Effects of Affirming Values on Self-Compassion and Mental Health Treatment Stigma

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Stigma surrounding mental disorders deters many people from treatment, and prior studies have shown that internalization of stigma is inversely correlated with self-compassion. We examined the effect of a values-affirmation task shown to increase state self-compassion on attitudes about mental disorders and their treatment. Participants completed measures of their mental health attitudes and experiences prior to a values-affirming writing task or control writing task, and afterward completed measures of state self-compassion, attitudes about mental disorders, and treatment. Participants in the values-affirming condition showed significantly higher state self-compassion and lower levels of desired social distance and internalized stigma toward people with mental disorders, relative to the control condition. Significant interactions also showed that affirmation of values was effective in decreasing internalized treatment stigma and increasing willingness to seek help among those high in perceived public stigma and among those with positive attitudes about treatment. These findings suggest that interventions that focus on affirming values increase self-compassion, reduce stigma surrounding mental disorders, and also reduce stigma about mental health treatment among individuals for whom perceived public stigma is a treatment barrier. Our study extends previous research showing that affirming values increase self-compassionate and pro-social responses, to show that it can help reduce stigmatizing views of mental disorders and their treatment, in both the self and others.

Keywords: values affirmation, perceived public stigma, self-stigma, self-compassion, willingness to seek mental health treatment

Untreated mental disorders have an enormous personal and societal cost; including suffering, impairment, and increased risk of suicide. In 2017, less than half (42.6%) of all American adults experiencing mental illness had received treatment in the past 12 months, and young adults received treatment at lower rates than other age groups (Substance Abuse & Mental Health Services Administration, 2019), making it crucial to understand and reduce treatment barriers.

Societal stigmatization of mental disorders interferes with treatment in multiple, overlapping ways (Corrigan et al., 2014). The ways in which communities devalue people with mental disorders, including structural/systemic barriers limiting treatment access, direct experiences of rejection and discrimination, as well as indirect cultural messages, encourage community members to hide their mental health treatment needs. Moreover, internalization of public stigma leads people with mental disorders to stigmatize themselves, and the resulting feelings of isolation, shame, and hopelessness further diminish treatment engagement. Perceiving higher levels of societal stigma toward mental disorders is associated with lower levels of help-seeking attitudes, intentions, and behaviors (Conner et al., 2010; Jones, 2017; Pompili et al., 2003), and the association between perceived public stigma and negative attitudes about mental health treatment is significantly explained by greater endorsement of attitudes involving internalized self-stigma (Jennings et al., 2015). Interventions to help people view mental disorders and the experiences of rejection/discrimination associated with them through a lens of compassion hold unexplored potential for increasing willingness to engage in treatment.

Self-Compassion and Stigma Surrounding Mental Disorders and Treatment

Self-compassion is a personality characteristic in which one responds to their own imperfections with kindness, feelings of inclusion, and effective self-regulation rather than harshly judging, self-ostracizing, and fixating on them (Neff, 2003a). Not surprisingly, low self-compassion is associated with distress, self-criticism, shame, and self-punishment, whereas high self-compassion is related to many positive facets of a healthy life; such as lower levels of negative affect, better coping with stress, and greater engagement in health-promoting behavior (Krieger et al., 2013; Neff & McGehee, 2010; Sirois et al., 2015). While it is correlated with self-esteem, self-compassion is less competitive and therefore more stable in the face of unfavorable social comparisons and other disappointments; in other words, relative to self-esteem, self-compassion is more compatible with self-acceptance (Neff & Vonk, 2009).

Recent studies suggest that self-compassion may be helpful in buffering against the adverse effects of stigma (Wong et al., 2019; Yang & Mak, 2017). Self-compassion is correlated with lower
internalized stigma and more positive attitudes about mental disorders (Jones, 2017). It also moderates the relationship between perceived public stigma and self-stigma of seeking help (Heath et al., 2018; Portt & Maranzan, 2017). These findings suggest that self-compassion may diminish the extent to which perceived public stigmatization of mental health treatment is internalized, and thereby facilitate seeking treatment. However, the focus of previous studies on associations with self-compassion as a trait (i.e., the level of self-compassion a person reports tending to have on average, as an enduring characteristic of this individual) precludes causal conclusions about whether interventions that increase self-compassion could reduce stigma toward mental disorders and their treatment. To draw these conclusions requires research that measures self-compassion as a momentary state, and examines how it changes with time, context, and experimental interventions.

