Using Role-Play and Promotion of Self-Acceptance to Reduce Mental Illness Self-Stigma in a Group Setting

by

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The procedures in this staff workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
Dedication

To Dad, Mom, and Jonathan.
Thank you for the guidance, home-cooked meals, and funny Internet videos at 2 a.m. You all drive me crazy, but I guess that’s what family is for.

To Rachel.
Thank you for being my partner in crime, my voice of reason, and my best friend. Let’s go to the Christmas Bowl together.
Abstract

Self-stigma is a serious potential issue for those who live with a mental illness. It has been shown to exacerbate stressors related to mental health issues, thus making it an appropriate and crucial target for intervention as it can interfere with or even prevent individuals from seeking treatment. Various techniques for reducing self-stigma have been explored in the literature. This thesis research project sought to determine if self-stigma of mental illness could be reduced using two interventions. One focussed on improving levels of self-acceptance and another using role-play techniques; both in a group setting. Participants were outpatient adults seeking additional mental health services and support at a hospital’s intensive transitional treatment program. A series of two separate sessions, one on self-acceptance and the other on role-play, were repeated twice for a total of four sessions aimed at teaching about and reducing self-stigma. The Self-Stigma of Mental Illness Scale – Short Form (SSMIS – SF; Corrigan, 2012), which measures four self-stigma constructs in four subscales, was used to collect pretest and posttest data before and after each individual session. The data analysis evaluated combined data from the two self-acceptance sessions together and the two role-play sessions, as well as for each individual session. Visual analysis suggested that changes from pretest to posttest were in the desired directions. Descriptive statistics and statistical analysis demonstrated that these changes were mostly statistically nonsignificant as the only significant changes were seen in one subscale for the combined self-acceptance data. When broken down by session, a significant change was found for one subscale for an individual self-acceptance session and one role-play session. This suggests that the hypothesis was partially supported. Recommendations for future research include having more time to implement each session and to close participant intake in order to maintain participant consistency.
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Chapter I: Introduction

Individuals who experience a mental illness often face many problems and barriers to normal daily functioning. Arguments have been made that the stigmatization of mental illness can lead to significant interference with normal functioning, primarily due to the widespread negative impacts it can have in multiple domains of an individual’s life (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Rüsch, Angermeyer, & Corrigan, 2005).

Stigmatization, also known as stigma, is defined as a process that integrates stereotyping, prejudice, and discrimination against membership in a socially castigated group, combined with the strong likelihood that those negative social views will be internalized by a member of such a group (Hinshaw, 2005). As such, stigmatization can be subcategorized into public stigmas, defined as any prejudice held by the general public that affects an individual, and self-stigma, which is the result of an individual internalizing stigma from external sources (Corrigan et al., 2012). Individuals with mental illness may experience either or both types of stigma. However, self-stigma has been demonstrated to have particularly widespread negative effects, which include, but are not limited to, reduced levels of hope, empowerment, and quality of life, as well as a reduced likelihood to seek out mental health services (Hoge et al., 2004; Livingston & Boyd, 2010). A consequence of not seeking help includes not receiving any treatment for the mental illness at all. Perceived barriers to treatment have been demonstrated to exacerbate stress and further deteriorate psychological wellbeing (Britt et al., 2008). Considering the numerous potential negative effects, self-stigma is a considerable obstacle to the well-being of individuals with mental illnesses.

When an individual’s self-stigma is reduced, there are various demonstrated positive effects that occur across multiple domains in life. For example, improved levels of self-acceptance, self-esteem, and overall mental health have been correlated with lower levels of self-stigma (MacInnes & Lewis, 2008), as have lower levels of shame and rates of self-concealment of a mental illness (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008). Lowering self-stigma may also help improve preparedness to discuss their mental health with loved ones. The literature posits that this is important because not only do relationships provide critical safety nets, individuals with secure relationships report having better treatment outcomes (Perry & Pescosolido, 2015). These demonstrate some direct benefits of lowering an individual’s perceived levels of self-stigma.

Fortunately, various techniques have shown significant positive results in terms of reducing an individual’s self-stigma. Participants from programs that emphasize unconditional self-acceptance report significantly lower rates of self-stigma, higher rates of self-acceptance and self-esteem, and overall improved psychological health (MacInnes & Lewis, 2008). As well, drama therapy, which includes role-playing and modelling as some of the core techniques of this style of therapy, has also been shown to be a useful tool in decreasing self-stigma in a group setting (Orkibi, Bar, & Eliakim, 2014). Finally, group Cognitive Behavioural Therapy (CBT) and peer settings have been repeatedly demonstrated to effectively lower self-stigma while improving negative emotional symptoms (Foster, Lewis, & McCloughen, 2014; MacInnes & Lewis, 2008; Shimotsu et al., 2014). Based on the above literature, it is suggested that improving self-acceptance and using role-plays in a group treatment setting may lower self-stigma of having a mental illness.

It is hypothesized that focusing on self-acceptance and role-playing in a group setting will reduce self-stigma in individuals with a mental illness. This thesis will further examine which type of intervention is more effective.
Overview of Chapters

Subsequent chapters of this thesis will include a literature review, a description of the project’s methodology, an overview and analysis of the obtained results, and a final discussion to summarize the project. Chapter 2 with the literature review will summarize contemporary information regarding all topics involved in this thesis project, including the selection of a group setting, the decision to address self-stigma of mental illness in participants, and the decision to use self-acceptance and role-playing as the intervention. The literature review will compare and contrast the findings and views of different published authors, as well as identify any areas in the literature recommended for further research. Finally, findings will be summarized and a relationship between those findings and the thesis project will be outlined. Chapter 3 on the methodology will provide a detailed overview of all procedures developed and applied in the course of the thesis project’s implementation. This will include participant selection procedures, informed consent procedures, detailed overview of the group treatments which will include the location, materials needed, and method of delivery, and pretest-posttest measures. Chapter 4 will examine the results of the completed measurement scales, which will then be summarized, analyzed, and presented in graphs and tables. Finally, Chapter 5 on the discussion section will summarize the entire thesis project by examining strengths and limitations of the project, multilevel challenges to the project, any ethical concerns that were recognized, and how the project contributes to the field of behavioural psychology.
Chapter II: Literature Review

Self-Stigmatization of Mental Illness

As stated earlier, individuals who have a mental illness may experience a plethora of barriers and difficulties with daily functioning. These can include difficulty with acceptance into and the completion of a post-secondary education (Schindler & Kientz, 2012), difficulty in obtaining, maintaining, or being promoted in a job (Rebeiro Gruhl, 2012), higher likelihood of utilizing permissive or authoritative parenting styles (Oyserman, Bybee, Mowbray, & Hart-Johnson, 2005), increased vulnerability to barriers preventing healthy lifestyle changes (Yarborough, Stumbo, Yarborough, Young, & Green, 2015), and lowered accessibility to quality physical health care (Happell, Scott, & Platania-Phung, 2012). Furthermore, some of these factors can affect an individual’s ability to attain and maintain independence both socially and economically (Schindler & Kientz, 2012). However, it has been argued that stigmatization may be the most damaging effect of having a mental illness.

Rüscher, Angermeyer, and Corrigan (2005) identified two types of stigma. The first type is social stigma, which is defined as a combination of the social constructs known as stereotypes, prejudice, and discrimination. Corrigan and Watson (2002) further elaborated on these terms, defining stereotypes as a socially collective view of a group of individuals, prejudice as the belief and endorsement of negative stereotypes, and discrimination as an individual’s active negative and prejudiced behaviours towards people of a stigmatized group. Thus, as Rüscher et al. identified, individuals with mental illnesses have to cope with two sets of problems that come from facing the negative attitudes of others as well as the problems that come from the symptoms of a mental illness. The problems that result from social stigma greatly impact individuals with a mental illness and their livelihoods as basic progress in life, such as finding a job or leasing an apartment, can be denied because of stigma (Corrigan et al., 2001). Furthermore, Vogel, Wade, and Hackler (2007) found that perceived social stigma can interfere with an individual’s likelihood to seek out mental health help because of further fears of being stigmatized. In their survey of college student attitudes about stigma of mental health and seeking out mental health help, Vogel et al. found that perceived public stigmas and help-seeking behaviours were directly related to self-stigma and attitudes of mental illness. They concluded that these results can be explained by the theory of reasoned action, which proposes that attitudes towards specific behaviours are influenced by expectations of the behaviour’s outcomes, and therefore individuals who perceive negative social attitudes towards help-seeking are more likely to believe negative outcomes will come from engaging in help-seeking.

Rüsch et al. (2005) identified that self-stigma is the second type of stigma. Self-stigma is defined as the internalization of stereotypes, prejudice, and discrimination towards oneself due to membership in a stigmatized group (Rüscher et al., 2005). Examples of self-stigma include an individual believing that they are incapable of caring for themselves or failing to pursue employment due to lack of belief in their ability to maintain a job (Rüscher et al., 2005). Given that social stigma is difficult to change, Vogel et al. (2007) have identified that self-stigma of mental illness is a more feasible target for intervention. They explain that while changing stigmatizing societal attitudes is an important goal, targeting self-stigma is a more manageable intervention and can lead to individuals engaging in help-seeking behaviour. Self-stigma is also important to target as it may be linked to anticipating social stigma and discrimination, which in turn contributes to internalization of negative beliefs about oneself potentially resulting in self-fulfilling prophecies (Quinn, Williams, & Weisz, 2015), not seeking out help for mental illness due to a higher need to be self-reliant (Jennings et al., 2015), higher rates of psychiatric hospitalization (Rüscher, Corrigan, Wassel, Michaels, & Larson, 2009), and compounded stresses
due to combinations of not seeking help and stress levels exacerbating current symptoms (Livingston & Boyd, 2010).

The numerous potential negative effects that can result from self-stigma of having a mental illness and the fact that self-stigma is within the individual’s control make it an appropriate target for intervention. Overall, several areas of functioning may be improved when self-stigma is reduced or avoided.

**Providing Treatments in Group Settings**

The literature supports that peer support provided in groups has multiple benefits over providing individualized treatment, and several of these benefits may be directly relevant to treating self-stigma.

Verhaeghe, Bracke, and Bruynooghe (2008) found that peer support can increase self-esteem while also buffering the negative impact on self-esteem from stigmatization. Further, Castelein et al. (2008) conducted a study that compared a control group receiving usual care alone with a treatment group of individuals who received additional treatment in the form of a peer-guided support group. Participants filled out scales that measured size and content of personal social networks, positive interactions with others, self-efficacy, self-esteem, and overall quality of life. Castelein et al. found improved rates of social support, self-esteem, self-efficacy, and overall quality of life for those who more frequently attended the treatment. Additionally, participants who had longer experiences with mental illness and had more symptoms at baseline had the greatest improvement to quality of life. Castelein et al. stated their results help establish the need for more peer support groups as individuals with psychotic disorders tend to have smaller social networks and do not have as many opportunities to connect and share with similar individuals. As outlined in previously mentioned studies, higher self-stigma has been shown to correlate with lower self-esteem (MacInnes & Lewis, 2008) and quality of life (Livingston & Boyd, 2010).

Bouchard, Montreuil, and Gros (2010) conducted interviews with 10 inpatients regarding peer support and relationships with other inpatients. The interviews identified several factors that were important to peer support, including sharing tangible goods on the unit, helping each other with daily routine activities, developing a peer network, exchanging advice and information, and providing emotional support to each other. Furthermore, strong peer relations were noted to directly improve emotions, behaviours, and outlook on their hospitalization. Bouchard et al. posited that these findings can help mental health care providers have a better understanding of the importance of peer support and the unique ability that other patients can have in improving treatment outcomes for their peers, which in turn may help improve overall prognosis.

Finally, Oliver, Pearson, Coe, and Gunnell (2005) found further support that close peer relations may mediate seeking out mental health services. Oliver et al. sent out surveys to 15,222 adults registered with a general practitioner with a questionnaire about general psychological distress and questions about help-seeking attitudes and behaviours. Of the responders, 81.2% replied that they would seek out help if they thought they needed it, and 63.1% identified a close friend or relative to be the preferred source of help. Furthermore, for those who identified actually seeking out help, the most common source of help was friends or family.

It is hoped that effects similar to those found in Castelein et al.’s (2008) study will also occur in the current study because there is potential for reducing self-stigma if peer support and connecting with similar individuals can help participants increase their self-esteem and overall quality of life. It is reasonable to suggest that Bouchard, Montreuil, and Gros’ (2010) study
supports Castelein et al.’s results in that peer support can help reduce self-stigma through increasing self-esteem and quality of life, especially since Bouchard et al. found that strong peer relations positively affected emotions. This would further support the notion that peer settings can improve self-stigma. It is acknowledged that Bouchard et al. interviewed inpatients and that the strength of their peer relations may have been affected by the considerably increased time spent together. However, since Bouchard et al. found that providing emotional support was important to peer support, and the current study aims to use discussions to enable this between participants, it is reasonable to suggest that Bouchard et al.’s study is still relevant and supportive of the current study.

Oliver et al.’s (2005) results further suggest that close peers and relationships are mediating factors in seeking mental health services, especially since 14.3% of their respondents indicated that they would not seek out help from a general practitioner. While it is recognized that they surveyed a non-clinical population, the participants in the current study can be referred to the hospital program from community resources, including general practitioners, which supports potentially generalizing Oliver et al.’s results. As well, since Hoge et al. (2004) found in their study that self-stigma is one of the most significant barriers to seeking out mental health services, it is hoped that addressing and encouraging participants to talk to others about mental illnesses can have a reverse effect on self-stigma in reducing it.

The previously mentioned studies results demonstrate the value in peer support groups, especially to a stigma-related treatment process for individuals with a mental illness.

**Psychoeducation**

Each of the proposed group sessions for this thesis project will involve a component of psychoeducation on stigma and its effects on individuals who have a mental illness. Psychoeducational mental health programs typically involve presenting factual information about mental illness and treatments, improving optimism on treatment outcomes, and disputing myths and misconceptions (Alvidrez, Snowden, Rao, & Boccellari, 2008). An example of using psychoeducation therapeutically is when patients receive treatment for traumatic experiences. Phoenix (2007) discussed that trauma education is vital to providing a cognitive and normalizing framework for trauma victims to improve objective analysis of their experiences, as well as providing opportunities to better understand, cope with, and minimize adverse stress responses while improving a sense of control over their lives. Furthermore, Gould, Greenberg, and Hetherton (2007) conducted a study to examine if the trauma risk management (TRiM) psychoeducational program could positively modify attitudes about PTSD and help-seeking behaviours in both regular military social support personnel and TRiM-trained personnel. Their participants were nonclinical, active UK Armed Forces members, assigned to either the TRiM treatment group or the control group. Participants were measured on attitudes towards mental illness, attitudes towards the stigma of seeking mental health help, and overall current mental health. The results demonstrated improved attitudes towards mental illness and a nonsignificant increase in help-seeking in the treatment group. Gould et al. concluded that these results are promising for supporting other psychoeducational programs.

