to Better Oneself

The theme 'taking actions to better self' underscored these participants' drive to work on themselves and their mental health. Personal reflection, acknowledgment of one's mental health, and self-validation coincided with compassion directed inward. The journey to self-compassion varied among the participants. For Cami, it was rendering her compassion for others into self-compassion. For Nicholas, it was translating the compassion he receives from others into self-compassion (although he also had experiences of giving compassion to others). Similar to the

self-compassion findings in Study 1, the results support Stringer and colleagues' (2018) theoretical model of both compassion and self-compassion moving an individual away from self-stigma and toward resilience. Compassion is a deep form of empathy that also fosters social connections and support, as seen in the next theme.

Therapeutic approaches to reducing stigma (MacInnes & Lewis, 2008; Mittal et al., 2012) were meaningful for two participants, Ava and Jordan, while the other three participants did not explicitly mention therapy in their journey of stigma resistance. While not explicitly talking about stigma in therapy, skills of mindfulness and self-compassion were intrinsic in their learning of new skills and ways of thinking. Despite the success, Jordan mentioned that a therapy session specifically addressing internalized stigma would have been helpful. Most treatment interventions in the literature targeted populations with severe mental illness (see review by Yanos et al., 2015), yet a new treatment could be created or adapted specifically to target self-stigma of depression or anxiety. For instance, cognitive psychotherapy can be adapted to address self-stigma and shame (Larson & Corrigan, 2010).

Nicholas sought help in the form of peer support. A recent scoping review indicated promise for the positive impact (e.g., reduced depression, stress, and anxiety) of peer support on young adults and university students, with the benefits of being accessible, affordable, and less stigmatized than formal mental health services (Richard et al., 2022). Interventions targeting depression specifically revealed that peer support was superior to usual care and comparable to group cognitive behavioral therapy (Pfeiffer, Heisler, Piette, Rogers, & Valenstein, 2010). The literature also suggests that peer support, similar to other interventions, can significantly improve empowerment and self-efficacy (Burke et al., 2019), which are substantial factors of stigma resistance.

Even though full recovery was not noted, efforts seen to date and moments of achievement helped minimize the impact of stigma, supporting Stringer et al.'s (2018) model, including competence as an avenue for self-determination and resilience. All participants were university students at the time, indicating a level of academic success and adaptive functioning. Moreover, the participants self-selected into the current study on mental health stigma resistance and as such, had experienced at least a few years of mental health discovery, struggles, and progress. Although still identifying with other forms of mental illness, Heather was proud of recovering from an eating disorder. Others discussed an abatement in symptoms, increasing coping skills, and development in communicating one's needs. While the participants were still on a journey with future goals of further stigma resistance, they showed strengths and areas of growth already empowering them with resilience.

Theme Five: Receiving Social Support

Validation and support from family, friends, therapists, and society in general were significant factors contributing to stigma resistance. Participants received compassion from others and learned, in turn, to give themselves compassion. This ties the current theme of 'receiving social support' to the motifs of self-acceptance and self-compassion. For instance, Ava was first supported by her mom to talk about her struggles and initiate therapy and Nicholas received peer support that encouraged him to internalize all of the compassion from others and the skills he learned.

Stigma resistance also stemmed from having a supportive network of people with shared experiences and access to open public discourse concerning mental health. Both Nicholas and Ava were a part of a peer mental health group that enhanced a sense of togetherness. Cami gained a sense of support from online social media posts. Whether in person or online, having

others to relate to makes one not feel alone or misunderstood. Perceiving a network of people in similar circumstances fits with the common humanity factor of self-compassion (Neff, 2003b). Ava, Cami, and Nicholas were so inspired by their peer networks that they hoped to work or volunteer in positions that would support others to learn about mental health and reduce stigma.

A study with college students found that increased communication about mental health issues was associated with reduced levels of personal stigma (Carmack et al., 2018). While perceiving societal stigma hindered stigma resistance, sensing increased societal awareness, understanding, and validation facilitated stigma resistance. Cami was particularly drawn to a social media account that helped her not feel alone, and she was hoping to one day be able to post there with self-confidence. While keeping in mind the contextual factors of appropriate disclosure, it is imperative for there to be accessible information and openness to mental health information so that individuals who are struggling know they are not alone.

Furthermore, social support and community with others are critical to address public and societal stereotypes. Having a sense of understanding from other people can allow for personal validation as well as advocacy to spread stigma resistance to others. This points to the importance of integrating social support-oriented strategies to assist with young adults' mental health (Bjørlykhaug et al., 2021), and subsequently, mental health stigma resistance.

Theme Six: Extending Stigma Resistance to Others

Aspects of compassion appeared throughout the findings, be it compassion from others, to oneself, or toward others. Sometimes participants began with a mentality of standing up against stereotypes on behalf of others, even before they had processed their own experiences. Other times the personal journey of self-acceptance and self-compassion snowballed into a passion for teaching others acceptance and giving compassion to others. Ava and Cami had

career goals related to mental health and Nicholas hoped to continue to work or volunteer alongside mental health clubs. All participants identified with stigma resistance, and by participating in the current study, they actively shared their stories with others. This involved normalizing the experience of mental illness and internalization of stigma and encouraging a message of empowerment rather than being dragged down by the dispiriting messages of society.