Values Affirmation and Compassion for the Self and Others

Values-affirmation exercises, in which participants are experimentally induced to focus on values of great personal importance to them (e.g., family, work, humor) increase resilience to perceived threats to self-evaluation as evidenced in a wide variety of positive outcomes, and these effects cannot be simply explained by improvements in mood (Cohen et al., 2006; McQueen & Klein, 2006; Purdie-Vaughns et al., 2009). Affirming a personal value in turn affirms the self, and the indirect aspect of this process is central to its effectiveness. Tasks that participants perceive as intended to induce positive self-evaluation tend to fail or backfire in the face of threatening contexts or long-standing negative self-views (Crocker & Park, 2004; Wood et al., 2009). By contrast, Lindsay and Creswell (2014) found that values-affirmation may be especially effective for individuals who are unusually prone to harsh self-judgment, because an increase in state self-compassion is among its active mechanisms. Not only does values affirmation increase self-reported state self-compassion above and beyond its effects on general mood, but it makes people treat themselves and others with more kindness in observed behavioral tasks in the laboratory (see also Gregory et al., 2017). Compassion for the self and compassion for others are strongly related (Neff, 2003b; Neff & Pommier, 2013), and increasing state self-compassion appears to make more resources available for giving compassion to others (Lindsay & Creswell, 2014).

Lannin et al. (2013) found that undergraduate students experiencing clinical levels of psychological distress reacted less defensively to information about psychotherapy if they received this information right after completing a values-affirmation exercise rather than a neutral control task. Specifically, the values-affirming group reported less self-stigma about seeking psychotherapy, and in turn, more willingness to seek psychotherapy. These findings suggest the potential benefits of self-affirmation for increasing mental health treatment-seeking. However, the notion that values affirmation increases compassion for both the self and others suggests that this intervention may also have broader effects on attitudes about mental disorders and treatment, even among people who haven’t personally experienced them. In the research presented in this article, we aim to expand Lannin et al.’s (2013) inquiry by (a) linking it to the self-compassion literature and (b) considering the implications of self-affirmation for a wider range of attitudes about mental disorders and mental health treatments in a general sample of participants, as a function of individual differences in their attitudes and experiences.

The Present Research

We examined the effect of a values affirmation task previously shown to increase state self-compassion on attitudes toward mental disorders and their treatment among young undergraduate women. We hypothesized that participants who completed a values-affirmation task would experience an increase in self-compassion, lower levels of desired social distance and internalized stigma toward people living with mental disorders, lower levels of internalized stigma toward mental health treatments, and higher levels of willingness to seek mental health treatment relative to participants randomly assigned to a control condition. We believed that these effects would occur in a general undergraduate sample including individuals without mental health problems, because priming a participant’s own values would indirectly activate more compassion for the self and others.

We also examined possible moderators of these effects, including personal experience of mental disorder, perceived public stigma, and attitudes toward mental health treatment at baseline. Participants who already have very compassionate attitudes about mental healthcare needs in themselves and others may not have much room for improvement in these attitudes as a function of values affirmation. Indeed, prior studies have found that values affirmation made more of a difference in outcomes related to self-compassion among participants with low trait self-compassion (Gregory et al., 2017; Lindsay & Creswell, 2014) than for individuals already inclined to be kind to themselves even in the control condition. It is also sensible to expect that questions about mental health treatment needs would be more emotionally meaningful to people who have directly experienced them. Likewise, past research has shown that individuals with mental disorders respond better to stigma interventions than those with no diagnoses (Saporito et al., 2011). Individuals low in psychological distress show a stronger association between stigma and reluctance to seek help, in part because they lack any motivation to seek mental health care (Surapaneni et al., 2019). We therefore expected the benefits of values affirmation to be stronger for individuals with personal experience of a mental disorder and for individuals reporting higher levels of perceived public stigma, who do not already have unequivocally positive attitudes about mental health treatment.

Method

Participants

Participants were 94 undergraduate women at a small liberal arts college in the U.S. who responded to an advertisement. In a
collegiate newsletter seeking paid volunteers for a psychological study of attitudes. Their ages ranged from 18 to 22 (M = 19.87) and they identified as White (71.3%), Hispanic/Latina (12.8%), Asian or Pacific Islander (11.7%), or Other/Multiracial (4.3%). Of the 94 included participants, 45 were randomly assigned to the control condition and 49 to the experimental condition.