In addition to providing normalcy, psychoeducation has been shown to improve treatment compliance and outcomes. Degmečić, Požgain, and Filaković (2007) conducted a study comparing a psychoeducation program to a control group for patients with schizophrenia. Measures for schizophrenia symptomology, treatment compliance, attitudes towards medication, and social functioning were used. Degmečić et al. found the psychoeducational group significantly improved scores on all measured domains both at discharge and at the 3-month
follow-up. Degmečić et al. attributed the better clinical outcomes to psychoeducation’s empowering and enabling effects on patients through increased understanding of their illness.

Baüml, Froböse, Kraemer, Rentrop, and Pitschel-Walz (2006) posited that psychoeducational programs present great value in establishing a fundamental understanding of one’s mental illness and treatments while laying foundations for success for additional treatments. As well, Baüml et al. stated that psychoeducational programs can be most effective if used as precursory treatment before admittance into other treatment programs, such as CBT, which is particularly relevant to the current study as some participants who attend the study’s agency may graduate to receive further treatment like CBT.

In terms of the impact of psychoeducation on perceptions of mental health stigma, Alvidrez, Snowden, Rao, and Boccellari (2008) conducted a study to compare the differences on help-seeking behaviours in individuals currently after receiving either a psychoeducational booklet with advice and written experiences from other mental health consumers or a general information booklet with a brief overview of local mental health. Outcomes measures included symptomology, perceived need for treatment, concerns about receiving treatment, perceived mental illness social stigma, and how helpful they found the information provided. Overall, both types of booklets were rated equally helpful and levels of perceived stigma were similar. However, Alvidrez et al. determined that participants with a higher self-reported perceived need for treatment had lower rates of perceived social stigma if they received the psychoeducational booklet. Furthermore, they stated that their results indicated that both types of information were well received by the participants, which led Alvidrez et al. to conclude that delivery of information by another person is more beneficial to the treatment engagement process than information delivered automatically without the presence of another person.

It should be noted, however, that psychoeducational programs have not universally been found to be an effective treatment. Han, Chen, Hwang, and Wei (2006) conducted a study to determine whether psychoeducational programs on biological causes for depression or destigmatization programs could impact decisions on help-seeking behaviour. They randomly assigned 299 participants to receive biological information, destigmatization information, both types of information, or none in the control group. Han et al. found that biological attribution information improved participants’ attitudes towards seeking help while destigmatizing information did not. Han et al. theorized that biological attribution information legitimized mental illness as a real disease and therefore is more practical for encouraging help-seeking behaviours, especially in societies where mental illness is not as widely recognized. While Han et al. concluded that the psychoeducational destigmatizing program did not affect help-seeking attitudes as intended, they did find that it reduced negative attitudes towards people with depression. This finding is more relevant to the current study as reducing negative attitudes towards mental illness in others may also help with reducing self-stigmatizing attitudes.

Han et al.’s (2006) study was similar to the previously outlined studies on the benefits of psychoeducation. The studies by Gould et al. (2007), Degmečić et al. (2007), Alvidrez et al. (2008), and Han et al. have similar procedures in that psychoeducational programs were provided and compared to other types of information or control groups. Most of the findings universally supported psychoeducation as an important aspect of mental health services. However, it should be noted that the populations were culturally different between Han et al.’s study and the others. While the other studies were conducted in predominantly Caucasian societies, Han et al.’s study was conducted across universities in Taiwan. Han et al. discussed how mental health issues are not as widely accepted or acknowledged in Chinese populations and that many Taiwanese individuals only seek out mental health services when they experience
resulting physical symptoms. It can be inferred that cultural differences in Han et al.’s study could have influenced their results, and therefore further suggests that psychoeducation is a reasonable treatment practice to include in the current study.

With the information above, it is shown that the provision of psychoeducation can be used in a variety of populations for different mental illnesses and for the purposes of improving attitudes towards mental illness and treatments, and improving overall treatment outcomes. It is plausible that the benefits seen in the research by Gould et al. (2007) and Degmečić et al. (2007), such as improving one’s sense of control and understanding of stigma, may be observed due to the inclusion of psychoeducation. As well, while Bäuml et al.’s (2006) model was designed for patients with schizophrenia, other populations could gain similar benefits, such as normalizing having a mental illness, by having an improved fundamental understanding of mental illness. Finally, Alvidrez et al.’s (2008) conclusion on personal contact supports the use of psychoeducation to help reduce perceived levels of stigma and assist the treatment engagement process. While not all research demonstrates effectiveness in the use of psychoeducational approaches, as demonstrated by Han et al.’s (2006) work, it is reasonable to suggest that providing psychoeducation on social stigma and self-stigma may help provide a framework to the participants in the current study to better understand and view the types of experiences they may experience.

**Self-Acceptance Treatment**

Self-acceptance is defined as the ability to accept oneself fully with all personal traits, both positive and negative, and has been recognized to be an important aspect to overall psychological health (Morgado, Campana, & Tavares, 2014). Furthermore, it is important for individuals to learn the ability to accept themselves without needing to rely on external approval or reaching some goal (Hill, Hall, Appleton, & Kozub, 2008). Research has determined strong relationships between unconditional self-acceptance and overall psychological well-being (Flett, Davis, & Hewitt, 2003). For example, Flett, Davis, and Hewitt (2003) wanted to determine associations between perfectionism, self-acceptance, and overall psychological health, and to further determine if unconditional self-acceptance played a mediating role between perfectionism and psychological distress. They provided questionnaires to 94 university students that measured perfectionist attitudes, levels of unconditional self-acceptance, and depressive symptoms. The results demonstrated correlations between lower rates of self-acceptance with higher rates in both perfectionism and depressive symptoms. As well, a path analysis model established that unconditional self-acceptance mediated the relationship between perfectionism and depression. Therefore, self-acceptance may have an important role in overall mental health and its role in reducing self-stigma will be further explored.

MacInnes and Lewis (2008) used self-acceptance to reduce self-stigma in individuals with serious and enduring mental illnesses. They implemented a 6-week group treatment program with measurements of self-stigma, self-esteem, self-acceptance, and overall psychological well-being conducted at pretest and posttest. The program had a cognitive approach but had substantial emphasis on developing unconditional self-acceptance. Posttest measures indicated significant changes in all outcome measures. The authors theorized that promoting self-acceptance allowed participants to challenge societal stigmatizing beliefs.

Mindfulness will also be included in the current study as a part of the treatment. The practice of mindfulness allows an individual to openly and nonjudgmentally examine and observe their current feelings, both physically and mentally, in order to promote acceptance of one’s experiences (Nykliček, Hoogwegt, & Westgeest, 2014) while simultaneously mentally and physically relaxing the individual through the release of ruminating thoughts (Blackledge &
Hayes, 2001). Carson and Langer (2006) explain that mindfulness incorporates self-acceptance since mindful attention can bring one’s attention to the present moment instead of self-evaluations or criticisms. As such, it is reasonable to infer that mindfulness can reduce self-stigma since negative self-evaluations can affect self-esteem, and self-esteem has been correlated with self-stigma. The effects of mindfulness on self-stigma are explored further below.

To support the inclusion of mindfulness to affect self-stigma, Mersh, Jones, and Oliver (2015) conducted a survey among 34 participants experiencing first-episode psychosis. Participants fill out questionnaires to show self-reported levels of mindfulness, self-stigma, social functioning, and severity of current symptoms. They found that higher levels of mindfulness correlated with lower rates of self-stigmatizing thoughts, resulting in better overall social functioning. Mersh et al. stated that their results suggest that mindfulness reduces overall self-stigma.

Lillis, Hayes, Bunting, and Masuda (2009) examined acceptance and mindfulness effects on weight-related self-stigma with 84 participants recruited from local weight loss clinics. The participants completed measures for overall psychological distress, quality of life in relation to obesity, weight-related self-stigma, psychological flexibility, psychological flexibility in relation to physical weight, and distress tolerance. The participants were then assigned to either a 1-day Acceptance and Commitment Therapy workshop or the waiting list control group. Follow-up measurements found statistically significant effects in the treatment group for every measured trait, including self-stigma. Differences in populations will be addressed further below.

Finally, positive self-statements will also be included as a part of the treatment. Link and Phelan (2001) identified that appropriate language can have a significant impact on how an individual perceives themselves and how others perceive them in turn. Link and Phelan explained that identifying oneself as a mental illness diagnosis (i.e., mentally ill) creates a label and socially categorizes the individual as different. Rüsch et al. (2005) drew parallels between the language used in physical illnesses and mental illnesses. They stated that, for example, the language used to describe an individual with cancer should be the same language used to describe a person with depression; just as nobody would say an individual is cancer, others should not say that someone is depressed. Rüsch et al. posit that language that identifies having a condition, rather than being a condition, has the ability to reduce one’s self-stigma as it reduces labelling while normalizing mental illness.

To further expand on positive self-talk, Puhl and Brownell (2006) conducted a study among 2,671 overweight and obese adults in which participants completed a number of scales, including self-reported frequency of socially stigmatizing experiences, frequency and type of coping strategies for socially stigmatizing experiences, general self-worth and self-esteem, and depressive symptoms. The results showed that positive self-talk was associated with lower levels of depression and was one of the most common coping methods for both male and female participants.

It is acknowledged that the population and targeted symptoms of Lillis et al.’s (2009) study and Puhl and Brownell’s (2006) study are different than the ones in the other reviewed studies as it targeted a physical health stigma instead of mental health stigma. However, despite differences in intervention targets, the procedures remained similar. The studies examined how acceptance and mindfulness affected self-stigma and other related constructs, finding similar results despite differences in population. Lillis et al. also acknowledged that ACT has established efficacy in treating populations with mental illnesses and based their study on the assumption that similar effects would generalize to obesity-related issues and stigma. The
successful application of acceptance and mindfulness to reduce self-stigma in generalized populations further supports the decision to include those methods in the current study. MacInnes and Lewis (2008), Merch et al. (2015), and Lillis et al. (2009) demonstrated that self-acceptance and mindfulness can decrease self-stigma while Rüscher et al. (2005) and Puhl and Brownell (2006) found evidence to suggest that positive self-talk can decrease self-stigma too. Therefore, it is reasonable to suggest that self-acceptance, mindfulness, and positive self-talk are relevant to the current study’s goal of reducing self-stigma in participants with a mental illness. While some studies aimed to reduce stigma in populations with physical issues, the same approaches to self-stigma and related constructs were used and those researchers found similar results to other self-stigma studies. Overall, the studies outlined demonstrated effectiveness in the use of various self-acceptance approaches, and therefore it is reasonable to suggest that encouraging self-acceptance processes in participants will assist the process of reducing self-stigma.

**Role-Play Treatment**

The research on the use of role-play to change attitudes has been limited and varied in results, but the theoretical benefits of practising role-plays are intuitively logical. Furthermore, the use of role-plays has been shown to result in several beneficial outcomes, some of which are relevant to reducing self-stigma. For example, Perry and Pescosolido (2015) discuss the importance of social ties for individuals with mental illness as social safety nets are crucial to the management and coping with a crisis. They further explored in their study that individuals who carefully secured social links had better treatment outcomes than in individuals who carelessly or sporadically activated a social network. They theorized that promoting and practicing drama-therapy, with emphasis on role-play, could effectively encourage participants to approach and activate social ties, or otherwise strengthen existing relationships. In their study of examining social stigma among obese individuals, Puhl and Brownell (2006) found that individuals who coped with social stigma by seeking out and obtaining social support self-reported higher levels of self-esteem. As self-esteem and self-stigma have been negatively correlated in previous research, encouraging mechanisms that may in turn improve self-esteem may have an effect on self-stigma in the participants of the current study.

Orkibi, Bar, and Eliakim (2014) conducted a drama-based therapy treatment. The study evaluated if using a role-play therapy group combining individuals with and without mental illness would affect self-stigma and self-esteem in the individuals with mental illness. The study further examined whether the role-play therapy group would concurrently decrease social stigma in the participants without mental illness. The intervention drama activities fostered spontaneity, creativity, and playfulness in hopes of encouraging trust, self-expression, and authentic experiences between all participants. On measures of self-stigma, self-esteem, and public stigma, Orkibi et al. found the expected results of increased self-esteem, decreased self-stigma, and decreased public stigma in both groups of participants. The researchers hypothesized that using role-plays concerning mental illness and role-playing having a mental illness allowed participants to experience more empathy while simultaneously experiencing more personal insight.

Stuart (2006) utilized both psychoeducation and role-play to reduce mental illness stigma in high school students, which was defined as social distancing from individuals with mental illness. The intervention was comprised of presenting a psychoeducational video on serious mental illness, featuring interviews with teenagers and their experiences with family members with mental illnesses. The video session was followed by role-play to further strengthen the lessons and to better understand the experiences that individuals with mental illness go through.
Self-report measures were used to assess high school students’ knowledge of mental illness and to assess social distancing from individuals with mental illness. At the conclusion of the session, Stuart found that nonsignificant changes in social distancing were demonstrated, with the exception of participants reporting higher rates of not being afraid to talk to someone with schizophrenia at the posttest measurement. This study demonstrated potential in the use of role-play to further supplement psychoeducational interventions for social stigma.

It should be noted, however, that role-plays have not always been found to be effective. Roberts, Wiskin, and Roalfe (2008) conducted a study to determine if role-play exercises could lower stigma towards mental illness. Their hope was that the role-plays would facilitate complex social skills regarding mental illness stigma and would further reinforce positive attitudes. Participants were 332 undergraduate medical students who were randomly assigned to the treatment group, comprised of both communication skills training and role-play scenarios, or the control group with only communication skills training. Self-report measures were used to assess personal stigma, social distancing from mental illness, and their perceptions of social stigma. The role-play scenarios involved the student participants interacting with actors pretending to have a mental illness. The results showed no significant differences between the treatment groups in any outcome measure. Roberts et al. did, however, acknowledge that certain limitations, such as the use of a male character with the mostly female student participants, may have interfered with the efficacy of the role-plays.

The current literature on role-play is still relatively limited and results are somewhat mixed. The above studies are similar in the sense that role-play was a central aspect of the implemented treatments. Stuart (2006) and Orkibi et al. (2014) helped establish a working foundation for other drama-based treatments to be further explored in the pursuit of reducing self-stigma of mental illness, as they have noted that there is limited research currently available in this field.

However, details and results differ. While Orkibi et al. (2014) found significant reductions in self-stigma in their participants through the use of role-play, Stuart (2006) and Roberts et al. (2008) found nonsignificant results for role-play’s efficacy. As well, while Orkibi et al. specifically focused on reducing both self-stigma and social stigma, the studies by Stuart and Roberts et al. focused on social stigma. Still, taking into account the acknowledged limitations of Roberts et al.’s study, the theories beneath all three studies to facilitate complex social skills and improve stigmatizing attitudes can still be logically applied to the current study.