Anti-stigma efforts in the literature were noticeable among the current participants. Peer-supported learning, education, and contact-based approaches to stigma resistance (Arboleda-Flórez & Stuart, 2012) were influential for Nicholas and Ava, who had access to peer mental health groups. Similarly, Cami described stigma reduction coming from social media efforts, which include informal education and contact-based features (e.g., people sharing their stories on Instagram). The passionate efforts of the participants are encouraging, considering that most anti-stigma interventions aimed at educational institutes successfully reduced stigma, knowledge, attitudes, and beliefs regarding mental health (Waqas et al., 2020). However, when attempting to reduce stigma via education, it is imperative to keep in mind the dilemma regarding the potential for an increase in other forms of stigma when teaching biogenetic explanations of mental illness (e.g., may lower blame but increase fear and pessimistic views of prognosis; Larkings & Brown, 2018).

Anti-stigma interventions may be particularly helpful for addressing public stigma on a larger scale, yet they also show promise for reducing self-stigma indirectly. To also extend stigma resistance further to others, direct self-stigma interventions for those with severe mental illness (see review by Yanos et al., 2015) could be tailored for depression and anxiety. For instance, the university population might be reached by targeting young adults with high levels

of distress, and teaching them to identify their mental health problems, become comfortable talking to others about their experiences, and develop self-compassion.

Conclusion

Studies 1 and 2 intended to gain insight into help-seeking and mental health stigma in order to identify factors and experiences that contribute to stigma resistance. This research was imperative due to the emphasis on stigma and the need for more exploration of the positive and inverse side of stigma—stigma resistance.

Connections Among Studies 1 and 2

Stigma vs. Stigma Resistance

Both studies revealed that help-seeking stigma, mental health stigma, and mental health stigma resistance were influenced by many of the same factors. The quantitative analyses showed that positive psychosocial variables (e.g., self-compassion, mental health self-efficacy) were generally associated with decreased self-stigma and increased stigma resistance, while negative psychosocial variables (e.g., self-coldness, psychological distress, perceived stigma) were generally associated with increased self-stigma and decreased stigma resistance. Similar parallels were found with the qualitative responses, as participants shared experiences of positive coping strategies and support allowed for more stigma resistance while increased symptom severity and less support made resisting stigma difficult, often leading to internalized stigma.

One exception among the quantitative variables was that perceived mental health stigma did not have a significant negative relationship with stigma resistance. This foreshadowed the complexities between perceived and internalized stigma and stigma resistance, as revealed in the qualitative studies. In both qualitative studies asking about stigma resistance, ongoing experiences of perceiving societal stigma and struggling with internalizing pervasive stereotypes

were present. For some participants, knowledge concerning societal prejudice opened their eyes to the unfairness and misinformation, which led them to want to be transparent about their own diagnoses and openly challenge other people who were unkind about mental illness. For others, not talking about mental health while growing up led to a concealed burden of having to ignore or deal with their mental health and stigma on their own. Some appeared to have a mixture of experiences of perceiving, internalizing, ignoring, and fighting against the stigma. Having one experience did not exclude the other, and it depended on ongoing personal self-growth and self-discovery, social support, and life circumstances.

Self-Compassion, Self-Coldness, and Stigma Resistance

Self-compassion was identified as a significant contributor to less self-stigma and more stigma resistance in both studies. However, some of the quantitative analyses revealed that only either self-compassion or self-coldness (not both) contributed to less stigma (i.e., help-seeking or mental health). This highlighted how low self-compassion and high self-coldness were not synonymous but supported two separate constructs (Muris & Otgaar, 2020). A nearing significant buffering effect of self-compassion was also confirmed between perceived and self-stigma of help-seeking. The qualitative responses from Study 1 revealed that self-kindness, self-care, normalizing experiences as a common part of humanity, and being mindful in evaluating public stigma allowed for stigma resistance. On the other hand, struggles with practicing self-compassion and subsequent stigma resistance were hard to tackle when they were self-critical and hard on themselves (i.e., self-coldness). However, it was not just self-coldness that prevented self-compassion; some had self-kindness but could not internalize it because the reality of their mental illness was too debilitating. This potentially indicates that mental health self-efficacy is needed alongside self-compassion to lead to consistent stigma resistance.

Study 2 further clarified the mechanisms connecting self-compassion to stigma resistance. Although they identified some examples of internalizing stigma and self-criticism, the experiences were no longer prominent. These participants were not explicitly asked about self-compassion, yet self-compassion was generated as a subtheme within the theme of 'taking actions to better oneself,' as they intentionally engaged in self-care, used kind self-talk, and tried to believe the positive things other people said about them. Beyond this, self-compassion more subtly appeared throughout most of the themes. 'Accepting one's mental health experiences' included a mindful acceptance of their mental illness and self-validation as they realized their struggles were valid and they were not alone. 'Transparency about mental health experiences' showed that refusing to be ashamed and hide one's struggles was an act of self-care and an empowering action that allowed for mindful rejection of societal stigma. Furthermore, 'blocking public stigma' tied in with the self-compassion component of mindfulness vs. overidentification (Neff, 2003b), in the form of ignoring societal and self-judgment with mindful evaluations of causes of mental illness (which reduced self-blame) and not overidentifying with others' stigmatizing beliefs. Lastly, 'receiving social support' comprised receiving compassion from others while 'extending stigma resistance to others' involved wanting to help others as they have been helped and empowered. This showed the intertwining of experiences of self-compassion, receiving compassion from others, and having compassion for others.