Materials

Premanipulation Measures

Trait Self-Compassion. Participants first completed the Self-Compassion Scale (SCS; Neff, 2003b) by rating how often 26 statements (e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need”) were characteristic of themselves from almost never (1) to almost always (5). We averaged their ratings for the total scale (α = .92) and its six subscales: Self-Kindness (α = .88), Self-Judgment (α = .85), Common Humanity (α = .81), Isolation (α = .80), Mindfulness (α = .72), and Over-identification (α = .71).

Treatment Attitudes. After reading definitions of mental health professionals and mental health treatment, participants completed the Inventory of Attitudes Toward Seeking Mental Health Services (IATSMHS; Mackenzie et al., 2004) by rating 24 items from disagree (1) to agree (5). The total scale (α = .85) was comprised of three 8-item subscales reflecting positive attitudes about treatment. Psychological Openness (α = .71) items assessed the participant’s willingness to acknowledge psychological problems and consider treatment for them, for example, “People with strong characters can get over psychological problems by themselves and have little need for professional help (reversed).” Help-Seeking Propensity (α = .73) addressed feeling capable of seeking mental health care (e.g., “If I were to experience psychological problems, I could get professional help if I wanted to”). Indifference to Stigma (α = .75) measured the degree to which the individual’s willingness to seek necessary mental health treatment would be unimpeded by concern about social stigma, in statements such as “I would feel uneasy going to a professional because of what some people would think (reversed).”

Perceived Public Stigma. The Perceived Devaluation-Discrimination Scale (Link, 1987) is an established measure of the stigma that participants perceive in society toward people with mental disorders (Vogel et al., 2007). Participants rated how true they believed 12 statements to be of the public (e.g., “Most people think less of a person after they have been hospitalized for a mental disorder”) from strongly disagree (1) to strongly agree (4). We computed the perceived public stigma scale as mean of these ratings (α = .88).

Personal Experience of Mental Disorder. We asked participants a series of questions about their direct personal experiences of mental disorders and contact with others who have had these experiences. Specifically, we asked: “At the present time, do you identify as someone who has a mental disorder? Examples of common mental disorders include depression, alcohol or drug problems, eating disorders, generalized anxiety, social phobia, panic disorder, PTSD, OCD, ADHD, autism spectrum disorder, schizophrenia, bipolar disorder, personality disorders, and others”; “Have you ever had a mental disorder in the past?”; “Have you ever received talk therapy treatment for a mental disorder?”; “Have you ever received medication for a mental disorder?”; “Has there ever been a time when you wanted to receive treatment for a mental disorder but couldn’t because you did not have the means to do so? (e.g., due to a lack of financial resources or access to nearby services, etc.)”. Response options for each question were Yes, No, Not Sure, or Prefer not to answer. We combined the five questions about personal experiences of mental disorders into one dichotomous variable: 55 participants responded Yes to at least one of these experiences, and the other 39 participants endorsed none of them.

Social Desirability. The Balanced Inventory of Desirable Responding short form (BIDR-16; Hart et al., 2015) includes both positively and negatively phrased items reflecting self-deceptive enhancement and impression management. Participants rated the 16 items from strongly disagree (1) to strongly agree (8). Internal consistency (α) for the total scale was .76.

State Mood. Participants completed the Positive and Negative Affect Schedule (Watson et al., 1988) immediately before and after the experimental manipulation. Participants rated the extent to which they were experiencing 10 positive and 10 negative moods in the moment, from very slightly or not at all (1) to extremely (5). Examples include “Right now, I feel enthusiastic” and “Right now, I feel upset.” For each administration, we calculated the mean score after reverse-coding the negative items. Internal consistency (α) was .80 at time 1 and .84 at time 2.

State Self-Compassion. Mixed with the state mood adjectives, participants also rated adjectives relevant to state self-compassion on the same 5-point Likert scale, immediately before and after the manipulation. This state self-compassion measure, which we adapted from a similar measure by Lindsay and Creswell (2014), included: accepted, trusting, grateful, open, loving, accepting, welcoming, kind, at peace, disconnected, criticized, judged, unacceptable, self-critical, isolated, unwelcome, inadequate, and alone. For example, participants rated the statement “Right now, I feel accepted.” We averaged all the items (with the nine negative items reverse-coded) to create a scale with an internal consistency (α) of .88 at time 1 and .90 at time 2.