Therefore, taking the similarities and differences of the role-play studies into account, utilizing role-play as a part of the current study’s treatment program still has an empirical foundation that supports its inclusion. While not every study showed significant effects, the limitations allow for the hypothesis that role-playing may help reduce self-stigma.

Conclusion of Literature Review

In conclusion, the current literature available supports that self-stigma has been established as a serious problem that individuals with mental illness face as it can both exacerbate and create obstacles to normal daily functioning. The reviewed empirical studies indicate that psychoeducation, self-acceptance and related constructs, and role-playing may help in reducing self-stigma in individuals with a mental illness.

The provision of treatment in a group setting has many established benefits such as fostering peer support and relations, which can have positive impacts on treatment outcomes, such as increasing self-esteem and overall quality of life, as demonstrated in the research by Castelein et al. (2008). Psychoeducational programs have been demonstrated to improve treatment compliance, provide an important foundation for other treatment approaches, provide a
normalizing cognitive framework to view ones mental illness, and foster empowerment through increased knowledge, results which can be found in works by Baüml et al. (2006) and Han et al. (2006). Self-acceptance, mindfulness, and positive self-talk have been shown to have mediating effects on other domains, such as self-esteem and self-efficacy that can impact self-stigma and other perceptions of oneself. The literature by MacInnes and Lewis (2008), Mersh, Jones, and Oliver (2015), and Rüssch et al. (2005) suggests that these domains relate to self-stigma and the improvement of overall psychological well-being. Finally, as demonstrated by Orkibi et al. (2014), role-playing has suggested efficacy in treating self-stigma and social stigma, though it is still a limited field of research and could benefit from further research. Through the examination and comparison of various stigma-related studies with established or promising efficacy, this thesis project will incorporate those techniques together because of their focus on individuals who are affected by stigma, which was noted to be a more feasible and manageable approach to addressing stigma in general. As well, the combination of the treatment techniques will help provide a best-practices treatment plan for the participants.
Chapter III: Methodology

Participants

As the project treatment program was integrated into an already existing program schedule for mental health services at a local hospital, all individuals who participated in the treatment program were those who were already actively attending the hospital’s program. This hospital day program is categorized as an intensive transitional treatment program (ITTP) and provides a variety of outpatient mental health services and skill building sessions in a group setting. Acceptance into ITTP, and therefore the project treatment program, is preceded by referrals from a variety of sources, including, but not limited to, the hospital’s inpatient department for mental health services, attending psychiatrists or residents, the hospital’s emergency department, local community mental health or addictions organizations, or from general practitioners, but not through self-referrals. Inclusion criteria for being accepted into ITTP includes being 18 years old or older, being able and willing to participate in treatment sessions within a group setting, and being identified as having a need for more intensive and ongoing support. ITTP admission criteria favour individuals with a diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013). Examples of DSM-5 diagnoses that could be present in clients typically admitted can include, but are not limited to, mood disorders, adjustment disorders, personality disorders, and other concurrent disorders. However, participants are not required to have an official diagnosis. Exclusion criteria that would not make an individual suitable for ITTP, and therefore the project treatment program, includes actively being in a crisis situation, which is further defined as being a danger to themselves or others, as well as individuals experiencing delirium, dementia, or individuals with a developmental delay. As well, all individuals who are considered to potentially be disruptive to the group experience for other individuals are not accepted into ITTP.

ITTP accepts clients on a continuous intake basis, meaning that at any given session, some clients are nearing completion of the program while other clients have started recently. For the present study two different intervention sessions were implemented but each session included some of the same individuals and some unique individuals given the turnover of participants from session to session. The study intervention was provided to the entire group of ITTP clients as part of their ITTP treatment but data was only collected for those who signed a consent form.

The number of participants for the current study intervention was dependent on the number of ITTP participants present on the study intervention days. Two different intervention sessions were implemented, each repeating once, for a total of four sessions during this study. Participants would be able to receive both types of intervention sessions if they attending ITTP as required; statistics of participants who actually attended both will be discussed. During the first study intervention session, there were 13 ITTP participants in attendance but only 12 signed a consent form. For the second session, all 12 ITTP participants in attendance either signed a new consent form or did not ask to withdraw their consent from the previous session. Of those who answered whether they attended the previous session, four said they attending the last session while five did not. In the third session, 12 of the 14 present provided signed consent, of which seven reported being in the last session while three reported not. Finally, eight out of a total of nine participants provided signed consent in the last session, of which three reported attending the previous session while two did not. Self-reported attendance regarding previous sessions did not always match the actual attendance for each session because some participants skipped the question.
Informed Consent Procedures

Prior to implementation of the project treatment program, an informed consent form (Appendix A) was developed and reviewed by the Research Ethics Committee – Psychology at St. Lawrence College, who provided revisions for the consent form to meet the standards of practice. The informed consent form was also reviewed and revised by staff at ITTP to ensure that the form met the hospital’s own standards of practice as well.

The hospital staff required that the study intervention group sessions be made available to all ITTP participants who arrived for ITTP that day regardless of whether they chose to participate in the data collection. During the overview of the consent form, participants were informed that completion of pretest data, posttest data, as well as participation in the group session, was optional and voluntary.

The consent form was reviewed and explained in detail prior to the beginning of the study intervention. The purpose of the research project was explained to the participants, as well as their role and responsibility within the study. Benefits and risks of participating in the group were explained, and participants were informed that they could talk to the group facilitator or to the co-facilitating ITTP staff member regarding any concerns about participating in the study intervention at any point before, during, or after the group session. Participants were also informed that their participation would be kept confidential and their identifying consent forms would be secured within a locked cabinet at ITTP. Participants who attended both types of intervention sessions were informed that they did not have to sign another consent form but were reminded they could withdraw their consent for the second session.

Signed consent forms and completed pretest measures were obtained at the beginning of each study intervention session. Posttest measures were completed at the completion of the group sessions.

Design

This project used a pretest-posttest design in order to measure if there were any changes in participants’ perceived levels of self-stigma during each group session. The dependent variable was the level of perceived internalized self-stigma in regards to having a mental illness as measured by a self-report scale. The independent variable was the implementation of group sessions; two psycho-educational sessions on self-acceptance and two sessions using role-plays.

Setting and Materials

The group sessions were conducted in the hospital conference room where all of ITTP’s group sessions are held. All sessions were conducted with participants sitting around the group table and facing the facilitator at the front of the room where a whiteboard was located on the wall. Materials included the whiteboard and dry erase markers to write out key points during group sessions, the worksheets developed as a part of each group session, and writing utensils. Participants were told they could keep the worksheets to either create more or refer to them outside of ITTP.

Measures

A modified version of the Self-Stigma of Mental Illness Scale – Short Form (SSMIS – SF; Corrigan, 2012; Appendix B) was used to measure levels of internalized self-stigma reported by participants. The SSMIS – SF measures awareness of common mental illness stereotypes, agreement with common stereotypes, application or internalization of common stereotypes, and harm to self-esteem due to internalization. The SSMIS – SF is a condensed form of the original Self-Stigma of Mental Illness Scale and retains only 20 of the original items as a method of improving on critiques of the longer original version, such as saving administration time (Corrigan, Michaels, et al., 2012). Those 20 items are equally divided into the four subscales,
which were determined to be related to self-stigma (Corrigan, Watson, & Barr, 2006) and have supported validity, as the subscales were demonstrated to correlate with the appropriate constructs, and supported reliability, as the same results were found across multiple samples with different mental illnesses and in two languages (Corrigan, Michaels, et al., 2012). The SSMIS – SF was considered an appropriate scale for measurement the present study it has acceptable reliability and validity and takes relatively little time to complete, maximizing the time available for the intervention.

Modifications to the SSMIS – SF involved adding a feedback page asking participants if they had attended the other self-stigma group session yet. There were also questions asking if they enjoyed the session, what they liked or did not like, and any additional comments or recommendations. As well, a note was added on the first page of both copies of the SSMIS – SF to denote whether it was for completing before or after the group session. The SSMIS – SF scoring sheet was omitted from the modified SSMIS – SF that was delivered to participants as ITTP staff were concerned about participants being exposed to the phrase "Hurts Self" on the scoring sheet. ITTP staff were worried that the phrase might cause emotional distress or a recollection of unpleasant memories in participants. The measurement was provided to every consenting participant immediately before and after each group session.

Procedure

Each of the project’s 1 hour long group sessions were integrated into ITTP’s already existing group session schedule. One session was dedicated to one topic, followed by the other session 2 weeks later, and then the sessions were repeated again with 2 weeks in between every session. This meant that each of the two sessions were replicated for a total of four sessions over the course of 2 months.

The student researcher facilitated the sessions while an ITTP staff attended the group to observe the group and occasionally co-facilitate group discussions during each session.

As with all ITTP group sessions, each of the project group sessions were designed to discuss the single common topic of self-stigma, although the two different study sessions used different approaches that were unique enough that participants could attend both without feeling they received redundant information.

The first group session focused on increasing self-acceptance as a method of decreasing self-stigma of having a mental illness. The group mediator notes for the self-acceptance group can be found in Appendix C. This group session included psychoeducation on stigmatization and self-stigma, followed by information on positive self-talk and mindfulness. Participants were also given handouts during the group and were encouraged to keep them. These handouts were developed in conjunction with ITTP staff (Appendix D). One handout summarized the information presented in the group session and the other was designed for participants to keep a record of mindful and positive self-statements.

The role-play group had a similar structure to the self-acceptance group, and the mediator notes for this group session can be found in Appendix E. Psychoeducation on stigmatization and self-stigma was also included in this group session, though the information was more condensed than the information presented in the self-acceptance group session. The decision to have a shorter psychoeducation segment came about for time-management purposes as ITTP staff theorized the role-playing group would take longer to complete due to the inclusion of open discussions. Other material that was presented in the group session included playing audio tracks from videos that are a part of the Bell Let’s Talk 2015 campaign. These audio tracks were played as a method of encouraging participants to discuss mental illnesses and societal issues
regarding mental health. The first audio track was of a testimonial by Howie Mandel (Bell Canada, 2014a), followed by a discussion of the testimonial. A second audio track of a testimonial by Michael Landsberg (Bell Canada, 2014b) was played, followed by another discussion. Transcripts for both videos were developed (Appendix F) for the student researcher to read in the event that the CD player would not work. A handout that was developed in conjunction with ITTP staff was then distributed to participants (Appendix G). This handout was meant to help participants plan for potentially difficult conversations with others. Finally, a role-playing scenario was introduced (Appendix H) and acted out between the student researcher and one volunteering group member. This was presented as part of the role-play in order to encourage participants to practice having their planned difficult conversations. Following this scripted scenario, participants were then presented the option of either sharing their plans for a conversation with the group and the student researcher could act in one role of the conversation, or group members could separate into groups of two or three and practice having their discussions amongst themselves.

**Statistical Techniques**

The first statistical technique used was visual analysis, where the pretest and posttest means of each of the subscales were calculated and displayed in bar graphs. Data from each of the four sessions was displayed in an individual graph. As well, data from the two self-acceptance sessions were combined while the data from the two role-play groups were combined. These two sets of data were then displayed in two separate graphs to see overall changes between pretest and posttest data according to intervention type.

This information was followed by descriptive statistics and statistical analysis based on the visual analysis of the graphs. Paired *t*-tests were used to compare pretest and posttest data from each individual session as well as the pretest and posttest data for combined data.

The means, standard deviations, *t*-values, and *p*-values of the pretest and posttest data from all four group sessions were calculated and displayed in a table. Furthermore, data was again combined according to intervention type and displayed in a separate table.

The data was reviewed to determine if there appeared to be any differences in SSMIS – SF scores within a single session and if there were any differences between all four sessions. The means of the combined pretest and posttest data of each group type were also reviewed to determine if there appeared to be a treatment effect according to intervention type.
Chapter IV: Results

The aim of the current thesis study was to determine if a focus on self-acceptance and the use of role-plays could decrease self-reported levels of self-stigma related to having a mental illness. Out of the 48 total participants who were present for the intervention sessions, 44 participants signed a consent form, or otherwise did not ask to withdraw their consent from a previous session, and then completed the SSMIS – SF before and after the session they were present for. The participation rate of all ITTP participants who attended the thesis study’s sessions was 91.67%. Three participants either only partially completed their SSMIS – SF or completed it incorrectly, leaving 41 of the originally submitted SSMIS – SF to be used for data analysis.

Visual Analysis

Scores for the SSMIS – SF are calculated by summing up the raw scores of each of the four individual subscales, resulting in four scores for the scale (Appendix I). As mentioned previously, the four subscales assess different aspects of mental illness stereotypes and stigma. The first subscale assesses one’s awareness of stereotypes, the second assesses one’s agreement with stereotypes, the third assesses one’s application of stereotypes, and the fourth assesses harm to self-esteem due to internalization. These subscales will be referred to as Awareness, Agreement, Application, and Harm, respectively, for brevity. The hypothesis anticipated for the scores of each of the subscales to decrease in score from pretest to posttest, with the exception of the Awareness subscale. Each participant’s scores were summed according to the subscale, and presented in bar graphs displaying pretest and posttest data.

The data from the two self-acceptance sessions were combined and the group mean data from all of the participants is displayed in Figure 1, which represents the mean scores of each subscale from both pretest and posttest measurements. There were overall decreases across all four subscales for the group sessions focusing on self-acceptance. The Awareness and Agreement subscales appear to both decrease the most between pretest and posttest scores.

![Figure 1. Combined SSMIS – SF pretest and posttest self-acceptance group session data, n = 23.](image-url)
The combined data from both role-play sessions also appeared to decrease across all four subscales between pretest to posttest measurements. This data can be seen in Figure 2. There appeared to be minimal changes between pretest to posttest in the Awareness and Agreement scales, while the Harm subscale appeared to have decreased the most.

Figure 2. Combined SSMIS – SF pretest and posttest role-play group session data, n = 18.

Following the combined data analysis, each individual session’s data was analyzed with a bar graph. The first session that was implemented focused on self-acceptance. During this session, 12 out of the 13 participants who arrived for treatment at ITTP that day signed a consent form and completed the SSMIS – SF. The data from pretest and posttest measurements can be seen in Figure 3, in which decreases in all four SSMIS – SF subscales were observed, with the largest decrease appearing to be in the Awareness subscale, though this was not the intended change in direction as participants would have been more aware of public stereotypes after intervention.
Figure 3. The SSMIS – SF pretest and posttest data for the first group session, which focused on self-acceptance, n = 12.

The second session that was implemented focused on role-playing. In this session, 12 out of 12 participants signed a consent form and submitted a SSMIS – SF. However, two of the submitted scales were partially incomplete and could not be included for data analysis. The remaining pretest and posttest data was compiled and displayed in Figure 4. Increases from pretest to posttest were observed in the Awareness and Agreement subscales while decreases were observed in the Application and Harm subscales. The Agreement and Application subscales appeared to equally change the most between pretest and posttest scores.