As self-compassion may both decrease self-stigma and increase stigma resistance, there are robust implications for intervening with populations vulnerable to increased distress, such as undergraduate students. A brief self-compassion intervention in just three group meetings for college students showed significant increases in self-compassion, mindfulness, optimism, and self-efficacy (Smeets et al., 2014). While no significant changes for worry or mood symptoms

were found after three meetings (Smeets et al., 2014), the increase in self-compassion and self-efficacy may be promising for ensuing increases in stigma resistance. Other studies on self-compassion and mindfulness have found increased resilience among school-age children (Gueldner & Feuerborn, 2015) and self-compassion and better well-being controlled to a waitlist among adolescents (Bluth et al., 2015). Interventions to improve self-compassion regarding help-seeking may also potentially improve actual help-seeking behavior (Heath et al., 2018).

Mental Health Self-Efficacy, Perceived Competence, and Skills and Stigma

Perceived competence was theorized to be another factor moving an individual away from self-stigmatization to resilience (Stringer et al., 2018). Competence has been seen as a component of self-determination theory (Deci & Ryan, 2012) and measured through the construct of self-efficacy (Hughes et al., 2011). The quantitative study used mental health self-efficacy to measure perceived competence in coping with mental health difficulties. Mental health self-efficacy emerged as a significant predictor of less mental health self-stigma and increased mental health stigma resistance. Additionally, mental health self-efficacy was found to buffer the strength of the relationship between perceived and self-stigma of depression and anxiety; although individuals may perceive public stigma of mental illness, having a strong sense of self-efficacy may make the stereotypical messages less applicable. Beyond mental health stigma, mental health self-efficacy strongly related to decreased help-seeking stigma. This is an important takeaway, as just as mental health stigma relates to decreased help-seeking (Clement et al., 2015), improving mental health self-efficacy and stigma resistance may also have implications for increasing help-seeking behavior.

Participants in Study 1 were asked about competence and mastery of skills in various life domains that may have impacted stigma resistance. Some participants wrote along the lines of

mental health self-efficacy, referring to having healthy coping skills and how this helped them resist internalizing mental health stigma. Although not asked directly about competence, participants in Study 2 referred to using skills learned in therapy and how working toward recovery of mental health was advantageous in their journey in resisting stigma. This supports the quantitative findings of mental health self-efficacy as a contributor to decreased self-stigma and increased stigma resistance. Participants in both qualitative studies identified how they were more than their mental illness. For instance, some people in Study 1 wrote that skills at school, in sports, and at home gave them a solid outlet to feel capable and self-esteem. Others in Study 2 spoke of feeling valid as separate from their diagnoses even when they experience dysfunction, showing how stigma resistance can be present even without perceived competence.

One critical finding regarding perceived competence, in general, is that it can be a double-edged sword with stigma. Many participants in Study 1 and a few in Study 2 noted that the idea of perceiving competence or having skills rendered concealment of their actual suffering. Having tangible skills or greater perceived power may successfully minimize some forms of public stigma or structural discrimination yet increase internalized stigma. For instance, appearing skilled or competent may cause the mental illness to be less visible, leading to public and self-inflicted invalidation. One study with undergraduate students found that early treatment of depression was associated with higher illness invalidity stigma, indicating that one can be judged for being “not sick enough” (Henshaw, 2014). This judgment may not lead to outright discrimination but likely will cause individuals to feel misunderstood by others and internalize the shame and feelings of invalidation.

Participants had described feeling like a completely different person in their mental health struggles from the person they showed others. This masking may cause individuals to

miss out on a mental health diagnosis (Shetty et al., 2018; Stolzenburg et al., 2017) and the support that might follow this discovery. On the other hand, individuals who felt empowered by working toward recovery appeared to integrate their sense of competence and self-efficacy with authentic transparency about their struggles. This argues for finding a balance between feeling good about one's progress while also acknowledging one's struggles that need support.

As there is a connection between mental health self-efficacy and stigma resistance, there is a robust case for promoting or inducing self-efficacy in vulnerable populations despite distress levels, pathology, or diagnoses. Teaching people in society that one can have struggles or a diagnosed mental illness while also having resilient coping skills may be very empowering for those who feel as if it is one or the other. For undergraduate students, this might be seen in the form of a resilience training program (some of which include self-compassion and mindfulness components; Joyce et al., 2018). Also, encouraging help-seeking for the benefit of skill development may show people that they are capable of growth and maybe even recovery. Hopefully, positive results from seeking professional help will, in turn, reduce help-seeking stigma as well (Clement et al., 2015).