In support of the validity of this measure, we found a significant partial correlation between our State Self-Compassion adjective measure at time 1 and Trait Self-Compassion (r = .24, p = .022), controlling for state mood at time 1 and socially desirable responding. However, partial correlations with specific subscales of Trait Self-Compassion suggest that our measure particularly captures Self-Kindness (r = .37, p < .001) and low Self-Judgment (r = −.31, p = .002). No significant partial correlations emerged with the other aspects of the construct; including Common Humanity (r = .05, p = .643), Isolation (r = −.08, p = .454), Mindfulness (r = .16, p = .137), or Overidentification (r = .00, p = .973). The zero-order correlations among these measures of self-compassion are shown in the last column of Table 1.

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2 We discarded incomplete data from two additional women who selected the “refuse to answer” option for very many items.

3 Although not counted as personal experience, we also asked the participants if they had contact with other individuals that they knew to have experienced a mental disorder or treatment for one, either in their social circles or volunteer/work activities, and nearly all of them (88) did.
Table 1  
Correlations Among Initial Measures of Mental Health Experience/Attitudes and Self-Compassion (n = 94)

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>3a</th>
<th>3b</th>
<th>3c</th>
<th>4</th>
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<td>.15</td>
<td>.20*</td>
<td>.25*</td>
<td>.46**</td>
<td>.45**</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Treatment attitudes (total)</td>
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<td></td>
<td></td>
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<td>.11</td>
<td>.15</td>
<td>.00</td>
<td>.14</td>
<td>.20*</td>
</tr>
<tr>
<td>Help-seeking propensity</td>
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<td>.16</td>
<td>.10</td>
<td>.20*</td>
<td>.21*</td>
<td>.18*</td>
<td></td>
</tr>
<tr>
<td>Indifference to stigma</td>
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<td>.09</td>
<td>.27**</td>
<td>.21*</td>
<td>.02</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>State self-compassion adjectives</td>
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<td>.27**</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Trait self-compassion (total)</td>
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<td>.06</td>
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<td>.00</td>
<td>.20*</td>
<td>.21*</td>
<td>.45**</td>
</tr>
<tr>
<td>Self-judgment</td>
<td>.28**</td>
<td>.28**</td>
<td>.18*</td>
<td>.12</td>
<td>.09</td>
<td>.21*</td>
<td>.49**</td>
</tr>
<tr>
<td>Common humanity</td>
<td>.05</td>
<td>.05</td>
<td>.05</td>
<td>.02</td>
<td>.12</td>
<td>.05</td>
<td>.04</td>
</tr>
<tr>
<td>Isolation</td>
<td>.24*</td>
<td>.24*</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mindfulness</td>
<td>.00</td>
<td>.00</td>
<td>.08</td>
<td>.11</td>
<td>.20*</td>
<td>.11</td>
<td>.29**</td>
</tr>
<tr>
<td>Overidentification</td>
<td>.20*</td>
<td>.20*</td>
<td>.08</td>
<td>.08</td>
<td>.02</td>
<td>.09</td>
<td>.28*</td>
</tr>
</tbody>
</table>

*p < .10  *p < .05  **p < .01.

Postmanipulation Measures

Immediately after the writing task, participants rated the State Mood and State Self-Compassion Adjectives for a second time, and then completed the measures described below.

Desired Social Distance. Participants completed a measure of their desired social distance from people diagnosed with mental disorders (Gureje et al., 2005) by rating six items from definitely not (1) to definitely (4). For example, this scale included: “I would feel inadequate if someone in my family was diagnosed with a mental disorder.” We calculated total desired social distance by averaging responses to the items, with an internal consistency (α) of .71.

Willingness to Seek Mental Health Treatment. Participants completed eight items adapted from Chandra and Minkovitz (2006) that assessed hypothetical willingness to seek medication, talk therapy, treatment, and professional help, in case of a mental disorder (e.g., “How likely would you be to seek medication if you had a mental disorder?”). All were rated from very unlikely (1) to very likely (7), and internal consistency (α) was .80.

Internalized Stigma Toward Mental Health Treatment. Participants rated the extent to which they agreed with 10 statements measuring internalized stigma toward mental health treatment (Vogel et al., 2006) from strongly disagree (1) to strongly agree (4). A sample item is “I would feel inadequate if I went to a therapist for psychological help.” We calculated the scale as the mean of participants’ responses, and internal consistency (α) was .86.