Figure 4. The SSMIS – SF pretest and posttest data for the second group session, which focused on role-playing, n = 10.
In the third session, self-acceptance was again the focus, and 12 out of the 14 present participants signed for consent and submitted a SSMIS – SF. However, one submitted scale had to be omitted from data analysis due to being incomplete. The remaining completed scales were compiled and displayed in Figure 5. Decreases across all four subscales were observed. The largest decrease seemed to be in the Agreement subscale while the smallest decrease seemed to be in the Awareness subscale.

In the fourth session, role-play was the focus and eight out of the nine participants that day signed for consent and submitted a SSSMIS – SF. The completed scales were compiled and the data displayed in Figure 6. Again, decreases across all four subscales were observed. The largest decrease appeared to be in the Harm subscale.

Figure 5. The SSMIS – SF pretest and posttest data for the third group session, which focused on self-acceptance, n = 11.
Figure 6. The SSMIS – SF pretest and posttest data for the fourth group session, which focused on role-play, n = 8.

Participants consistently scored higher on the Awareness subscale compared to other subscales when both individual and combined session data was visually analyzed. As well, noticeable decreases were observed in most subscales from pretest to posttest. Exceptions include increases in the Awareness and Agreement subscales during the second session, and the minimal overall changes of the Awareness and Agreement subscales of the combined role-play data. This is promising as the Awareness scale should have increased from pretest to posttest with the intervention. The visual analysis demonstrated that the majority of the data noticeably changed from pretest to posttest measurements. As a result, descriptive statistics and statistical analysis methods were used to further determine if a statistically significant change on any of the subscales occurred between pre and post-intervention.

**Descriptive Statistics and Statistical Analysis**

Descriptive statistics in the form of means and standard deviations were used to determine the quantitative changes across all subscales while paired t-tests were used to determine if any of those changes were significant. A paired t-test was used to compare each group session’s subscale’s pretest and posttest data. The confidence level was set to 95% for all paired t-tests.

The data from the self-acceptance group sessions were combined into one set to represent pretest and posttest data for self-acceptance sessions as a whole. The same was done to the data from the two role-play group sessions, and the means, standard deviations, t-values, and p-values for both data sets be found in Table 1.

In the self-acceptance group sessions, the Agreement mean decreased by 2.70 with a 0.89 increase in standard deviation, $t(22) = 2.32, p = 0.03$, which indicated a significant effect from pretest to posttest. For the combined role-play data, all changes in each subscale were nonsignificant.

The data from each individual sessions was also analyzed with descriptive statistics and statistical analysis. This data for all four sessions can be found in Table 2.
Table 1

Mean Scores, Standard Deviations, t-Value, and p-Value for Combined Data

<table>
<thead>
<tr>
<th>Data source</th>
<th>SSMIS-SF subscale</th>
<th>Pretest M (SD)</th>
<th>Posttest M (SD)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined self-acceptance groups</td>
<td>Awareness</td>
<td>29.57 (6.88)</td>
<td>26.87 (8.86)</td>
<td>1.62</td>
<td>0.12</td>
</tr>
<tr>
<td>n = 23</td>
<td>Agreement</td>
<td>15.87 (5.89)</td>
<td>13.17 (6.77)</td>
<td>2.32</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>Application</td>
<td>15.30 (7.34)</td>
<td>14.35 (7.29)</td>
<td>1.36</td>
<td>0.19</td>
</tr>
<tr>
<td></td>
<td>Harm</td>
<td>17.70 (8.99)</td>
<td>16.17 (7.87)</td>
<td>1.02</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Combined role-play groups | Awareness | 31.67 (9.81) | 31.61 (8.56) | 0.02 | 0.99 |
| n = 18 | Agreement | 15.33 (5.79) | 15.06 (7.78) | 0.18 | 0.86 |
| | Application | 14.83 (8.79) | 13.11 (8.09) | 1.51 | 0.15 |
| | Harm | 16.78 (9.63) | 14.67 (10.53) | 1.86 | 0.08 |

Note. Some participants were able to attend both types of group sessions.

Table 2

Mean Scores, Standard Deviations, t-Value, and p-Value for Individual Sessions

<table>
<thead>
<tr>
<th>Data source</th>
<th>SSMIS-SF subscale</th>
<th>Pretest M (SD)</th>
<th>Posttest M (SD)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1 self-acceptance</td>
<td>Awareness</td>
<td>29.50 (5.89)</td>
<td>24.50 (7.37)</td>
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<td>0.08</td>
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<td>n = 12</td>
<td>Agreement</td>
<td>14.67 (6.53)</td>
<td>12.92 (8.30)</td>
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<td></td>
<td>Application</td>
<td>15.75 (6.37)</td>
<td>15.25 (7.03)</td>
<td>0.63</td>
<td>0.54</td>
</tr>
<tr>
<td></td>
<td>Harm</td>
<td>19.67 (9.66)</td>
<td>17.50 (8.51)</td>
<td>0.88</td>
<td>0.40</td>
</tr>
<tr>
<td>Session 2 role-play</td>
<td>Awareness</td>
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<td>33.20 (4.76)</td>
<td>-0.46</td>
<td>0.66</td>
</tr>
<tr>
<td>n = 10</td>
<td>Agreement</td>
<td>16.20 (3.77)</td>
<td>17.80 (8.05)</td>
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<td>0.47</td>
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<tr>
<td></td>
<td>Application</td>
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<td>0.10</td>
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<tr>
<td></td>
<td>Harm</td>
<td>17.70 (9.32)</td>
<td>16.80 (11.15)</td>
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<td>0.63</td>
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<tr>
<td>Session 3 self-acceptance</td>
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<td>29.64 (8.13)</td>
<td>29.45 (9.94)</td>
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<td>0.92</td>
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<td>Application</td>
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<td>0.26</td>
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<td></td>
<td>Harm</td>
<td>15.55 (8.09)</td>
<td>14.72 (7.23)</td>
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<td>0.60</td>
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<tr>
<td>Session 4 role-play</td>
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<td>31.38 (11.89)</td>
<td>29.63 (11.87)</td>
<td>0.31</td>
<td>0.76</td>
</tr>
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<td>n = 8</td>
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<td>1.34</td>
<td>0.22</td>
</tr>
<tr>
<td></td>
<td>Application</td>
<td>13.50 (8.86)</td>
<td>12.25 (8.40)</td>
<td>0.56</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>Harm</td>
<td>15.63 (10.53)</td>
<td>12.00 (9.74)</td>
<td>3.07</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Note. Some of the participants in sessions 2, 3, and 4 were able to attend previous sessions.

In the first session, which focused on self-acceptance, each of the four subscales decreased in mean from pretest scores to posttest scores, but the effects were nonsignificant. In the second session, focusing on role-playing, the effects were also nonsignificant. As mentioned previously, an additional question was included in the SSMIS – SF asking whether
the participant had attended the previous group session for the current research project. Of the nine individuals who answered this question, four indicated that they attended the previous session while five indicated that they did not. It cannot be determined if this had an impact on the results as the study did not add a component of tracking individual participants as time restraints and confidentiality issues became barriers. This limitation applies to the rest of the sessions and will be discussed in detail later.

For the third session, which was a self-acceptance focused group session, the only significant difference was in the Agreement subscale, which decreased in both mean and standard deviation, by 3.73 and 0.07, respectively, \( t(10) = 4.96, p = 0.00 \). A total of 10 participants answered the question regarding attendance of a previous session. Of those responses, seven indicated that they attended a previous session while three answered otherwise.

In the last group session, focusing on role-play, the Harm mean decreased by 3.63 and the standard deviation decreased by 0.79, \( t(7) = 3.07, p = 0.02 \), which also indicated a significant effect between pretest and posttest scores. Of the five participants who answered if they attended a previous group session related to the current study, three answered yes while the other two answered no.

Overall, the statistical analysis for combined self-acceptance and role-play sessions demonstrated a significant difference only on the Agreement scale for the combined self-acceptance sessions. This result may suggest that, following the self-acceptance sessions, participants were less likely to endorse agreement with mental health stereotypes, though a higher repeated attendance rate may have affected the self-stigma reducing process. When analyzed by individual sessions, significant effects were seen for the Agreement subscale in the self-acceptance (third) session and for the Harm subscale in the role-play (fourth) session. However, as noted above, when the data was combined, this significant impact remained only for the reduction on the Agreement scale for self-acceptance sessions. This is likely because the reduction on the Harm scale during the second session (first role-play session) was minimal. Interestingly, while the remaining subscales did not demonstrate statistically significant changes, the obtained changes occurred in the desired direction of lower scores of self-stigma. It is possible that significant differences could have been found with a larger sample size.

In conclusion, the results partially support the original hypothesis that self-acceptance and role-play groups can reduce self-stigma of mental illness as the changes in SSMIS–SF scores occurred in the desired direction and there were some instances of significant changes. However, most results were nonsignificant and the Agreement subscale scores sometimes changed in the undesired direction. Limitations and suggestions for future improvement of this intervention will be discussed in the next chapter.
Chapter V: Discussion

Summary

As previously outlined, self-stigma is a serious potential consequence of having a mental illness or experiencing overall mental health issues. Self-stigma has been demonstrated to strongly correlate with several internal constructs, and it has been argued that the therapeutic process can be impaired, or completely interfered with, when individuals with mental illness experience self-stigma. The literature has found that self-stigma is a promising target for intervention, and that group settings, psychoeducation, self-acceptance approaches, and role-play approaches have had promising results in reducing self-stigma.

The current study sought to determine if self-stigma could be targeted and reduced by improving unconditional self-acceptance in participants while also using a role-play approach. The Self – Stigma of Mental Illness: Short Form (SSMIS – SF) was used for pretest and posttest measures with optional comments sections for participants to provide anecdotal feedback. The data was first visually analyzed in six bar graphs, which showed scores mostly changing in the preferred direction. The overall changes suggested that descriptive statistics and statistical analysis would be required to further analyze whether the effects were significant.

Significant changes were seen in the Agreement subscale for combined self-acceptance data, the Agreement subscale for the second self-acceptance (third overall) session, and in the Harm subscale for the second role-play (fourth overall) session. All other subscale changes from pretest to posttest, in both combined data and individual session data, were non-significant, though the changes did occur in the desired directions.

These results suggest that the hypothesis was partially supported in that the interventions had some, although limited, impact on self-stigma as assessed by the SSMIS-SF. However, the majority of changes were non-significant and the hypothesis cannot be completely confirmed by the present study. The strengths of this study, as will potential explanations for the non-significant findings, will be explored further below.

Comparison of Results to Existing Literature

Many of the articles and studies on self-stigma in the current literature explore its side effects and the relationship between self-stigma with different internal constructs. The treatment and reduction of self-stigma is a continuously growing field of research as understanding the phenomenon of self-stigma can facilitate and promote help-seeking behaviours and treatment adherence. While the current study did not demonstrate changes in all of the assessed areas, the intended directional changes does suggest that there was potential for this intervention to work.

Some participants commented on the optional feedback page regarding their satisfaction with the group sessions. While anecdotal, some participants commented that they enjoyed learning about different aspects of self-stigma, self-acceptance, and positive self-talk, which aligned with Alvidrez et al.’s (2008) comments on the usefulness of psychoeducation. Comments were generally favorable for the psychoeducation. For example, one participant wrote, “Great information and very helpful”. To answer the question of what they enjoyed about the group, one participant wrote, “Steph’s presentation, the group input”, suggesting that the psychoeducational portion of the session was favored. Further comments suggested that the psychoeducational portion was a useful component as some commented that the session, “Was informative” and, when answering the question on what they would change about the group, wrote “nothing”. There was some negative feedback for the psychoeducational portions, as one participant, who responded to the question of what to change in the session for the future, wrote, “Nothing really, maybe a handout on stigma and references (web or otherwise).” Another participant explained in detail that she found the session unhelpful, suggesting to, “Have it
provide specific strategies on how to problem-solve. More variety perhaps? The stigma definition was great and well-defined.” After several comments about the student researcher’s presenting skills, the participant concluded her comments with, “The content was well put-together even if it didn’t help me specifically.” Again, this feedback is anecdotal, but the comments suggest that psychoeducation was a relatively well received and considered a valuable aspect of the overall intervention to some participants, as Alvidrez et al. (2008) and Baiml et al. (2006) suggested about psychoeducation in their research. It is possible that the inclusion of psychoeducation laid a working foundation for further content in each session, which aligns with findings in the literature about the usefulness of psychoeducation in overall treatment.

The significant changes observed in the combined self-acceptance group data and the second self-acceptance group session (third overall session) suggests that this type of intervention may hold promise, which is consistent with the existing literature by Flett et al. (2003) and MacInnes and Lewis (2008) that suggests self-acceptance can reduce self-stigma. Moreover, the majority of participant comments suggested that they enjoyed these sessions and found them useful. For example, one wrote, “It made me realize how hard I am on myself and how it’s not healthy.” Another participant wrote, “Liked! Inspired me to break stigma habits, internalizing, and ‘I have vs. I am’”, the latter of which referenced the use of positive self-talk. However, a participant was dissatisfied with the session, commenting, “I felt the content was covering material that is commonly-known and was more like ‘Make something look prettier’. Positive affirmation is cliché and not enough to ‘fix’ me so I don’t find it useful.” This demonstrated that the self-acceptance approaches were not universally received well. Overall, however, it appeared that self-acceptance was both seen to be helpful to participants and that the data partially aligned with self-acceptance research in its efficacy for decreasing self-stigma.

Similar to the other studies reviewed that focused on role-play, the results were mostly non-significant. However, the current study did observe one significant change, and all non-significant changes were in the anticipated direction. Furthermore, as this is a relatively new field of study there is a limited amount of research available and particularly regarding treating self-stigma with role-playing. These limitations could have affected treatment efficacy because of the inability to utilize empirically sound methods. Participants, however, seemed to enjoy the role-play sessions, particularly due to the content encouraging everyone to participate and that it allowed participants to recognize the prevalence of mental illnesses in others. This is demonstrated by one participant writing that they liked that “everyone participated.” Another wrote, “I enjoyed this session because it was an eye opener to how to ‘communicate’ with people.” Finally, another participant wrote, “I liked the fact that you played the tape of celebrities that have mental illnesses,” referencing the use of recorded celebrity voice clips to generate discussion and facilitate a safe environment to discuss mental health. These comments suggest that despite a lack of change on the assessment tool, participants found the discussions and role-plays helpful in generating conversations and facilitating comfort in discussing mental health issues. However, one participant wrote negative feedback about the sessions, despite circling “yes” to “Did you find the group session helpful?” The participant wrote that she would change the group session to “only [have] one presenter,” referencing how both the student researcher and the supervising ITTP staff member were both present.

Out of all 32 participants who answered whether they found the sessions useful or not, 29 answered with “yes.” Specifically, 10 out of 12 in the first session found it useful, two out of two in the second session found it useful, nine out of 10 in the third group found it useful, and all eight responders found the fourth session useful.
The combination of using psychoeducation, self-acceptances approaches, and role-play approaches has not been explored in the current literature. The findings continue to support the use of psychoeducation and self-acceptance approaches, as posited in the literature, while strengthening the foundations that previous role-play studies have established for further research in this relatively new approach to self-stigma.