Limitations and Future Research

The current research should be interpreted with some limitations in mind. For Study 1, all the participants were recruited from the same university and were primarily female, White/Caucasian, and identified as heterosexual. Some ethnic/racial groups were underrepresented, leaving subgroups too small to be examined in comparison statistical analyses; this may have caused me to miss potential differences in stigma and other psychosocial variables among different ethnic groups, as previous research has indicated this is an important consideration in help-seeking (Clement et al., 2015; Eisenberg et al., 2009). The homogeneity of

the sample could be addressed by recruiting participants with a diversity of background demographics (e.g., age, race/ethnicity, sexual orientation). Future research should examine the salient intersectionalities of mental health, culture/ethnicity, and other identities that can create altogether different realities of lived experiences.

Participants were recruited for identifying as having or having had a mental health problem, yet only about half of the participants had a mental health diagnosis. This leaves some unknowns regarding the mental health status of the other half of the participants. It is possible that participants could overidentify with the term "mental health problem" even if the topic was not relevant to them. The single question for inclusion criteria may also have been answered incorrectly by undergraduate students who wanted to receive extra credit for their participation (although the inclusion criterion was emphasized in the study advertisement and other studies were available via the same research website). Future research could utilize more exhaustive criteria for inclusion or study clinical samples to ensure relevance to mental health stigma. However, I believe the inclusivity of all university students who identified as having a mental health problem (diagnosed or undiagnosed) allowed me to examine a more representative sample of a vulnerable population. Rather than excluding individuals without a diagnosis, further research could gather more demographic and mental health information to have a more comprehensive understanding of the population.

I attempted to measure two separate forms of stigma: help-seeking stigma and depression and anxiety stigma. However, the Self-Stigma of Depression and Anxiety Scale comprises a subscale entitled "help-seeking inhibition" which includes a few items related to help-seeking for depression and anxiety. This indicates that some forms of the help-seeking and mental health stigma constructs are less distinct than originally thought (Lannin et al., 2014), and

interpretations regarding these two forms of stigma should be made with this in mind. This also potentially reveals that some findings related to depression and anxiety self-stigma may extrapolate to some aspects of help-seeking stigma.

I also attempted to measure the broad construct of competence as theorized to impact stigma resilience (Stringer et al., 2018), yet the measure of competence for college students did not have adequate inter-item reliability and could not be used; mental health self-efficacy was a robust variable but only accounted for one aspect of perceived competence. Future research in stigma resistance could utilize multiple measures of self-efficacy (e.g., academic, social, vocational) and compare what facets may associate with mental health stigma experiences.

Another limitation is a study procedural error regarding the scale measuring perceived stigma of depression and anxiety (PSDAS). The first 79 included study participants completed the PSDAS with an error in the Likert rating scale (there were two labels of "Agree" and none for "Disagree.") Participants were given the opportunity to complete the 10-item scale with the correct labels, for which they were compensated with .25 bonus marks; this was approved by the Research Ethics Board. However, seven of the included study participants did not redo this scale, which removed them from analyses that used this measure. Beyond the loss of a few participants, this make-up scale was completed at a separate time than the rest of the scales, rendering elapsed time of the entire study and prior completion of the scale as potentially confounding factors.

The quantitative research was cross-sectional, limiting any firm conclusions concerning the causal nature of variable relationships. The brief qualitative responses from Study 1 were also cross-sectional, not allowing for any clarification of the prompts or follow-up on my end as the researcher. Longitudinal or experimental testing of self-compassion and self-efficacy interventions targeting stigma could compensate for the cross-sectional limitations. Additionally,

structural equation modeling (SEM) could be used to examine the multiple variables at play; potentially, perceived stigma and self-stigma of mental health along with mental health stigma resistance could be investigated in one model.

Study 2 relied on the participant's ability to communicate their complex experiences through the limitation of language (Smith et al., 2009) and excluded other forms of communication, such as through writing and other forms of creative expression. IPA should be interpreted with the acknowledgment that the experiences are an insight into a particular cohort for a specific point in time. Conclusions must be extrapolated with caution when applying to other undergraduate students who have resisted mental health stigma. IPA is also incomplete in answering questions around the phenomenology of stigma resistance, as experiences were described and explored, yet IPA does not attempt to explain why people experienced stigma resistance in certain ways (Tuffour, 2017; Willig, 2013). IPA includes an interpretative component that is subjected to the biases of the researchers. Lastly, the validity procedure of member checking was attempted (Creswell & Miller, 2000); yet most of the participants did not choose to follow up.

Further qualitative research could comprise IPA or another approach (e.g., grounded theory; Strauss & Corbin, 1997) with the same participants at a few points in time; this has the potential to allow for more robust member checking and collaboration. Research could also examine the developmental trajectories of self-stigmatized individuals with mental illness, following individuals over some time to see if stigma resistance emerges (Stringer et al., 2018).