Internalized Stigma toward Mental Disorders. We used the Community Attitudes toward the Mentally Ill Scale (CAMI; Taylor & Dear, 1981) to measure participants’ internalized stigma toward mental disorders. Participants rated their agreement (from 1 = strongly disagree to 5 = strongly agree) with 40 statements reflecting authoritarian and socially restrictive attitudes toward people with mental illness, as well as more benevolent attitudes informed by community mental health ideology. Internal consistency (α) was .95 for the total measure. For the 10-item subscales, internal consistency coefficients were .71 for Authoritarianism, .82 for Social Restrictiveness, .89 for Benevolence, and .89 for Community Mental Health Ideology.

Demographics. Finally, participants reported their age, gender, and race/ethnicity. They also reported parental education level as an index of socioeconomic status.

Procedure

We administered the study by computer in individual 30-min lab sessions with each participant. After participants arrived for a study of attitudes, we told them “People have a wide range of attitudes regarding mental health, mental health treatment, and people living with mental disorders. The purpose of this research study is to examine how these attitudes are related to differences in personality and experiences.” We also told participants that every question asked during the study would have a “refuse to answer” option, and that they could select it at any time without penalty. After providing informed consent, participants completed questionnaires about their trait self-compassion, attitudes about mental health treatment, perceptions of public stigma surrounding mental disorders, past experiences of mental disorders/treatment, social desirability, state mood, and state self-compassion. Participants then completed a writing task during which they were randomly assigned to either affirm a personal value or to describe their morning routine (described below). We presented the task instructions on a computer screen, along with a timer displaying the remaining time for the task. The experimenter was blind to assigned condition but present in the testing room to ensure that the participant continued to type for the entire 5-min period. After the writing task, participants completed measures of dependent variables (state mood, state self-compassion, attitudes about mental disorders and treatment) and demographic information.

Note that we made minor modifications to the wording of several questionnaire items to better apply to contemporary young adults at a residential college in the United States. For example: we asked about willingness to be in a serious relationship with instead of willingness to marry; we used the term mental disorder instead of mental illness; we changed all British spellings to American spellings; and we used the singular they instead of he/she. The exact wording of all items and instructions are available upon request.
In the values-affirmation condition, participants saw an alphabetical list of 13 values (e.g., adventure, faith/religion, honesty, love, etc.) and rated each for personal importance from not at all important to me (1) to extremely important to me (5). Afterward, they selected the one value that was most important to them and wrote for 5 min about how it is important in their life. This task has previously been shown to increase state self-compassion relative to a control condition (Gregory et al., 2017; Lindsay & Creswell, 2014).

In the control condition, participants saw a list of the days of the week and rated each one for how consistent their morning routine is on that day, from not at all regular/routine (1) to extremely regular/routine (5). Afterward, participants read instructions to select the morning of the week in which their schedule is most regular and write for 5 min about their routine on that day from when they wake up until noon, step-by-step.

Results

Associations of Initial Mental Health Attitudes and Experiences With Self-Compassion

Table 1 shows correlations among measures of mental health attitudes and experiences, and self-compassion, all administered prior to the experimental manipulation. Personal experience of mental disorder was associated with significantly higher scores on subscales reflecting self-judgment and isolation, but was not significantly associated with any of the positive trait self-compassion subscales, treatment attitudes, or perceived public stigma.

Although perceived public stigma showed no significant associations with any of the self-compassion measures, it was inversely associated with indifference to stigma, a subscale of the treatment attitudes measure that was itself associated with higher self-kindness, lower self-judgment, and lower isolation. The help-seeking propensity subscale of treatment attitudes was also positively associated with self-kindness and mindfulness.

Correlations with baseline state self-compassion adjective ratings were consistent with our evidence that this measure captures the self-kindness versus self-judgment aspects of the self-compassion construct, because like those subscales of trait self-compassion it was inversely associated with personal experience and positively associated with indifference to stigma.

Effect of Condition on State Self-Compassion

To examine the efficacy of the values affirmation task for increasing self-compassion, we compared postmanipulation ratings of state self-compassion adjectives by condition, controlling for initial state self-compassion. As predicted, state self-compassion was significantly higher in the experimental condition, $M (SE) = 3.89 (.05)$, 95% confidence interval (CI) $= [3.79, 3.99]$, than in the control condition, $M (SE) = 3.53 (.05)$, 95% CI $= [3.43, 3.64]$. $F(1, 91) = 23.30, p < .001$, $\eta^2_p = .20$ suggesting that the manipulation was effective. Next, we repeated this analysis controlling for both initial and final state mood. The effect of condition remained statistically significant, $F(1, 89) = 18.49, p < .001$, $\eta^2_p = .17$, suggesting that the observed increase in state self-compassion in the values affirmation condition cannot be better explained by a general improvement in mood.