**Strengths**

A core strength of this research project is that it was the first one to utilize a combination of self-acceptance approaches with role-play to reduce self-stigma while previous research typically focused on one type of intervention. This study developed a working foundation for future research in this specifically combined field of treatment. As well, the research not only expanded upon the current research on self-acceptance literature, but it also partially supported the continued use of self-acceptance to treat self-stigma. Furthermore, the current study expanded upon the literature on role-play to treat self-stigma. As previously mentioned, this particular field of research is still relatively new, especially since the few studies found and reviewed had either non-significant results or focused only on social stigma over self-stigma.

Another strength of this study is that it can be easily replicated as there were minimal materials required other than participant handouts, a speaker to play the tape recordings, and a white board to write ideas and concepts, which may not even be required if group participants are content with only conversation. This is related to another strength of the intervention in that the focus was primarily on the processes occurring between participants rather than simply teaching and telling participants what to do.

Finally, if participants were accurate with their written feedback, it appeared that the interventions provided participants with more information about self-acceptance values and the techniques of how to communicate about mental illness as intended. It is hoped that participants will graduate ITTP with these skills in their toolbox as they transition back to their daily routines.

**Limitations**

One of the first limitations of this study was the time limit imposed by the ITTP daily agenda. Since participants were only at the agency for a few hours in the morning, time that was shared with other ITTP group facilitators, the group sessions for the current study were limited to only 1 hour, during which consent, pretest, and posttest measures had to be explained and collected. This reduced the amount of time available for the session content itself, which was noted by some participants. This is supported by one participant’s comment that suggested to, “Make it longer!” As well, another participant’s main complaints of the sessions included, “I wish we have more time to discuss stigma” and, if they could change anything about the sessions, they would include, “More opportunity for members of the group to discuss their ideas instead of moving on to the next session.” It was anticipated that the time limit would be a challenge for session implementation. However, agency staff stated that they have needed a group intervention on self-stigma for some time and would integrate this intervention into their typical schedule after the student researcher left.

Another time-related limitation was related to how long the student researcher was available at the agency. By the time the project was approved, there was only enough time left at the agency for the researcher to complete four sessions. It is possible that additional time to run more sessions could have collected enough data to demonstrate more significant results.

Another limitation was the small sample size. Only 44 participants signed consent forms and completed measurement scales across all four group sessions, averaging at about 11 participants per session. It is likely that larger sample sizes would have resulted in more...
significant results. As well, since measurement data was combined for all participants in a single session, data for repeating participants was mixed with participants who attended for the first time. This created a confound in which the researcher was unable to determine if changes were due to attending a single session or could be attributed to a practice effect from attending both sessions. Further, having some participants who attended both types of therapy made it difficult to obtain a comparison of the two interventions.

**Multilevel Challenges to Treatment Implementation**

There are barriers to service implementation within any mental health outpatient program, and the current research project met some such difficulties. These barriers can be found at the client level, the program level, the organization level, and the societal level of service implementation.

**Client Level.** There are various types of personal qualities which can interfere with the client experiencing the maximum benefits from being in the outpatient program. Different types of skills are taught and refined at the program, as well as opportunities to examine and brainstorm different solutions for a variety of problems. However, some clients are resistant to learning or trying new skills in their personal lives, or resistant to adapting habits to form more effective or beneficial ones. This resistance may or may not relate to having a specific mental illness, but it still interferes with a client’s ability to fully benefit from the program. Clients cannot be forced to adopt and apply the skills taught in programs, especially if the outpatient program is voluntary. One of the only options available for care providers when working with these clients is to remind them of the value of the taught skills and to highlight any damage being done by less adaptive behaviours.

**Program Level.** Despite the project intervention being voluntary, many clients may arrive and not actively participate in sessions due to a variety of factors. These factors can include large group sizes, group conversations being controlled by more extroverted clients, gender disproportions between the clients, not understanding the material, or having interpersonal difficulties with specific staff members. These various factors typically relate to the nature of group sessions, which creates barriers to the staff’s ability to provide treatment equally to all group members. These effects can sometimes be balanced out through the provision of one-to-one counselling sessions outside of group sessions, but these are only provided once a week for one hour, and not every program will have the resources available to provide this type of additional support.

**Organizational Level.** At a local hospital where the research project was conducted, there are multiple strict protocols in place regarding any research involving live human participants. While still achievable, it takes a great deal of time to go through the necessary routes in order to have a research project approved for implementation within hospital grounds. Due to miscommunication, the approval process of the present research study did not begin early enough time. However, through research regarding the qualifications surrounding studies that needed hospital ethics board approval, it was determined that the current study would not need to go through the typical channels of approval and research was able to begin immediately.

**Societal Level.** Clients dealing with mental health issues can face various issues in their personal lives outside of the program, including public stigma of mental illness. The literature posits that this public stigma is the cause of self-stigma, the focus of this research. The procedure was designed in a way to have the participants go home and complete the homework or process the information from one session before attending the next session. While data for individual participants was not tracked, it can be anticipated that longer histories of experiencing public stigma may have interfered with the study’s teachings about reducing self-stigma. As
such, societal issues regarding stigma may continue to pose an issue for any self-stigma research, particularly outpatient research.

**Implications for the Behavioural Psychology Field**

As previously outlined, this study contributed to the field of self-stigma by expanding on the research currently available for the use of self-acceptance approaches and role-play. While the results of the current study only partially supported the hypothesis that these approaches can reduce self-stigma, they still contribute to the overall literature and even help fill the gap left by a lack of research for role-plays with stigma. Furthermore, the supervising ITTP staff member of this project found use for the content as her role as a behavioural science technician. There is value of this research in the behavioural psychology field as targeting self-stigma can reduce the impact it has on other aspects of a person’s life, such as increasing engagement in more meaningful and fulfilling behaviours. From a behavioural perspective, it can be argued that counselling individuals with mental illnesses may need to first target self-stigma if it interferes with or causes avoidance of meaningful treatment seeking behaviours. The field of behavioural psychology aims to improve lives by making appropriate changes in people’s behaviours to be more meaningful or adaptive. Therefore, targeting any unhelpful and interfering constructs, especially self-stigma, would be the first step in the therapeutic process for many.

**Recommendations for Future Research**

The first recommendation for future research would be to increase the amount of time allotted for the study. Time was a considerable limitation for this study, both within a single session and for the total number of sessions allowed. It is suggested that at least 1 hour and 30 minutes be allotted for future sessions in order to leave adequate time to complete any measurement scales and for any discussions between group participants, which can provide the added benefit of building rapport between members. As well, running the group sessions multiple times instead of two times each would likely increase the chances of observing significant results, although this would require multiple groups of participants if the format of two group sessions is kept the same.

The second recommendation is to keep group participants the exact same for both sessions. Even if the sessions are repeated to collect more data, the participants should remain the same for each set of group sessions (one self-acceptance session and one role-play session). The open intake model of ITTP may have confounded treatment efficacy since the attendance for each session was completely unique each time due to the combination of repeating participants and participants who are attending for the first time. Maintaining the same participants for both sessions may help reduce potential confounding errors as it could not be determined if repeating sessions had an impact on the results, and therefore future studies should add a component of tracking individual participants. Furthermore, it may also be beneficial for treatment efficacy purposes to divide participants into two treatment conditions and for each to receive either the self-acceptance treatment or the role-play treatment. This implementation format and a comparison of therapies may yield further insight into which approach can be more effective for reducing self-stigma.

Finally, a larger sample size would increase the statistical power and, consequently, the chances of achieving significant results. Therefore, it is recommended that the sessions be run at different agencies and at different times throughout the year. This would allow for researchers to constantly find new participants as people cycle through different health care services throughout the year. As well, the material is portable since handouts and a tape recorder are the only required materials and that the focus of intervention was to present a process group rather than an information group.
Conclusion

This thesis sought out to determine whether the use of self-acceptance approaches and role-playing could reduce levels of perceived self-stigma in participants with a mental illness. In a group setting, participants of an outpatient hospital program participated in intervention sessions and completed pretest and posttest measures of self-stigma. The changes in scores were mostly nonsignificant but were in the desired change in direction. Significant changes were found in the combined self-acceptance session data for the Agreement with common stereotypes subscale, in the second individual session for self-acceptance (or third overall individual session) for the Agreement subscale, and in the second individual session for role-playing (or fourth overall individual session) for the Harm to self-esteem subscale. This study had limitations to its implementation, but expanded upon the current literature for both intervention types and its use for reducing self-stigma, arguably one of the most damaging aspects of having a mental illness. Future research may help refine this intervention for better practical use and further contribute to the field of behavioural psychology.
References


Appendix A: Informed Consent Form

Consent Form

TITLE: Using Role-Play and Promotion of Self-Acceptance to Reduce Mental Illness Self-Stigma in a Group Setting

STUDENT: Stephanie Wu

COLLEGE SUPERVISOR: Dr. Yolanda Fernandez

INVITATION
You are invited to participate in a research study. I am a 4th year student in the Behavioural Psychology program at St. Lawrence College and I am currently on school placement at Kingston General Hospital. As a part of this placement, I am doing a special project called an applied thesis and am asking for your help to complete this project. The information in this form is to help you understand my project so that you can decide whether you want to participate. Please carefully read the information below and ask any the questions you have before you decide to participate.

WHAT IS THE PURPOSE OF THE STUDY?
My project is to see if promoting self-acceptance and drama therapy delivered in a group setting are effective at reducing feelings of self-stigma in participants dealing with mental illness. Self-stigma is when public prejudice and discrimination becomes how a person views themselves. I will use tools to measure levels of self-stigma. Using these tools before and after giving group therapy to participants will show if these interventions are effective at reducing self-stigma in this group. I am also hoping to compare the two interventions to see if one is more effective than the other. This information can help other people who experience self-stigma because it can determine if intervention is effective and if so, which style of therapy works best.

WHAT WILL YOU NEED TO DO IF YOU TAKE PART?
If you decide to take part in this study, you will be a part of a group therapy session. The session will be 1 hour long. You also have to complete two questionnaires, one before and one after the group session, to see what kind of effects the session had on you. This questionnaire is called the Self-Stigma of Mental Illness Scale – Short Form and is used to measure levels of self-stigma as reported by the person completing the form.

WHAT ARE THE POTENTIAL BENEFITS TO ME OF TAKING PART?
Benefits of taking part in this study may include lowering your levels self-stigma. Additionally, you might also have a better understand of what self-stigma is and how it affects people. It is hoped that some positive changes that can occur may include feeling happier or having more satisfaction with yourself.
What are the possible disadvantages and risks of taking part?

It is possible that the topic of self-stigma and other activities in the session will make you feel uncomfortable. It might even cause some emotional distress.

What happens if something goes wrong?

Participants vary from each other, so it is hard to tell what kind of effect the therapy will have on you. However, if something did go wrong, such as you being upset or worried by the therapy, you are encouraged to talk to the KGH staff member who is helping me run the group session. Participation is voluntary and you may choose to not engage with the rest of the group for the remainder of the group session. You may also choose to not give your questionnaire back, even if you signed the consent form already.

Will my taking part in this project be kept private?

Unless required by law, we will keep your information confidential. Identifying information, including your signed consent form, will be kept confidential under KGH’s strict procedures in securing identifying information. The consent forms will be kept in a secure, locked cabinet in the ITTP office for a minimum of 10 years. You will be given a code for the researchers to identify you. This ensures that any and all data collected from you that will be used in the research report will not be able to personally identify who you are. No identifiers, including your name, will be used in any reports, publications, and presentations that come from this research project. All data used will be group data, not individual data. All data will be transcribed into electronic form, again in a non-identifying way, and protected with an electronic password. This data will be kept by the student researcher for a period of 7 years. Hard copies of forms will be destroyed.

Do you have to take part?

It is your choice to take part in this research study. It is completely up to you and we will accept either decision. If you decide to take part in the study, you will need to sign at the end of this consent form. However, you are still free to stop participating in the study at any time, even without giving a reason. You will not be punished or experience any negative impact from me or my research team if you decide to not participate in the study. You are still allowed to participate in the group session even if you decide to not be a part of the study. You may also ask for your data to not be used in the research at any time.

Contact for further information.

This project has been reviewed by the Research Ethics Board at St. Lawrence College. The project will be completed under the supervision of Dr. Yolanda Fernandez, my supervisor from St. Lawrence College. I appreciate your help and if you have any other questions or concerns, feel free to ask me at swu27student@sl.on.ca. You can also contact Jessica Lankmann at 613-549-6666 ext. 7604 or at lankmanj@kgh.kari.net, or you can contact Dr. Yolanda Fernandez at 613-449-0081 or at Yolanda.fernandez@csc-scc.gc.ca. You may also contact the St. Lawrence College
Research Ethics Board at reb@sl.on.ca.

CONSENT
If you agree to participate in the project, please complete the following form and return it to me as soon as possible.
CONSENT

By signing this form, I agree that:

- The research project has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits (if any) of this project have been explained to me.
- I understand that I have the right not to participate and the right to stop participating at any time.
- I am free now, and in the future, to ask any questions about the research project.
- I have been told that my personal information will be kept confidential.
- I understand that the results of this project may be published or presented in a professional forum.
- I understand that no information that would identify me will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.
- I understand that the data from this study will be presented at the St. Lawrence College Behavioural Psychology Poster Gala, and may be reported at other conferences or published in a scientific journal. No identifying information will be included in these reports.

I hereby consent to participate.

Participant Printed Name: ______________________
Signature: ______________________ Date: ________

SLC Student Signature: ______________________ Date: ________
Printed Name: _______________________________
Witness: ___________________________ Date: ________
Printed Name: ___________________________
Appendix B: Modified Self-Stigma of Mental Illness Scale – Short Form

Self-Stigma of Mental Illness Scale – Short Form (SSMIS – SF)

SSMIS-SF: Before Session

Have you attended the self-stigma group session before?   Yes/No

Today’s Date ______________

The public has believed many different things about persons with serious mental illnesses over the years, including some things that could be considered offensive. We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental illnesses at the present time. Please answer the following items using the 9-point scale below.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>Neither agree nor disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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<td>3</td>
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<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Section 1:

I think the public believes…

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.
Section 2:

Now answer the next 5 items using the agreement scale.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>Neither agree nor disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>7</td>
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</tr>
</tbody>
</table>

I think…

1. _____ most persons with mental illness are to blame for their problems.

2. _____ most persons with mental illness are unpredictable.

3. _____ most persons with mental illness will not recover or get better.

4. _____ most persons with mental illness are dangerous.

5. _____ most persons with mental illness are unable to take care of themselves.

Section 3:

Now answer the next 5 items using the agreement scale.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>Neither agree nor disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>6</td>
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<td>7</td>
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</tbody>
</table>

Because I have a mental illness…

1. _____ I am unable to take care of myself.

2. _____ I will not recover or get better.