Furthermore, evolving research could include the development of a measure of help-seeking stigma resistance to examine the relationship between perceived and self-stigma of seeking help with a positive stigma variable; help-seeking stigma resistance may also be seen

parallel to and in comparison to mental health stigma resistance (e.g., the Stigma Resistance Scale; Firmin, Lysaker, et al., 2017). Like the need for a quantitative measure for help-seeking stigma resistance, future qualitative research questions in the area of stigma resistance could be conducted regarding experiences of help-seeking stigma resistance. Experiences with help-seeking stigma may share some similarities with mental health stigma, yet findings could highlight factors and turning points that decrease negative help-seeking attitudes and increase shame-free help-seeking. In fact, individuals with less severe forms of mental health problems may have unique stigmatizing attitudes that need to be addressed (Sickel et al., 2014). Further research in help-seeking also has the potential to include populations like the participants in this study that may be "passing" but still have high levels of distress.

Overall, future research in stigma resistance has the potential to show positive psychosocial variables and experiences to highlight and develop. Initiatives may focus on reducing symptoms or negative impressions of stereotypes; yet the opposite end of increasing resilience may occur simultaneously whether or not psychopathology is present. Research targeting stigma resistance rather than stigma shows the potential to enhance authenticity and empowerment for individuals and in society overall.

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Appendix A

Cover Letter for Study A

Dear potential participant,

Thank you for your interest in this study. We invite you to participate in this research study, to help us assess mental health, self-compassion, and competence, and other psychosocial variables among individuals who identify as having had mental health problems. This study entitled "Stigma Resistance, Self-Compassion, and Competence Among University Students with Mental Health Problems" is being conducted by Ph.D. student researcher Christiana Goetz Fidler under the supervision of Dr. Amanda Maranzan.

In this study, you will be asked to complete online questionnaires about mental health and various psychosocial factors. Participation is voluntary, and you may withdraw at any time up until you submit your responses with no consequence. Data collected from this study will be kept de-identified and confidential, and there will be no directly identifying information associated with the data. Withdrawal post-submission is not possible due to the anonymous nature of the survey. This study involves approximately 45-60 minutes and participants will receive one bonus mark towards a psychology course where permitted. If you choose not to complete this study, alternative assignments to receive bonus marks are offered for psychology courses where bonus marks are permitted.

There is minimal risk for psychological harm associated with participation in this study. There is a chance that answering some of the questions about personal characteristics and attitudes toward mental health in the survey may cause distress. If you are distressed during or after your participation in this study please contact the Student Health and Counselling Centre at Lakehead University at 1-807-343-8361. Potential benefits of participating in this study include learning about the research process, learning about mental health, personal psychological factors, and attitudes concerning mental health.

Please note that the online survey tool used in the study, SurveyMonkey, is hosted by a server located in the USA. The US Patriot Act permits U.S. law enforcement officials, for the purpose of anti-terrorism investigation, to seek a court order that allows access to the personal records of any person without the person's knowledge. In view of this we cannot absolutely guarantee the full confidentiality and anonymity of your data. With your consent to participate in this study, you acknowledge this.

Data will be analyzed on a locked laptop only accessible by the researchers and data will be stored in the Department of Psychology at Lakehead University for 5 years.

We intend to present the findings from this research at professional academic conferences and to submit a manuscript to a peer-reviewed academic journal. No identifying information will be associated with the data for these purposes.

After this project, you will have the opportunity to learn about the results of this study. We can arrange for you to receive a written summary of the results via email. If you are interested in learning more about the results of this study or have any questions, please contact student researcher Christiana Goetz Fidler at cgoetz1@lakeheadu.ca or Dr. Amanda Maranzan at kamaranz@lakeheadu.ca.

This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Thank you for your consideration in participation.

Appendix B

Consent Form for Study A

I have read and agree to the above information and by completing and submitting this survey, agree to participate.

I agree to the following:

1. I have read and understand the information contained in the Information Letter
2. I agree to participate
3. I understand the risks and benefits to the study
4. That I am a volunteer and can withdraw from the study at any time up until I submit my responses with no consequence, and may choose not to answer any question
5. That the data will be securely stored within the Mental Health Research Lab at Lakehead University for a minimum period of 5 years following completion of the research project
6. I understand that the research findings will be made available to me upon request
7. I will remain anonymous
8. All of my questions have been answered

By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.

Appendix C

Preliminary Data for Study A

Inclusion Criteria:

(Yes or No)

Have you ever experienced a mental health problem?

Demographics:

1. Gender (female, male, other ___)
2. Age (drop down 0-100)
3. Race/ethnicity
    - Aboriginal (e.g., Inuit, Métis, North American Indian)
    - African
    - Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
    - Caucasian/White
    - Chinese
    - Filipino
    - Haitian
    - Jamaican
    - Japanese
    - Korean
    - Latin American
    - South Asian
    - South East Asian
    - Other__________
4. University major (____)
5. University year (1, 2, 3, 4, other ___)

Mental Health and Use of Psychological Services (Control variables):

1. Have you ever received a diagnosis from a mental health professional?
    a. (Multiple choice: none, depression disorder, anxiety disorder, bipolar disorder, eating disorder, schizophrenia spectrum disorder or psychosis, substance use disorder, ADHD, other ___)
2. Have you ever sought help from a mental health professional? (Yes or No)

Appendix D

Depression Anxiety Stress Scale (DASS)

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:
0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree or a good part of the time
3 Applied to me very much or most of the time