Effect of Condition on Attitudes About Mental Disorders and Treatment

We conducted multiple regression analyses to test our hypotheses about the effect of our manipulation on attitudes toward people with mental disorders and mental health treatment. For each dependent variable, we first examined the main effect of condition (control $= 0$, values affirmation $= 1$) while taking into account personal experience of mental disorder (centered such that $no = -.59$, yes $= .41$), perceived public stigma (standardized), and attitudes about mental health treatment (standardized). In separate subsequent steps, we tested whether condition interacted with each of these baseline measures, and further examined all significant interactions with analyses of simple slopes in each condition. Although omitted to conserve space, analyses including additional covariates (demographic variables, socially desirable responding, baseline mood, and self-compassion) yielded the same conclusions as the analyses presented here.

Desired Social Distance From Mental Disorders

A main effect of condition (shown in Table 2) indicated that values affirmation significantly reduced the level of desired social distance from someone living with a mental disorder from $M (SE) = 1.56 (.06)$, 95% CI $= [1.43, 1.68]$ in the control condition to $M (SE) = 1.36 (.06)$, 95% CI $= [1.24, 1.48]$ in the values affirmation condition. The effect of condition was not significantly moderated by personal experience of mental disorder ($\Delta R^2 = .00, p = .779$), perceived public stigma ($\Delta R^2 = .00, p = .947$), or initial treatment attitudes ($\Delta R^2 = .00, p = .720$).

Internalized Stigma Toward Mental Disorders

A main effect of condition similarly showed that values affirmation significantly reduced the overall level of internalized stigma toward people with mental disorders (see Table 2). Specifically, internalized stigma scores were $M (SE) = 1.99 (.06)$, 95% CI $= [1.86, 2.12]$ in the control condition, and $M (SE) = 1.80 (.06)$, 95% CI $= [1.68, 1.92]$ in the experimental condition. This effect did not significantly differ depending on personal experience ($\Delta R^2 = .00, p = .966$), perceived public stigma ($\Delta R^2 = .02, p = .151$), or initial treatment attitudes ($\Delta R^2 = .00, p = .794$).

Exploratory follow-up analyses of the four CAMI subscales revealed that the manipulation was most effective in decreasing support for confinement/restraint of people with mental disorders (Social Restrictiveness; $B = -.21, SE = .10, \beta = -.19, t = -2.22, p = .029$), and increasing support for providing treatment for mental disorders within the general community (Community Mental Health Ideology; $B = .23, SE = .12, \beta = .18, t = 1.95, p = .054$). The decrease in Authoritarian attitudes toward people with mental disorders as a function of the manipulation was not statistically significant, $B = -.14, SE = .09, \beta = -.14, t = -1.61, p = .112$; nor was the increase in attitudes of Benevolence, $B = .16, SE = .10, \beta = .14, t = 1.52, p = .132$.

Internalized Stigma Toward Mental Health Treatment

Internalized stigma toward mental health treatment was not significantly predicted by a main effect of condition, the Condition $\times$ Personal experience interaction ($\Delta R^2 = .00, p = .717$), or the Condition $\times$ Treatment attitudes interaction ($\Delta R^2 = .00, p = .401$).
but it was significantly predicted by the interaction between condition and perceived public stigma ($\Delta R^2 = .02, p = .039$, see Table 2). We examined this interaction with simple slope analyses in each condition, as shown in Figure 1. In the control condition, perceived public stigma significantly predicted internalized treatment stigma, such that for every 1 SD increase in perceived public stigma, internalized treatment stigma increased by $B = .20, SE = .07, \beta = .32, t = 2.90, p = .006$. However, in the values affirmation condition, perceived public stigma was not significantly associated with internalized treatment stigma, $B = .03, SE = .06, \beta = .06, t = 0.56, p = .579$.

### Table 2

**Regression Models Predicting Postmanipulation Attitudes About Mental Disorders and Their Treatment**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>(SE)</th>
<th>$\beta$</th>
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<th>$p$</th>
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<td></td>
</tr>
<tr>
<td>(Constant)</td>
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<td>.06</td>
<td></td>
<td>24.56</td>
<td>.000</td>
</tr>
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<td>−0.06</td>
<td>−5.8</td>
<td>.562</td>
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<td>Perceived public stigma</td>
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<td>0.09</td>
<td>0.91</td>
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</tr>
<tr>
<td>Treatment attitudes</td>
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<td>−0.32</td>
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<td>−0.22</td>
<td>−2.21</td>
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</tr>
<tr>
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### Figure 1

**Internalized Stigma Toward Mental Health Treatment as a Function of Condition and Perceived Public Stigma**

Figure 1 depicts the relationship between internalized stigma and condition, with the effect size shown for each condition. The line for the control condition is dashed, indicating a weaker association, while the line for the values affirmation condition is solid, indicating a stronger association.