3. _____ I am to blame for my problems.

4. _____ I am unpredictable.

5. _____ I am dangerous.
Section 4:

Finally, answer the next 5 items using the agreement scale.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>Neither agree nor disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>7</td>
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<td>9</td>
</tr>
</tbody>
</table>

I currently respect myself less…

1. _____ because I am unable to take care of myself.

2. _____ because I am dangerous.

3. _____ because I am to blame for my problems.

4. _____ because I will not recover or get better.

5. _____ because I am unpredictable.
Self-Stigma of Mental Illness Scale – Short Form (SSMIS – SF)

SSMIS-SF: After Session

The public has believed many different things about persons with serious mental illnesses over the years, including some things that could be considered offensive. We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental illnesses at the present time. Please answer the following items using the 9-point scale below.

I strongly disagree    I strongly agree
Neither agree nor disagree

1  2  3  4  5  6  7  8  9

Section 1:

I think the public believes…

1. _____ most persons with mental illness are to blame for their problems.

2. _____ most persons with mental illness are unpredictable.

3. _____ most persons with mental illness will not recover or get better.

4. _____ most persons with mental illness are dangerous.

5. _____ most persons with mental illness are unable to take care of themselves.
Section 2:

Now answer the next 5 items using the agreement scale.

I strongly disagree
Neither agree nor disagree
I strongly agree

1  2  3  4  5  6  7  8  9

I think…

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

Section 3:

Now answer the next 5 items using the agreement scale.

I strongly disagree
Neither agree nor disagree
I strongly agree

1  2  3  4  5  6  7  8  9

Because I have a mental illness…

1. _____ I am unable to take care of myself.
2. _____ I will not recover or get better.
3. _____ I am to blame for my problems.
4. _____ I am unpredictable.
5. _____ I am dangerous.
Section 4:

Finally, answer the next 5 items using the agreement scale.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>Neither agree nor disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

I currently respect myself less…

1. _____ because I am unable to take care of myself.

2. _____ because I am dangerous.

3. _____ because I am to blame for my problems.

4. _____ because I will not recover or get better.

5. _____ because I am unpredictable.
Did you find the group session helpful?  Yes / No

What did you like/not like about this group session?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
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What would you change about the group session?

__________________________________________________________________
__________________________________________________________________
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Comments, Thoughts, and Feedback on the Group Session:

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Appendix C: Facilitator Notes for Self-Acceptance Group Session

Mediator Notes for Group Session on Improving Self-Acceptance to Reduce Self-Stigma

Part 1: Overview of Thesis Project

Good morning. As some of you know, I am completing my 4th year in a degree for behavioural psychology at St. Lawrence College. As part of this degree program, I have to complete a thesis, or a project, in order to graduate. For that thesis project, I have decided to do a group session on self-stigma of having a mental illness.

The data I am collecting is about how people perceive self-stigma of having a mental illness. The data is measured with a measurement scale on self-stigma. If you want to participate in my thesis project by completing this measurement, I need to have you complete a consent form. It is required by St. Lawrence College to collect written consent if I collect any data from people.

I have passed around both the consent form and the measurement scale. In the consent form, I have outlined that I am trying to see what is effective in lowering self-stigma about having a mental illness. To participate in this project, all you would need to do is participate in this group like you would for other group sessions here at ITTP. Those who sign the consent form will also need to complete that self-stigma measurement scale before and after the group session so that I can see if there were any changes during this group. Like with other groups in ITTP, you will get the chance to learn about something new and hopefully learn to apply to yourselves to lower any self-stigma you might have.

There is a chance that this topic might be upsetting for some people, so if you find yourself becoming upset by what we talk about, you are free to stop actively participating in the session and simply observe the group for the remainder. If you have any concerns, you can always talk to me or ITTP staff at any point now, during the group session, or after the group session.

People are affected by self-stigma to different degrees. However, regardless of where you stand in terms of self-stigma, any data I get back from any of you will help me a lot.

Again, participating is completely voluntary, but if you decide to sign the consent form, please know that the forms will be kept safe and locked up in KGH. Any information that I take outside of the hospital will be anonymous, coded, and password secured.

With the measurement scale, it is repeated twice for before and after the group. Please only fill in pages 1 through 3 for now. The rest will be filled after the group session. Having the Before and After data helps me see what kind of a difference the group had on you, but if at the end of group you don’t feel like filling out the “After” scale, you don’t have to. It is up to you.

Part 2: Psychoeducation on Stigmatization

Does anybody know what stigmatization is?

(Leave a pause for participants to respond.)

It has a Greek origin, where the word “stigma” referred to a visible mark, like a tattoo, on people from a “different” group, which could have meant anything other than what was “normal”. Nowadays, stigmatization is a word that has a more psychological meaning. It is not as visible. It is actually internal, and covers many different social terms.
There are three different ways that we develop images and ideas of people before we meet them or get to know them. Those pre-concepts typically come from traits, real and imagined, of whatever social groups they belong to.

1. Stereotyping – people of a certain group are viewed a certain way, with certain attributes, they are not necessarily negative views, but they are applied to an entire group of people. The blanket of the stereotype is thrown over everyone in that group. Ex: All Canadians say “eh”.

2. Prejudice – these are more negative, emotionally backed judgements of others before someone meets them because of whatever social group they belong in. Thoughts and ideas about a person are created before they actually get to know them. Ex: In the past, when mental illness was not as well understood as it is today, people might have had a prejudice against individuals with mental illness and believed all people with a mental illness need to be locked up.

3. Discrimination – active behaviours that interfere, limit, or reduce other’s progress or livelihood because they are part of a certain group. Ex: Continuing the example for prejudice, a discriminative behaviour included people actually locking up people with a mental illness.

To review, stereotyping is a blanket view of a group of people that may or may not be negative, prejudice is a negative blanket view, and discrimination is active negative behaviour.

Any questions so far?
(Leave a pause for participants to respond.)

Stigma is considered a combination of these factors. Stigma can happen to anyone in any situation for any reason and is considered a combination of all of these. Erving Goffman, a Canadian sociologist, did the most influential work about stigma and he was a pioneer in figuring out what stigma meant, what stigma was, and how it affected people. He defined it as “The phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute. Stigma is a process by which the reaction of others spoils normal identity.” Basically, this means that when someone has a trait or characteristic that is viewed in a bad way by others, that person can be socially rejected.

Goffman identified categories of social stigma, and these can be found in detail in his book called “Stigma: Notes on the Management of Spoiled Identity”:

- Physical (overt or external difference)
- Personal (person traits that deviate from societal norms)
- Societal (an ethnic group, nationality, or religion that is not that society’s norm)

Would anybody like to guess what each of these types describe? Or give an example of what you think might fit into these categories? Examples of groups with stigma include race, ethnicity, nationality, sexual orientation, gender identity, physical attributes or disabilities, being a single parent, having a disease like HIV/AIDS, having a low income, education level, being homeless, religion, ideologies, and having a mental illness.

(Use the following questions to generate discussion among the group participants). Any questions or comments? Do you guys think social stigma of mental illness exists? Have you
experienced it or seen it happen to others? What about yourself? Do you think it’s possible to stigmatize yourself?

Like it was mentioned before, stigma is a combination of stereotyping, prejudice, and discrimination. However, it goes one step beyond because it has the potential to become internalized. What this means is that everything we talked about before is about social stigma, which is the kind of stigma that occurs between people. Self-stigma is when someone hears something stigmatizing about the minority group they belong to, and then they apply those negative thoughts to themselves.

For example, someone who has depression is walking down the street and overhears two people talking about a co-worker. “Did you hear that Jenny is still not coming back to work? Apparently she’s depressed or something. If you ask me, that’s just an excuse to get paid time off of work. She should just get over her depression already and come back to work. Everyone all get sad sometimes, but we manage just fine.” It’s possible that the person walking by feels like these attitudes apply to them, and they start feeling shame and guilt about having depression, and having thoughts like, “I need to go back to work too. I shouldn’t feel this way. Why can I just get over it?”

What are other self-stigmatizing statements that the person might be thinking?

Self-stigmatizing thoughts can include

- “I’m weak.”
- “I should just get over this.”
- “I should be stronger than this.”
- “I am better than this.”

(Use the following questions to generate discussion among the group participants). Do you think self-stigma is real? Does anybody feel like they sometimes have self-stigmatizing thoughts? Does anyone have a coping method they would like to share?

**Part 3: Self-Acceptance**

A way to battle self-stigma can be to learn or improve self-acceptance. Self-acceptance is the ability to unconditionally accept who you are no matter what. It is the idea that accepting who you are is not conditional or dependent on other things or other people. Examples of conditional self-acceptance is if you only find yourself worthy only if you meet a criteria first, such as excelling on a test, setting goals that are unrealistic in reality, and if one gains other people’s acceptance first. Unconditional self-acceptance is to accept that you are you in this very moment in time, and you are just fine the way you are.

Research has been done that shows that people with higher levels of unconditional self-acceptance react less to negative feedback and are more objective when getting evaluated for a personal performance, such as a presentation.

Has anyone ever gotten feedback on something they did and felt like it was an attack on them? For example, “that presentation you made was great but you talked just a bit fast” and all one can think about is how they messed up by talking to fast and it is all they think about. When
you improve self-acceptance, you are able to look objectively at feedback and your own reactions as ways to improve, not as problems with you as a person.

Overall, self-acceptance has also been associated with better self-esteem, being more satisfied in how you interact with others and regulating moods better. It is nice to see so many reasons why unconditional self-acceptance is fantastic, but that is easier said than done. It would be nice to know how to go about this.

**Part 3b: Positive Self-Talk**

One way to improve self-acceptance is to understand that mental illness lies on a continuum of health. Just as someone have high blood pressure while still being generally healthy, someone can have great mental health while having a mental illness.

Do not think of it as managing a diagnosis. Mental illness is just as real as physical illness, but when people are physically ill, they do not become their illness. For example, people can develop lung cancer because they smoked their whole lives, because it is genetic, or both. Mental illness can emerge due to genetics, a specific situation in our lives, or both.

An illness, physical or mental, comes with a particular set of problems that need regulation, but it does not have to be one’s sole identity.

Has anyone used or heard someone else use the phrases “You are a depressed person” or “I am borderline.” This is incorrect. “You have depression” and “I have borderline personality disorder.”

You are not your diagnosis. You would not hear someone say “You are high cholesterol” or “I am diabetes”. Using a diagnosis in a sentence like “I am” or “They are” makes the diagnosis a label. Labels put us into categories. The way we say it, the language and the vocabulary we use, is so important to how we express what we are going through. You are not your label. You are not your diagnosis.

You might ask, then, why do we get a diagnosis in the first place because that already “labels” us. Well, knowing the term that helps describe the symptoms and problems you are experiencing helps health care providers better understand and plan the best type of treatments for you. Say someone broke his or her leg. The emergency team would pass on the information that they have a broken bone and the doctors and nurses would be able to treat it accordingly. They would not just start giving a heart transplant.

In the same way, we have a diagnosis to help teams of care providers help you better. There should be a distinction made, however, that you can sometimes feel an emotion that is also a diagnosis. There is a difference though. For example, sometimes people will suddenly feel scared or anxious and think “I am anxious right now”, and maybe they have an anxiety diagnosis. However, understanding that it was just the feelings in the moment is different from thinking that that feeling is their constant identity. People can feel anxious or depressed in a moment in time, but this is different than believing their identity is solely his or her diagnosis.

A trick to understanding which is which is to see if saying “I am anxious right now” can be replaced with “I feel anxious right now”.
As stated before, people can and will feel different emotions for whatever reason. It could also be for no reason. But has anyone ever had a moment where they felt a certain way and then got angry, ashamed, or guilty because of it? (Leave a pause for participants to respond.) How did those feelings affect the original emotion you were experiencing?

**Part 3c: Mindfulness**

An important aspect of self-acceptance is mindfulness. Mindfulness is the ability to pay attention to how you are feeling in a moment of time, and to pay attention both openly and without judgement. Mindfulness has been shown to help self-acceptance and can help stop the thought process of thinking about “Why do I have this illness” and worries about the future.

Mindfulness is also the ability and willingness to let other’s see you for you, your true self, without needing to change yourself or be concerned about judgements from others. Mindfulness is thought to work because it focuses on two things:

1. First, people tend to ruminate, or frequently think about over and over, on negative thoughts, like worrying about the past or future. Mindfulness helps people identify and let go of those persistent thoughts.

2. Second, mental and physical relaxation can help bring you to pay attention to the present moment and bring thoughtful focus to what you are experiencing in the moment.

This works because mindfulness has four components: being present and not ruminating about things from the past, being nonjudgmental about oneself, becoming more aware of present experiences, and looking at the world with “the beginner’s mind”, which is to pretend that you are experiencing something for the first time and simply observing it with innocent curiosity.

Other people have stated that mindfulness works because since you are concentrating so hard on the present moment and what you are experiencing right now, it is hard to also think about what was bothering you. You can use psychical mindfulness as a grounding technique to bring yourself back to the present moment by concentrating on what your senses are experiencing in the current moment, such as how your clothes feel against your skin, what noises you can hear, and thinking in detail about what you see.

Then after coming back, cognitive, or thinking, mindfulness involves nonjudgmentally looking at what negative emotions and thoughts you felt, and recognizing that it was a part of a very human experience. There is nothing wrong about feeling emotions. We are only human. The idea is that your mind should be flexible and open to the idea of actively and simply noticing what is happening both around you and in your mind. It is about viewing objects and situations from other perspectives and shifting your perspective depending on the context. This comes back to self-acceptance because mindful attention is on accepting and exploring the present moment instead of self-evaluating and self-criticising.

For example, say someone is suddenly feeling very anxious, and they start thinking “Oh great, not again. Why do I always have to feel like this? I’m so stupid to feel anxious.”

Being mindfully aware of one’s physical state will help ground them in the present moment to bring them back, and then mindfully approaching the thoughts can stop the person from having more bad feelings.
An example of mindful thoughts could include, “I feel anxious, but that’s okay. This feeling will pass, as it has before, and I will be okay. I do not have to be upset because it happened. It happened, and it’s uncomfortable, but I will be okay.”

Finally, we all make mistakes. A huge part of self-acceptance is to accept past mistakes. They happened, and sometimes bad things occurred because of it, but we cannot change the past. You can accept past mistakes by seeing them as learning opportunities. There is a lesson hidden in every mistake and it presents the potential for you to grow as a person if you look at it and examine it with the appropriate perspective. Making mistakes means that you were willing to go into the situation even if the outcome was uncertain. “It’s better to have tried and failed than to never have tried at all”, and this is especially true because mindfulness says that making mistakes provides new knowledge of the situation, motivation to change what did not go as planned, and a chance to teach others in the same situation a valuable lesson.

Let’s go through this worksheet I made for mindfulness. (Give participants the Mindfulness and Positive Self-Statements Record and explain how it works. Ensure to give participants a chance to ask questions.)