1. I found it hard to wind down
2. I was aware of dryness of my mouth
3. I couldn't seem to experience any positive feeling at all
4. I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)
5. I found it difficult to work up the initiative to do things
6. I tended to over-react to situations
7. I experienced trembling (e.g., in the hands)
8. I felt that I was using a lot of nervous energy
9. I was worried about situations in which I might panic and make a fool of myself
10. I felt that I had nothing to look forward to
11. I found myself getting agitated
12. I found it difficult to relax
13. I felt down-hearted and blue
14. I was intolerant of anything that kept me from getting on with what I was doing
15. I felt I was close to panic
16. I was unable to become enthusiastic about anything
17. I felt I wasn't worth much as a person
18. I felt that I was rather touchy
19. I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)
20. I felt scared without any good reason
21. I felt that life was meaningless

Appendix E

Self-Compassion Scale

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

5-point Likert scale: 1 ‘Almost never’ to 5 ‘Almost always’

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

Appendix F

Self-Perceived Overall Competence Scale

Please rate how strongly you agree or disagree with the following statements.

4-point Likert scale: (1) Strongly Disagree; (2) Disagree; (3) Agree; and (4) Strongly Agree.

1. I am a good student
2. I take part in activities at my university
3. I like to learn about new things
4. I am a creative person
5. I make good decisions
6. I make friends easily
7. I feel comfortable in social situations
8. I can handle problems that come up in my life
9. I can manage my emotions
10. I can handle being disappointed
11. I am aware of other people's needs in social situations
12. I have goals for my life
13. I know what I want to do for a career
14. I am interested in learning about careers I could have

Appendix G

Mental Health Confidence Scale (modified 14-item scale)

We would like to know how confident you are about your ability to help yourself deal with those things that commonly influence our lives. For each item, indicate *how confident you are that you could do something to help yourself right now.*

6-point Likert scale: (1) Very Nonconfident (2) Nonconfident (3) Slightly Nonconfident (4) Slightly Confident (5) Confident (6) Very Confident

1. Be happy
2. Feel hopeful about your future
3. Set goals for yourself
4. Get support when you need it
5. Boost your self-esteem
6. Make friends
7. Face a bad day
8. Deal with losing someone close to you
9. Deal with feeling depressed
10. Deal with feeling lonely
11. Deal with nervous feelings
12. Deal with symptoms related to your mental illness diagnosis
13. Say no to a person abusing you
14. Advocate for your needs

Appendix H

Stigma Scale for Receiving Psychological Health (SSRPH)

4-point Likert scale: (0) Strongly Disagree to (3) Strongly Agree

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

Appendix I

The Self-Stigma of Seeking Psychological Help Scale (SSOSH)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

5-point Likert Scale: (1) Strongly Disagree, (2) Disagree, (3) Agree & Disagree Equally, (4) Agree, (5) Strongly Agree

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

Appendix J

Perceived Stigma of Depression and Anxiety Scale (PSDAS)

Please rate how strongly you agree or disagree with the following statements concerning what you believe most people think.

5-point Likert scale: Strongly Disagree (0), Disagree (1), Neither Agree nor Disagree (2), Agree (3), Strongly Agree (4)

1. Most people think that depression and anxiety are not real medical illnesses
2. Most people think that depression and anxiety are signs of personal weakness
3. Most people think that people with depression or anxiety could snap out of it if they wanted to
4. Most people think that people with depression or anxiety should be ashamed of themselves
5. Most people think that people with depression or anxiety do not make suitable employees
6. Most people think that people with depression or anxiety are unstable
7. Most people think that people with depression or anxiety are to blame for their problem
8. Most people that people with depression or anxiety are just lazy
9. Most people think that people with depression or anxiety are a danger to others
10. Most people think that people with depression or anxiety are self-centered

Appendix K for Study A

Self-Stigma of Depression and Anxiety Scale (SSDAS)

Take a minute to imagine you are depressed or anxious or both. Think about how you might feel about yourself, then indicate how strongly you agree or disagree with each statement.

5-point Likert scale: Strongly Disagree (1), Disagree (2), Neither Agree nor Disagree (3), Agree (4), Strongly Agree (5)

1. I would feel embarrassed
2. I would feel ashamed
3. I would feel disappointed in myself
4. I would feel inferior to other people
5. I would think I should be able to ‘pull myself together’
6. I would think I should be able to cope with things
7. I would think I should be stronger
8. I would think I had only myself to blame
9. I would feel like I was good company
10. I would feel like a burden to other people
11. I would feel inadequate around other people
12. I would feel I couldn’t contribute much socially
13. I wouldn’t want people to know that I wasn’t coping
14. I would see myself as weak if I took medication for depression or anxiety
15. I would feel embarrassed about seeking professional help for depression or anxiety
16. I would feel embarrassed if others knew I was seeking professional help for depression or anxiety

Appendix L

Stigma Resistance Scale (modified 19-item scale)

Please read the following statements and indicate how much you disagree or agree.