**Note.** Predicted values control for personal experience of mental disorder and initial treatment attitudes. Error bars show standard errors.

### Willingness to Seek Mental Health Treatment

Willingness to seek treatment was not significantly predicted by condition nor by the interaction between condition and participants’ personal experience of mental disorder ($\Delta R^2 = .01, p = .218$). Yet condition did have significant effects on participants’ willingness to seek mental health treatment, in interactions with their perceptions of public stigma toward mental disorders ($\Delta R^2 = .03, p = .009$), and attitudes about mental health treatment measured at baseline ($\Delta R^2 = .02, p = .049$). Table 2 includes both of these significant interactions in the same model.

As depicted in Figure 2, participants’ perceptions of public stigma toward mental disorders were significantly associated with lower willingness to seek mental health treatment in the control condition, $B = −0.28, SE = .10, \beta = −0.34, t = 2.84, p = .007$. However, the association between perceived public stigma and willingness to seek treatment was eliminated in the values-affirmation condition, $B = .14, SE = .09, \beta = .14, t = 1.57, p = .124$.

As shown in Figure 3, more positive initial attitudes about mental health treatment predicted greater willingness to seek treatment in both conditions. However, this association was significantly stronger after values affirmation $B = .80, SE = .08, \beta = .85, t = 9.52,$
In our study, participants who reported personal experience of mental disorder were significantly lower in self-compassion than others, and while self-compassion was not related to perceptions of public stigma, it was related to personal attitudes about mental health treatment, especially indifference to stigma. Specifically, participants higher in self-compassion (especially those higher in self-kindness and lower in self-judgment and in isolation) reported that their willingness to consider mental health treatment was less affected by concern about social stigma. Our evidence that self-compassion may serve to buffer against the effects of societal stigma on one’s own attitudes about mental disorders and treatment is consistent with prior studies (e.g., Heath et al., 2018; Wong et al., 2019) and suggests that experimental interventions to increase self-compassion are an important direction for stigma research.

We found that a 5-min values-affirmation intervention effectively increased feelings of self-compassion involving higher self-kindness and lower self-judgment, consistent with previous studies (Gregory et al., 2017; Lindsay & Creswell, 2014). As predicted, this intervention also had significant effects on attitudes about people with mental disorders as well as attitudes about mental health treatment. These findings are consistent with those of Lannin et al. (2013), and expand upon them by considering impacts on self-compassion and a broader range of mental health treatment stigma variables, among participants who may or may not have personally experienced significant psychological distress.

Affirming participants’ values reduced negative attitudes toward people with mental disorders, including the desire to avoid closeness with them, and keep them separated from the community. Moreover, the interaction of our experimental manipulation with perceived public stigma showed that affirmation of values significantly decreased internalized stigma toward mental health treatment and increased willingness to seek treatment among the people whose perceptions of harsh societal attitudes would otherwise be an obstacle to receiving care. Interestingly, while buffering against the effects of perceived public stigma on willingness to seek mental health treatment, values-affirmation also appeared to potentiate participants’ initial attitudes about mental health treatment (increasing willingness to seek treatment among those with positive attitudes, and reducing it among those with negative attitudes). Though this effect was small, it does suggest there may be limits to the benefit of values affirmation for individuals whose own personal values strongly oppose compassionate treatment for mental disorders.

Limitations

Several limitations of our study should be taken into account and considered in future research. All main effects of condition and interactions with condition were small in magnitude. Moreover, though our study was well-powered for detecting main effects, it was underpowered for detecting interaction effects.

We had expected our values affirmation manipulation to have more powerful effects on our dependent variables among individuals with direct experience of mental disorder, and were surprised to find no support for this hypothesis. It is possible that weaknesses in the way we measured personal experience of mental disorder obscured the differences associated with it. Participants were asked to self-report their lifetime experiences with mental disorders and treatment, and no diagnostic interview was given. Some individuals who reported past experience may never have had clinically significant mental health concerns, or their concerns may have been too far
in the past to be currently meaningful. Other individuals experiencing high levels of psychological distress may not have recognized their symptoms as part of a treatable health condition, and therefore reported no history of mental disorder/treatment. Future research should better take into account levels of psychological distress (Lannin et al., 2013; Surapaneni et al., 2019) as well as more details about diagnoses and treatment types, given that different mental disorders and treatments are unequally stigmatized (Krendl & Freeman, 2019).