**Part 4: Close, and Completion of SSMIS - SF (Posttest)**

I will also give everyone a handout to summarize everything we talked about today. (Give participants the Stigma of Mental Illness and Self-Acceptance handout). To summarize, stigmatization can affect a lot of different people in a lot of different ways, but self-stigma is the first step because there are so many reasons to unconditionally accept who we are. We are not our diagnosis. We have a mental illness. When things go wrong, don’t get angry or upset at yourself. Observe what is happening and look at it as a way to improve how you are.

Finally, I will end this group session with a quote to strengthen the ideas of self-acceptance that I have covered today:

“Today you are you. That is truer than true. There is no one alive, Who is Youer than You.”  
– Dr. Seuss

Thank you for participating in my thesis project. If you completed a measurement scale before the group session, you now have the opportunity to complete the second one if you would like to. Otherwise, please enjoy the rest of your day.

**References:**


Appendix D: Self-Acceptance Group Session Participant Handouts

Stigma of Mental Illness and Self-Acceptance

What is stigma?

In essence, stigma is when a person is given a label that sets them apart from others in a negative way. At the core, stigma is a combination of three social factors that relate to seeing people who are different than us:

1. Stereotyping: Seeing a group of people by traits that can be positive or negative, but usually over-exaggerate what is actually true. Ex: All Canadians say “Eh?”
2. Prejudice: Seeing a group of people by negative traits that are not always true or over-exaggerate the truth. Ex: People who eat meat clearly do not care about animals.
3. Discrimination: Actively behaving in a negative way towards people because of negative views that may not actually be true. Ex: A talented girl soccer player wants to play for the boys’ soccer team but the coach refuses that she attends tryouts because she is a girl.

Stigma involves all of the above and can be seen as two subtypes: social stigma and self-stigma. Social stigma comes from others and can be about a number of things, such as race, ethnicity, sexual orientation, physical disabilities, being a single parent, education level, being homeless, religion, and having a mental illness. These can be divided into three categories:

1. Physical stigma of a visible, physically different trait.
2. Personal stigma of character traits that are seen as bad or not normal.
3. Societal stigma of being in a social minority group.

Self-stigma is when a person in a minority group is exposed to social stigmas and then applies those negative views to themselves. People who have a mental illness can sometimes feel like other people’s opinions are true and see themselves in that negative way.

Examples of negative self-statements that can come from self-stigma of a mental illness:

- “I am weak.”
- “I should just get over this.”
- “I should be stronger than this.”
- “I am better than this.”

Self-stigma affects people’s self-esteem, lowers their sense of hope and empowerment, and increases general stress. But how does someone lower their self-stigma?

Self-Acceptance

Self-acceptance is the ability for someone to unconditionally accept who they are no matter what. It is about accepting oneself without over-evaluating others’ opinions or perceptions, as well as other external factors. Conditional self-acceptance is only accepting oneself if, for example, a person gains other’s approval first or they must attain something first. Unconditional self-acceptance is about accepting yourself by recognizing that you are perfectly fine with the way you currently are.

Unconditional self-acceptance allows people to react less to negative feedback, objectively look at evaluations, have better self-esteem, regulate moods better, and have more satisfaction in how one interacts with others.

Ways to Increase Self-Acceptance

Positive Self-Talk

Mental illness lies on a range of overall mental health. Just as someone who has high blood pressure can still be considered generally healthy, someone who has depression can still have...
generally good mental health. Having a mental illness does not have to be one’s identity. A person is not a mental illness, but they have a mental illness. Look at these statements:

- “I am depressed.”
- “I am diabetes.”

- “I have depression.”
- “I have diabetes.”

The statements on the left are labeling statements and identify the person as their condition, when on the right, the statements mean something different.

**Mindfulness**

Mindfulness is an important aspect of self-acceptance. It is the process of paying attention to what you are experiencing, both physically and mentally, without judging yourself for what you feel. Physical mindfulness can be used as a grounding technique that allows you to focus on the here and now and stay connected with the present moment. Cognitive mindfulness, or mental mindfulness, is allowing yourself to be curious about your thoughts and feelings and examining them without criticizing or judging yourself. Mindfulness is also reminding yourself that thoughts and emotions are a part of human nature and it is okay to sometimes feel anxious, sad, afraid, or angry. It is also about viewing objects and situations from other perspectives and shifting your perspective depending on the context. Finally, we all make mistakes, and mindfulness helps remind people that it is okay to not be perfect because at least you can say you tried and learned something from the experience.

*Today you are you. That is truer than true.*

*There is no one alive, Who is Youer than You.*  - Dr. Seuss
### Mindfulness and Positive Self-Statements Record

<table>
<thead>
<tr>
<th>Negative Self-Statement</th>
<th>Evidence For</th>
<th>Evidence Against</th>
<th>Positive Self-Statement (What is a positive alternative to this negative thought?)</th>
<th>Acceptance/Mindful Observation (What can I do to accept the thoughts I am having?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>I spent all day at home and got nothing done. I am useless.</em></td>
<td><em>I only got through three things on my To-Do list for today. I spent the rest of the day watching TV.</em></td>
<td><em>Those three tasks took a long time to finish. They were important tasks that I needed to get done today. I am allowed to reward myself with TV.</em></td>
<td><em>I got some chores done. I still have tomorrow to get the rest of my tasks finished. I am not useless. I am capable.</em></td>
<td><em>I felt useless but just because I feel this way it doesn’t mean it’s true.</em></td>
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Appendix E: Facilitator Notes for Role-play Group Session

Mediator Notes for Group Session on Introducing and Using Role-play to Reduce Self-Stigma

Part 1: Overview of Thesis Project

Good morning. As some of you know, I am completing my 4th year in a degree for behavioural psychology at St. Lawrence College. As part of this degree program, I have to complete a thesis, or a project, in order to graduate. For that thesis project, I have decided to do a group session on self-stigma of having a mental illness.

The data I am collecting is about how people perceive self-stigma of having a mental illness. The data is measured with a measurement scale on self-stigma. If you want to participate in my thesis project by completing this measurement, I need to have you complete a consent form. It is required by St. Lawrence College to collect written consent if I collect any data from people.

I have passed around both the consent form and the measurement scale. In the consent form, I have outlined that I am trying to see what is effective in lowering self-stigma about having a mental illness. To participate in this project, all you would need to do is participate in this group like you would for other group sessions here at ITTP. Those who sign the consent form will also need to complete that self-stigma measurement scale before and after the group session so that I can see if there were any changes during this group. Like with other groups in ITTP, you will get the chance to learn about something new and hopefully learn to apply to yourselves to lower any self-stigma you might have.

There is a chance that this topic might be upsetting for some people, so if you find yourself becoming upset by what we talk about, you are free to stop actively participating in the session and simply observe the group for the remainder. If you have any concerns, you can always talk to me or ITTP staff at any point now, during the group session, or after the group session.

People are affected by self-stigma to different degrees. However, regardless of where you stand in terms of self-stigma, any data I get back from any of you will help me a lot.

Again, participating is completely voluntary, but if you decide to sign the consent form, please know that the forms will be kept safe and locked up in KGH. Any information that I take outside of the hospital will be anonymous, coded, and password secured.

With the measurement scale, it is repeated twice for before and after the group. Please only fill in pages 1 through 3 for now. The rest will be filled after the group session. Having the Before and After data helps me see what kind of a difference the group had on you, but if at the end of group you don’t feel like filling out the “After” scale, you don’t have to. It is up to you.

Part 1: Psychoeducation on Stigmatization

“Does anybody know what stigmatization is?”

(Leave a pause for participants to respond.)
There are three different ways that we develop images and ideas of people before we meet them or get to know them.

1. Stereotyping – people of a certain group are viewed a certain way, with certain attributes, they are not necessarily negative views, but they are applied to an entire group of people. The blanket of the stereotype is thrown over everyone in that group. Ex: All Canadians say “eh”.

2. Prejudice – these are more negative, emotionally backed judgements of others before someone meets them because of whatever social group they belong in. Thoughts and ideas about a person are created before they actually get to know them. Ex: In the past, when mental illness was not as well understood as it is today, people might have had a prejudice against individuals with mental illness and believed all people with a mental illness need to be locked up.

3. Discrimination – active behaviours that interfere, limit, or reduce other’s progress or livelihood because they are part of a certain group. Ex: Continuing the example for prejudice, a discriminative behaviour included people actually locking up people with a mental illness.

To review, stereotyping is a blanket view of a group of people that may or may not be negative, prejudice is a negative blanket view, and discrimination is active negative behaviour.

Stigma is considered a combination of these factors. Stigma can happen to anyone in any situation for any reason and is considered a combination of all of these.

Erving Goffman, a Canadian sociologist from the 1960’s, identified categories of social stigma:

- Physical (overt or external difference)
- Personal (person traits that deviate from societal norms)
- Societal (an ethnic group, nationality, or religion that is not that society’s norm)

(Use the following questions to generate discussion among the group participants). What have you heard others say about mental illness? What have you said about yourself or to yourself because of mental illness?

Like it was mentioned before, stigma is a combination of stereotyping, prejudice, and discrimination. However, it goes one step beyond because it has the potential to become internalized. What this means is that everything we talked about before is about social stigma, the kind of stigma that occurs between people. Self-stigma is when someone hears something stigmatizing about the minority group they belong to, and then they apply those negative thoughts to themselves.

Self-stigmatizing thoughts can include

- “I’m weak.”
- “I should just get over this.”
- “I should be stronger than this.”
- “I am better than this.”

(Use the following questions to generate discussion among the group participants). Do you think self-stigma is real? Does anybody feel like they sometimes have self-stigmatizing thoughts?

**Part 2: Communication**

A way to battle self-stigma can be to simply talk about it. (Use the following questions to generate discussion among the group participants). Does anybody ever feel like there’s a barrier between yourself and other people? Why do you think that barrier exists? Does it ever feel like it has to do with having a mental illness?

Communicating about how we feel and having those tough discussions about what is going on with us is important to breaking down those barriers. This is because clear, open communication about what is true and what is false about mental health helps teach others to understand mental illnesses. Other people may never fully be in your shoes, but they can at least have more perspective and understanding.

There have been recent, large movements in getting more recognition about how mental illness affects individuals and their loved ones. Has anyone heard of Bell Let’s Talk? Bell Canada has a huge campaign to reduce the stigma around having a mental illness. The campaign encourages Canadians to talk about mental illness, and donates money to mental health services for every text and social media mention about mental illness. They recognize the importance of having conversations about mental illness in reducing stigma. In fact, their website says “Talking is the first step towards meaningful chance and building greater awareness, acceptance, and action.”

I downloaded some of the vignettes from Bell Let’s Talk. The first one is of Howie Mandel’s experience when he was teased on television for his OCD and ADHD.

(Play the tape)

(Use the following questions to generate discussion among the group participants). What did everyone think of that short? Does he have a point that there is still stigma around taking care of our mental health over taking care of physical health?

He recently wrote an article about his life experiences with ADHD and OCD for the website *ADDitude*, which is a website on strategies and support for ADHD. I would like to read a bit from it:

“I have to admit that, at times, I’ve been afraid of being labeled “crazy.” In middle and corporate America, if you say, “I need Thursday afternoon off to go to the dentist,” nobody raises an eyebrow. If you say, “I need an hour off Wednesday morning to run to the psychiatrist,” your coworkers may not show their surprise and disapproval, but you may experience blowback later on. They might see you in a different light. You go twice a year to get your teeth cleaned, but God forbid that you go to a counselor and ask, “Is it normal that I’m reacting this way or thinking these thoughts?”

After I impulsively revealed that I have OCD on a talk show, I was devastated. I often do things without thinking. That’s my ADHD talking. Out in public, after I did the show, people
came to me and said, “Me, too.” They were the most comforting words I’ve ever heard. Whatever you’re dealing with in life, know that you’re not alone.”

Howie Mandel makes an incredible point that right now, it is still not common for people to work on their mental health like their physical health.

(Use the following questions to generate discussion among the group participants). Does anybody have any comments on what he said? Does anybody agree with him?

The last point he made that I want to draw attention to is that when he accidentally talked about his OCD, someone on the street approach him and said, “Me too”. It’s scary talking about mental illness because there still is stigma around mental illness, but if we don’t talk about it, we’ll never know if someone else comes up to us and will say “Me too” as well. The Canadian Institute of Health Research found that 1 in 5 Canadians will experience a form of mental illness at some point in their life. There’s a really good chance that someone else will know what you’re going through.

The next vignette I will play is by Michael Landsberg, one of TSN Canada’s best-known sports journalists.

(Play the tape)

Do you agree that language makes a huge difference? It actually does matter, whether we are aware of its impact or not. If we use words like “I’m such a psycho” or “I’m super nuts right now”, that only teaches others that it is okay to use those words as well because it is reasonable for others to assume that if someone who has a mental illness can use words like “psycho” and “crazy”, then it is okay for others to use it too. It is not okay. Language makes the difference in increasing stigma for both society and yourselves.

Does anyone have any comments on the power of language?

(Leave a pause for participants to respond.)

That said, there are two ways language can be approached in reducing stigma.

**Part 2b: Communication and Starting Conversations**

First, the language we use to describe what happens when mental illness occurs and how it affects a person. There was a recent internet video where the actors treated physical illnesses like mental illness? Some examples of the dialogues from this video are:

- People asking their friend with the flu, “Listen, I know you’re sick and all, but are you even trying to get better?”
- A man with a broken arm is struggling to type at his work station, and a co-worker says, “Hey, look at it this way, there are plenty of people who have it worse off than you.”
- An employee taking an insulin shot and his co-worker remarks, “I don’t think you need to be taking medication everyday just to feel normal.”

The point of this type of dialogue is that it outlines how silly it would be to approach physical illness the same way many treat mental illness. Both can affect people in huge ways. Hospitalization, rehabilitation, learning new life skills to adjust to having a condition, and so many other ways.
(Use the following questions to generate discussion among the group participants). Has anyone ever experienced something like this before? What did they say? How did it feel when you heard that and what did you say in response?

To outline how we approach this conversations, Michael Landsberg has some very good insight into great ways we can describe mental illness. He had an interview with the Ottawa Citizen regarding his battle with depression. When asked to describe his journey with mental health issues, he said:

“Depression doesn’t hit you like a car hits you. No one gets hit by a car and thinks, ‘I wonder what just happened?’ Depression is kind of like a change in temperature of the bath. You’re in it, it’s nice and warm. You don’t feel the temperature change but at one point you think, ‘Wow. It’s actually pretty cold in this bath.’”

The interviewer pointed out that even though he was successful, had fame, and wealthy, he still battled with depression, to which he replied:

“I had, by most people’s definition, everything that you would want. I had a job that I loved, a family I loved, I had parents in my life … but still I was sick. I try to convey the sense that having good things in your life doesn’t insulate you from cancer and it doesn’t insulate you from depression either. Not that there can’t be a link between life’s circumstances and depression, but for me it had nothing to do with it.”