5-point Likert scale: (1) Disagree, (2) Somewhat Disagree, (3) Neutral, (4), Somewhat Agree, (5) Agree

1. I know there is more to me than my mental health problems.
2. I can have a positive view of myself even when others don't have a positive view of me.
3. I believe teaching others about mental health problems is a way to fight stigma.
4. My lived experiences with mental health problems can help others with their recovery.
5. I question the misinformation I hear from others about mental health problems.
6. To resist stigma, I think about positive things about myself.
7. Resisting stigma means doing what I want to do, no matter what others think about me.
8. I can have a good, fulfilling life, despite my mental health problems.
9. I have done meaningful things in my life since having mental health problems.
10. The way I live shows other people that stigma is wrong.
11. Resisting stigma means speaking up when others say negative things about mental health problems.
12. I challenge negative thoughts that I may have about myself related to having a mental health problem.
13. I help others resist stigma by showing that person I believe in them.
14. I actively tell myself positive things to help resist stigma.
15. I share my story with others to let them know about mental health problems and recovery.
16. I help others see they should not be ashamed about mental health problems.
17. I encourage others who have mental health problems by showing them there is hope.
18. When I encounter stigma, I can think of why these attitudes are wrong.
19. I advocate for better treatment for people with mental health problems.

Appendix M

Optional Qualitative Stigma Resistance Questions

Due to the high levels of mental health stigma in society, individuals with mental health difficulties may internalize the stigma and apply it the themselves, leaving them to feel shame, unworthy, and less of themselves. Although people may struggle, they may also have experiences of resisting this internalized stigma!

1) Do you have experiences of resisting internalized stigma of mental health? If so, please share details of your journey toward and experiences of resisting stigma.

2) Has self-compassion impacted your experience with stigma resistance? Explain.

3) Has competence (i.e., skills in various life domains) impacted your experience with stigma resistance?

Appendix N

Instructed Response Questions (interspersed throughout survey)

1. In order to monitor for quality, please select "disagree" for this item.
2. For this question, please select "somewhat agree" to show that we still have your attention.

Attention Questions

It is vital to our study that we only include responses from people that devoted their full attention to this study. Otherwise years of effort (the researchers' and the time of other participants) could be wasted. You will receive credit for this study no matter what, however, please tell us how much effort you put forth towards this study.

	almost no	very little	some	quite a bit	a lot of
I put forth ____ effort towards this study.	○	○	○	○	○

Also, often there are several distractions present during studies (other people, TV, music, etc.). Please indicate how much attention you paid to this study. Again, you will receive credit no matter what. We appreciate your honesty!

	almost no	very little of my	some of my	most of my	my full
I gave this study ____ attention.	○	○	○	○	○

In your honest opinion, should we use your data in our analyses in this study?

○ Yes

○ No

Appendix O

Closing/Debriefing Screen for Study A

Dear Participant,

Thank you for your participation in this study.

If you would like a summary of the results of this study, feel free to send Christiana Goetz Fidler an email using the address below. If you are experiencing distress as a result of this study, or for any other reason, please contact the Student Health and Counseling Centre at 1-807-343-8361. You may also contact the Research Ethics Board at 1-807-343-8283 or research@lakeheadu.ca. To obtain your bonus mark, please click "done" at the bottom of the screen. SONA™ will be updated with your bonus mark. If you do not receive your bonus mark, please feel free to email Christiana Goetz Fidler at the address below. Please write this email down to ensure you will receive your bonus point.

Thank you again for your participation.

Regards,

Christiana J. Goetz Fidler, M.A.
Ph.D. Clinical Psychology Student, Lakehead University
cgoetz1@lakeheadu.ca

Dr. Amanda Maranzan, Ph.D.
Professor, Department of Psychology, Lakehead University
kmaranz@lakeheadu.ca

Appendix P

Advertisement for Study B

Do you have experiences with depression or anxiety yet RESIST mental health stigma?

Share your story in an interview to further advance knowledge on mental health stigma resistance!

- ✓ **Earn a bonus point for eligible undergraduate psychology classes or receive a $15 gift card to Tim Hortons!**
- ✓ **Contact student researcher cgoetz1@lakeheadu.ca to see if you qualify to participate and schedule an interview**

Appendix Q

Cover Letter for Study B

Dear potential participant,

Thank you for your interest in this study. We invite participants who have experience resisting mental health stigma to participate in this research study. Inclusion criteria is having (had) depression or anxiety. This study entitled "Stigma Resistance, Self-Compassion, and Competence Among University Students with Mental Health Problems" is being conducted by Ph.D. student researcher Christiana Goetz Fidler under the supervision of Dr. Amanda Maranzan.

In this study, you will take a brief survey to see if you qualify for an interview and in order to indicate whether or not you would like the researcher to contact you. If you are chosen for an interview, you will be interviewed about your experiences resisting stigma of mental health (particularly depression or anxiety). Interviews will be held in the Mental Health Research Lab (SN 1002J) and will take approximately 30-60 minutes. Interviews will be audio recorded and transcripts will be collected and analyzed.

You will be asked briefly of your mental health history and experiences of internalizing (being aware of and applying to oneself) stigma. Then, you will be asked of your experiences of resisting stigma of mental health, including any experiences that were impacted by self-compassion and competence (mastery of skills in various life domains).