The adjective-rating format of the state self-compassion measure that we adapted made it readily administered with state mood, with high reliability. Though it showed promising associations with the self-kindness versus self-judgment aspects of trait self-compassion, it was not associated with the other subscales. Now that validated state measures of the entire self-compassion construct are available (Neff et al., 2021), future studies should test whether values affirmation also changes the aspects of self-compassion involving common humanity versus isolation, and mindfulness versus over-identification. In addition, now that a standard protocol is available for inducing a self-compassionate frame of mind (Neff et al., 2021), it would be worthwhile to directly compare the effects of that intervention to values affirmation.

Given that our sample included only young women attending the same small predominantly White undergraduate institution in the U.S., it has limited generalizability. Significant differences in stigma and willingness to seek mental health treatment are associated with age, racial-ethnic background, educational attainment, and gender (Gonzalez et al., 2011).

Implications and Future Directions

Our findings suggest that interventions that can increase self-compassion warrant further research for their potential to decrease the detrimental effects of mental health stigma in college women. In recent years, college students (and especially those who identify as women or genderqueer) have been reporting increasingly high levels of mental health problems, and stigma is a well-known factor in college students’ decisions not to seek mental health treatment (Chen et al., 2016; Smith & Applegate, 2018). Given that low self-compassion and unfavorable attitudes about mental disorders and their treatment are linked with the various forms of maladaptive perfectionism (socially prescribed perfectionism, perfectionistic self-presentation, and effortlessly perfect self-presentation; Abdollahi et al., 2017; Berenson et al., 2018; Shannon et al., 2018; Zeifman et al., 2015) that have become increasingly characteristic of young adults in the United States (Curran & Hill, 2019), interventions to bolster indifference to stigma via increased self-compassion may be especially useful in this at-risk population. Longitudinal studies should also test whether interventions designed to increase self-compassion over longer periods of time (e.g., see Neff & Germer, 2013) might lead to lasting reductions in self-stigma about mental disorders and treatment, and increases in treatment utilization.

Complex gender differences in the constructs we investigated make it especially important for future research to examine whether interventions that increase self-compassion can effectively reduce self-stigma in men. Although the evidence on gender differences in self-compassion is inconsistent, a meta-analysis showed that men report higher self-compassion than women on average (Yarnell et al., 2015). Neff and Pommier (2013) found that while men and women reported similar levels of self-compassion, women reported significantly higher levels of other-focused concern, or compassion for others. Compared to women, men report less knowledge about mental health, higher levels of stigma, less positive attitudes about mental health treatment, and lower willingness to seek these treatments (Chandra & Minkovitz, 2006; Gonzalez et al., 2011). Beyond differences associated with categorical gender identification, valuing the traditional masculine gender role may make men especially susceptible to stigma internalization. Masculinity is especially associated with lower self-compassion (Heath et al., 2017; Yarnell et al., 2019) as well as lower psychological help-seeking and treatment engagement, with negative consequences for mental health outcomes (Neilson et al., 2020; Wong et al., 2017). Although men may express a lack of interest/motivation for interventions aimed at increasing their self-compassion (Neff & Germer, 2013), an intervention framed in terms of enhancing commitment to personal values may elicit less gender role conflict, and therefore warrants further research to increase men’s self-compassion and resistance to stigma.

That values affirmation was effective in reducing stigma about mental disorders and their treatment among individuals who denied any personal experience with them has intriguing implications, because it is not solely patients with psychiatric disorders who hold damaging attitudes. Overly pessimistic and otherwise stigmatizing views of mental health treatment are common among health-care providers (Corrigan et al., 2014; Knaak et al., 2017), family members (Larson & Corrigan, 2008), educators (Smith & Applegate, 2018), and religious leaders (Porter, 2017). Values-affirmation interventions may have utility for reducing the internalization of mental health stigma and increasing acceptance of treatment, both in patients and in the community members that patients most need to be their allies.

References

Krendl, A. C., & Freeman, J. B. (2019). Are mental illnesses stigmatized for


Jones, R. (2017)....

Jennings, K. S., Cheung, J. H., Britt, T. W., Goguen, K. N., Jef...


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