The point is that these are great ways to describe mental illness to others, and hopefully this gives you some ideas on the best way to help you get your points across to describe whatever you’re going through to others.

Does anyone have any thoughts or opinions on the matter?

(Leave a pause for participants to respond.)

Part 2c: Communication and the Language We Use with Ourselves

The second method of using communication to reduce stigma is to start by reduce stigma within ourselves. Reducing self-stigma can be done by making sure we use words that accurately describe our diagnosis. What this means is that there is a world of difference between saying you have a mental illness versus you are a mental illness.

It is also important to remember that we should not use a mental illness diagnosis to describe our state of minds. Has anyone heard something like “I have to straighten the currents and rug because I am so OCD that way” or “The sale was over before I got there! I’m so depressed now.”? Mental illness is a health problem, and not a way to describe our mood. Using it this way can minimize any real negative impacts such illnesses can cause.

That said, people sometimes genuinely feel depressed or anxious because those kinds of words also happen to describe emotions. However, in this case, saying “I feel depressed” or “I feel anxious” is less stigmatizing than saying “I am depressed” or “I am anxious”. This is because the word feel tells others that you are experiencing an emotion, while the word am labels a person as being the emotion.

Using the proper language can help reduce stigma for both yourselves and the people you talk to. Not everyone you talk to will understand. Many people will still believe things like
mental illness is not real and that we just need to get over it. The sad truth is that as much as we try to use the right language, not everyone will understand because we simply cannot control how others react or behave. It hurts when we do our best to get others to understand and they don’t get it or do what we hope they do. However, we can take pride in the fact that we did our best. Sometimes it won’t feel like it’s enough, just to say we tried, but it’s important to remember that it truly is better to try and not succeed than to never have tried at all.

Part 3: Role-play

We have discussed how to talk to people with the right language, and we’ve also discussed that communication is important in reducing stigma in others and in ourselves. However, there are a lot of other reasons why it’s important to be able to approach others on topics about mental illness.

First, it’s important to have at least one person we can go to when we have a problem. Now, we might have people who we can go to for problems like the car is broken, you need someone to watch the kids, etc. But it is really important to have at least one person to go to when the problem is concerning mental illness. This has to be a person who can help you get through whatever it is you’re experiencing through a supportive and validating way. For example, if you are experiencing a period of low mood and low motivation, this person could be someone you call to be your cheerleader and encourage you to do things again. Or if you are experiencing anxiety about something or feeling a panic attack, they can be someone to remind you to use anxiety tools for negative thoughts or to use your deep breathing. Whatever it might be, it’s important to have someone who can help through our issues.

Second, since it’s important to have someone support us, it’s important that we set up that support system in the first place. Even the most supportive parent, significant other, or friend will not automatically know what they can do to support you when you need it the most. Having a conversation with a trusted loved one about what they can do to support you in the future is really important.

Finally, it’s important to talk to people about mental illness in case they do not understand what you are going through. For a variety of reasons, stigma and myths about mental illness exist and continue to happen. It never helps when someone we know or have to interact with does not understand what we are going through. Therefore, having conversations with them to help them better understand the facts of mental illness can help them understand you better.

It is sometimes easier said than done, however, when it comes to having difficult conversations with people. Conversations trying to describe mental illness, conversations about creating a helpline when we’re in trouble, or conversations to simply talk about how we are doing can be difficult to approach. It might be even more difficult to talk about if a certain person you want to talk to does not understand mental illness the way you do.

(Use the following questions to generate discussion among the group participants). Has anyone ever had this experience of having difficult conversations, or talking about mental illness to someone who did not seem to understand it? How did it go? Is there anyone here who wants to have a conversation with someone about mental illness, whether it’s about setting up help or trying to get them to understand?
So when you approach people in these conversations, it’s important to remember what we outlined before: The language we use is important. Use words that emphasize having a mental illness, not being a mental illness because we are not our diagnosis. Using “I” statements to help describe why you feel a certain way that avoids putting blame on someone else, which would look like “I feel this way when…” instead of “You make me feel this way when you…”

As well, for people who have a lesser understanding of mental illness, approaching them with facts can be very beneficial. Here is a list of proper and improper words and phrases that can either increase or decrease mental illness stigma:

<table>
<thead>
<tr>
<th>Helpful Language</th>
<th>Disrespectful Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person with schizophrenia</td>
<td>Schizophrenic</td>
</tr>
<tr>
<td>Person with bipolar</td>
<td>Manic depressive</td>
</tr>
<tr>
<td>Person with a disability</td>
<td>Handicapped</td>
</tr>
<tr>
<td>Person with a mental illness</td>
<td>Mentally ill</td>
</tr>
<tr>
<td></td>
<td>Victim</td>
</tr>
<tr>
<td></td>
<td>Sufferer</td>
</tr>
<tr>
<td></td>
<td>Crazy</td>
</tr>
<tr>
<td></td>
<td>Lunatic</td>
</tr>
</tbody>
</table>

Looking over this list, has anyone ever heard someone say these or used these yourself?

(Leave a pause for participants to respond.)

Finally, to help prepare you actually have these conversations, practice what you want to say just like you would for a presentation or a speech. You can always do this by practicing in front of a mirror, in front of a trusted person who already understands, or even in front of a pet who won’t judge. Choose what works best for you.

With that said, here is a handout to help you plan on having those conversations with people. (Hand out the Planning for Tough Conversations handout). In the worksheet, there is an example of a girl named Jenny who wants to talk to her best friend, Taylor, about having depression. In the example, Taylor frequently tells Jenny that she should get over her depression and get back to work because Taylor believes that depression is just a low mood that can be overcome by just thinking about being happier. Taylor is not supportive of the fact that Jenny is depressed and has been battling depression for years. They are good friends but the mental illness becomes an area of arguments and misunderstanding. Jenny is tired of fighting with Taylor about her depression and wants to change this. So Jenny makes a plan to talk to her parents to practice talking to Taylor, and picks a time to approach Taylor on the topic.

After filling out this worksheet, and then practicing it with her parents, she goes ahead and has the conversation with her friend Taylor.

I have the script here of how the conversation went. Can someone read this part with me? (Wait for a volunteer and then read through the script with them).

Okay, so now that you guys probably have ideas of how conversations could go, go ahead and fill out the worksheet for yourselves.

(Pause and let participants fill out their worksheet. Give them opportunities to ask questions.)
Does anybody have a plan for what they want to say or an idea of someone they want to talk to? (Leave a pause for participants to respond.)

For the next bit, we have two options: Someone can share their story with the whole group and we can go through a practice conversation between us. We can either listen to you say what you want to say to that person, or I can take on a fake role of either you or that person and we go through a practice conversation. The other option is that we split into pairs or groups of 3 and you all can practice those conversations between each other.

(Allow participants to vote and choose an option).

Part End: Close, and Completion of SSMIS-SF-(After)

So to summarize, having conversations about mental illness is a really strong way to reduce mental illness stigma. In those conversations, awareness and using the proper language will increase understanding and reduce impact of hurtful words. It’s also important to remember that even if people don’t react the way we want them to, we can’t control how others react. We have to take pride in the fact that we did our best to educate and explain mental illness.

Thank you for participating in my thesis project. If you completed a measurement scale before the group session, you now have the opportunity to complete the second one if you would like to. Otherwise, please enjoy the rest of your day.

References:


BuzzFeedYellow. (2015, May 23). If physical health problems were treated like mental health problems [Video file]. Retrieved from https://www.youtube.com/watch?v=0B5nfkaeplc


Appendix F: Transcripts for Bell Let’s Talk Videos
Bell Let’s Talk 2015 – Howie Mandel Testimonial Transcript

In the United States, I was on the Howard Stern show, and I have OCD, and part of it is that I have these rituals and I can’t touch things. He thought it was funny to, well, the door was kind of dirty and nobody would open it for me and I started to panic and go through anxiety. I didn’t know we were still broadcasting. I said, “No, I see a psychiatrist! I have OCD! I’m medicated. I can’t - This is not funny. This is not a joke.” And they ended up opening the door for me, and I realized that this got broadcast. And I went down on to the street; this was in Manhattan, New York. And I walked out on to the street.

And I thought, “How can I deal with this? How can I even look at anybody?” And right when I was facing the traffic, somebody came up to me and said, “Are you Howie Mandel?” and I wouldn’t even make eye contact. I was so embarrassed.

I said, “Yeah” and they went, “I just heard you on Howard Stern.” And I thought, “Oh my god. What do I even do now? Do I just run into traffic and just end it here?”

And the next two words were the words that made my life different. The guy just said into my ear, “Me too.”

If we take care of our mental health like our dental health, we’ll be okay. We all take about our dental health. But talk about our mental health? No way. In corporate America and Canada you can say in the middle of the day, “I’ve got to leave at 3:00. I’ve got to see my dentist.” But you look at the looks in the office when you say, “You know what? I got to go to a psychiatrist.” You’ll get looks. And that’s what’s wrong. And that’s why we’ve got to talk about it. There’s no stigma. I’m crazy. I’m mental. I’m talking about it.
Bell Let’s Talk 2015 – Michael Landsberg Testimonial Transcript

Anything that contributes to the stigma, anything that makes an individual, and I’m
talking specifically to somebody who is keeping this inside, who’s not sharing, who’s not getting
help, who is struggling silently, any language that intimidates them, that makes them feel a little
bit smaller and a little bit weaker, that language is helping to keep them in the closet. It’s helping
to keep them away from the help. And as a result, it’s very destructive.

The stigma exists because, fundamentally, there’s a feeling in this country still that
depression is more of a weakness than a sickness. People use the word “depression” all the time
to describe a bad time in their life, a down time, but that’s very different than the illness itself.
For someone like me, language doesn’t really make a difference. You can call me “crazy” and
I’m not going to be upset because I’m out, I’m open, and many would say I am crazy. But to
others, that can be devastating. But me, a person that has used that word, would say, “Well, I
have been able to manage my life. I have done it in spite of it. So I am strong and he is weak.
And therefore, he is, to some extent, to blame for his illness.” And I think the stigma really
comes down to one, fundamental thing: We still believe that depression is more of a weakness
than a sickness.
### Appendix G: Role-play Therapy Group Session Participant Handouts

#### Planning For Tough Conversations

<table>
<thead>
<tr>
<th>Who do I want to talk to?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>My friend Taylor.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do I want to achieve?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>I want her to understand that my depression isn’t something I can just get over.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What can I say to help get my point across?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Depression is a real illness. I feel upset when they say I’m being lazy. I need her to give me space instead of scolding me for not going to work.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When would be a good time and place to have this conversation?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>This weekend at noon when I see her for our lunch date.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What could get in my way (barriers)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>She cuts me off. She doesn’t want to talk about it. She insists I just need to reframe my thinking.</em></td>
</tr>
</tbody>
</table>
Appendix H: Role-playing Scenario

Having Tough Conversations – Script

Jenny: Hey Taylor, can I talk to you about something?

Taylor: Sure, what’s up?

Jenny: Well, it’s about my depression. Sometimes, I feel like you don’t take it seriously.

Taylor: You’re right, I don’t take it seriously. Everyone gets sad sometimes. I just don’t get why you let it bother you so much.

Jenny: That’s just it though. I don’t want it to “bother me so much” but I can’t help it.

Depression is a real illness.

Taylor: Depression is a state of emotion, and emotions change. Just last week I took you shopping and you were smiling.

Jenny: And I’m happy you got me out of the house that day. It was really helpful for me, but you need to understand that going out shopping doesn’t automatically fix everything.

Taylor: Then let it fix everything! You’re stronger than this. If you just reframe the way you think, you’d feel better.

Jenny: But that is the problem with depression. No matter what I do to reframe how I think, it still comes back and it eats away at me.

Taylor: So, you’re saying you just going to sit there and let it eat away at you?

Jenny: No, I’m trying to fight it.

Taylor: Then you have to do it faster. You need to get back to work. You didn’t pay your rent last month and I don’t want to see you get evicted.

Jenny: I know, I know. I’m fully aware of what I have to do.

Taylor: You know I’m just trying to look out for you, right?
Jenny: I know, and I appreciate it. But I need you to understand that my depression is a real illness. Taylor, you need to understand. Almost 1 in 4 deaths for people aged 15-24 die from suicide.

Taylor: That can’t be right.

Jenny: It’s true. Depression is a real illness that hurts lives. And I need you to know that I’m doing everything I can to get over it right now.

Taylor: What are you doing right now then?

Jenny: I’m seeing a therapist and I take medication.

Taylor: Wait, you take medication for it? I thought only really crazy people take meds for their mental problems.

Jenny: Please don’t use the word “crazy”. Many people with mental illnesses take medication, just like people with physical illnesses like diabetes and high cholesterol need to take medication.

Taylor: They aren’t the same thing.

Jenny: Yes they are. Both mental and physical illnesses can severely impact lives, can happen for almost any reason, and can take life-long efforts to manage. Please understand that what I’m doing through isn’t just a sad mood. It’s depression.

Taylor: Okay, I hear you. Let’s say this is real and it’s affecting you. But what am I supposed to do? It’s not like it’s a broken leg and I can help you by doing your groceries or driving you to appointments.

Jenny: It’s exactly like that. You can still help me even though what I’m experiencing is a mental sickness and not a physical sickness.

Taylor: How can I help you if I can’t even see what’s hurting you?

Jenny: You can support me emotionally.
Taylor: What does that mean?

Jenny: It means giving me space when I need it, giving me words of encouragement that I’ll get through this, and giving me unconditional support.

Taylor: We’ve been good friends for 5 years. Of course I’ll give you unconditional support.

Jenny: Then let me see it when you give me the time to work through my depression.

Taylor: But your work and your bills… Those need to be taken care of.

Jenny: I know. I am in the process of asking for leave from work to deal with this.

Taylor: They won’t let you take leave for a mental illness.

Jenny: You’d be surprised at how many employers are now taking mental illness seriously. I have a regular form that I can fill out, but I have to write a formal letter along with it to my job’s HR department and you know I have trouble writing proper letters.

Taylor: Good thing I’m an English major.

Jenny: That’s what I was hoping for. If you have the time, could you come over tonight and help me write up this letter?

Taylor: I can, but I don’t know if I should. I don’t feel like I can help if I don’t see depression as, you know, a real illness.

Jenny: You can help. You still might not believe that depression is real but you can see me struggling, right? You can still help me in little ways, like helping me write this letter. It’s something that you’re good at, and something that will help me get better in the long run.

Taylor: Okay, if you say this will help you get back to normal, then I’ll help you. And you know if there are others things I can help with, I’ll do my best.

Jenny: Thank you. That means a lot to me.
Appendix I: Self-Stigma of Mental Illness Scale – Short Form Score Sheet

The SSMIS-SF Score Sheet

Name or ID Number________________________________ Date ______________

Summing items from each section represents the 3 A’s plus 1.

______ Aware: (Sum all items from Section 1).

______ Agree: (Sum all items from Section 2).

______ Apply: (Sum all items from Section 3).

______ Hurts self: (Sum all items from Section 4).