Participation is voluntary, and you may withdraw from the study at any time with no consequence. Data collected from this study will be kept de-identified and confidential, and there will be no directly identifying information associated with the data. Participants will receive one bonus mark towards a psychology course where permitted. If you are not eligible or choose not to receive a bonus mark, a $15 gift card will be offered for your research participation.

There is minimal risk for psychological harm associated with participation in this study. There is a chance that answering some of the questions about personal experiences with mental health and stigma, which may cause distress. If you are distressed during or after your participation in this study please contact the Student Health and Counselling Centre at Lakehead University at 1-807-343-8361. Potential benefits of participating in this study include learning about the research process, learning about mental health stigma resistance, and uncovering your own personal stories of stigma resistance.

A brief inclusion criteria survey will be conducted on SurveyMonkey in order to sign up for an interview. Please note that the online survey tool used in the study, SurveyMonkey, is hosted by a server located in the USA. The US Patriot Act permits U.S. law enforcement officials, for the purpose of anti-terrorism investigation, to seek a court order that allows access to the personal records of any person without the person's knowledge. In view of this we cannot absolutely guarantee the full confidentiality and anonymity of your data. With your consent to participate in this study, you acknowledge this.

Data will be analyzed on a locked laptop only accessible by the researchers, and data will be stored in the Department of Psychology at Lakehead University for 5 years.

We intend to present the findings from this research at professional academic conferences and to submit a manuscript to a peer-reviewed academic journal. No identifying information will be associated with the data for these purposes.

After this project, you will have the opportunity to learn about the results of this study. We can arrange for you to receive a written summary of the results via email. If you are interested in learning more about the results of this study or have any questions, please contact student researcher Christiana Goetz Fidler at cgoetz1@lakeheadu.ca or Dr. Amanda Maranzan at kamaranz@lakeheadu.ca.

This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Thank you for your consideration in participation.

Appendix R

Consent Form for Study B

I agree to the following:

- ✓ I have read and understand the information contained in the Information Letter
- ✓ I agree to participate
- ✓ I understand the risks and benefits to the study
- ✓ That I am a volunteer and can withdraw from the study at any time and may choose not to answer any question
- ✓ Only the researchers will have access to the data. Data collected will be stored within the Mental Health Research Lab at Lakehead University for five years.
- ✓ I understand that the research findings will be made available to me upon request
- ✓ I will remain confidential and de-identified
- ✓ All of my questions have been answered

By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.

Name:___________________ Signature:___________________ Date:___________________

Contact email for a request of research results:___________________

I agree to audio recording (circle your response): Yes/No

Appendix S

Interview Questions

Due to the high levels of mental health stigma in society, individuals with mental health difficulties may internalize the stigma and apply it to themselves, leaving them to feel shame, unworthy, and less of themselves. Although people may struggle, they may also have experiences of resisting this internalized stigma!

1) Briefly, what is your mental health history and/or diagnosis?

2) What are your experiences of internalizing (being aware of and applying to oneself) mental health stigma?

3) What are your experiences of resisting internalized stigma of mental health?

4) How has your resistance to stigma changed over time?

Appendix T

Interview Schedule

1. Gender:
2. Age:
3. Race/ethnicity:
4. University major:
5. University year:
6. What made you interested in this study?

General probes: Tell me more…, give me an example…, what I'm hearing is..

- what was that like? what were you thinking about?
- what did that feel like?
- I'm curious about that experience, can you tell me more about it?

Due to the high levels of mental health stigma in society, individuals with mental health difficulties may internalize the stigma and apply it to themselves, leaving them to feel shame, unworthy, and less of themselves. Although people may struggle, they may also have experiences of resisting this internalized stigma!

1) Briefly, what is your mental health history and/or diagnosis
    a. Official diagnosis?

2) What are your experiences of internalizing (being aware of and applying to oneself) mental health stigma?
    a. What does the word stigma mean to you?
    b. Are you aware of public stigma of mental health and how has that impacted you?
    c. Examples of stigma

3) What are your experiences of resisting internalized stigma of mental health?
    a. What does the term stigma resistance mean to you?
    b. Different areas of life: work, interests, relationships
    c. What has helped you resist stigma? What has prevented you from resisting stigma?

4) How has your resistance to stigma changed over time?
    a. past (childhood), present, plans for the future, turning points…more about what lead from stigma to resistance

Appendix U

Closing Letter for Study B

Dear Participant,

Thank you for your participation in this study.

If you would like a summary of the results of this study, feel free to send Christiana Goetz Fidler an email using the address below. If you are experiencing distress as a result of this study, or for any other reason, please contact the Student Health and Counseling Centre at 1-807-343-8361. You may also contact the Research Ethics Board at 1-807-343-8283 or research@lakeheadu.ca.

If you do not receive your bonus mark, please feel free to email Christiana Goetz Fidler at the address below.

Thank you again for your participation.

Regards,

Christiana J. Goetz Fidler, M.A.
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cgoetz1@lakeheadu.ca

Dr. Amanda Maranzan, Ph.D.
Professor, Department of Psychology, Lakehead University
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