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Mindfulness Increases Help-Seeking by Buffering Against Self-Stigma

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Abstract

Mindfulness has many psychological benefits, including less stress, improved sleep, increased resiliency, and reduced psychological distress, making it a focus of mental health research (Dvorakova et al., 2017; Mzarek, Franklin, Phillips, Baird, & Schooler, 2013; Vidico & Cherup, 2019). Mindfulness may also limit the formation of self-stigma, which comes from internalized stereotypes about oneself (Barr, Davis, Diguiseppi, Keeling, & Castro, 2019). When people experience self-stigma, they are less likely to seek help when they might need it, exacerbating current problems (Wilson, Bushnell, & Caputi, 2011). The present study explored the relationship between these three constructs of mindfulness, self-stigma, and help-seeking. It investigated if mindfulness could increase the likelihood that an individual would be willing to seek help by decreasing self-stigma. Responses of 189 participants were collected through Amazon Mechanical Turk. Mindfulness as an overall construct and two of its five facets (nonjudging and acting with awareness) had a negative direct effect on intentions to seek help. However, as predicted, it also had a mediated effect that was in the predicted positive direction. As mindfulness increased, self-stigma decreased, which in turn increased the willingness of participants to seek help. This paper ends by discussing how mindfulness can be used to increase engagement and retention in mental health services.

Mindfulness Increases Help-Seeking by Buffering Against Self-Stigma

Nearly one in five U.S. adults live with a mental illness, so to help this large portion of the population, research attention is directed towards discovering protective factors (NIMH, 2019). Protective factors consist of anything that decreases the symptoms or even prevents the development of mental illnesses, such as religiosity, resiliency, and mindfulness (Beshai & Parmar, 2019; Jansen, Motley, & Hovey, 2010; Pidgeon, Keye, & Pidgeon, 2014). Through various mechanisms, protective factors can improve the quality of life for those with mental illnesses. One protective factor that has gained increased attention in recent years is mindfulness. Mindfulness is a nonjudgmental, present-moment focused way of life associated with an array of psychological benefits. Not only can mindfulness decrease the risk of developing mental health symptoms, but it can also provide coping skills. It may also buffer against the self-stigma experienced by many people with a mental illness (Barr, Davis, Diguiseppi, Keeling, & Castro, 2019). When people experience less self-stigma they are more likely to seek help (Corrigan, Watson, & Barr, 2006). The present study investigated the relationship between these three concepts, hypothesizing that as people are more mindful, they experience less self-stigma, thus they will be more likely to seek help.

Self-stigma results from a process in which a person has aversive experiences due to some aspect of their person, such as experiencing a mental illness (Corrigan, Watson, & Barr, 2006). Often, when someone has a mental illness, say depression, they experience stereotyping from broader society. Someone with depression may struggle with a loss of energy that makes it difficult to complete tasks. This could result in the individual being labeled “lazy” or “incompetent” as they take longer to complete things. Over time, the stigmatized individual begins to internalize these stereotypes and believe that they apply to themselves. Often, the

person also carries a stigma associated with seeking help for the mental illness itself. These can impact self-esteem, self-efficacy, and depression and anxiety symptoms (Corrigan, Watson, & Barr, 2006; Göpfert, Von Heydendorff, Dreßing, & Bailer, 2019).

People who are mindful may be less likely to experience self-stigma. Mindfulness is perhaps best understood as a contrast to mindlessness (Carmody, Baer, Lykins, Olendski, 2009). We spend much of our daily lives in a mindless state. Many people experience driving to work, but they do not remember the trip because they were in "autopilot" mode upon arrival. If one were to drive to work mindfully, they might pay particular attention to traffic sounds or the smells they experience when they roll down their window. Likewise, sometimes we are also mindless of the emotional states we are undergoing. We feel angry or irritated, but we do not recognize that we are in such a state and instead lash out at those around us.

In addition to this present-moment focus, another key aspect of mindfulness is a nonjudgmental attitude towards one's experiences (Carmody, Baer, Lykins, Olendski, 2009). We are often critical of our emotional experiences. For example, when one feels sad, we often tell ourselves that we should not feel sad. This is a judgment towards our feelings, no matter the reason—or lack thereof—for feeling sad. People judge a wide variety of emotions and avoid certain emotions they consider undesirable, such as anxiety, anger, fear, etc. A nonjudgmental attitude still recognizes these emotions but does not value certain feelings or avoid less "desirable" attitudes. This nonjudgmental attitude could potentially impact the formation of self-stigma, which is one of the most significant barriers to seeking help for mental illness. Another aspect of mindfulness related to nonjudgment, and possibly self-stigma, is nonreactivity. We are often very reactive to emotions and experiences. For example, when being cut off while driving in heavy traffic, someone acting reactively might yell at the other driver, flip them off, and try to

speed around them. In contrast, someone who is nonreactive would still feel the anger, would note the feeling, and continue driving as before instead of acting impulsively on that anger.

Seeking help for mental illness typically involves reaching out to support structures such as family and friends, contacting mental health professionals, or using other resources to facilitate self-help strategies. Seeking help early on can prevent the symptoms from becoming more severe (Wilson, Bushnell, & Caputi, 2011). If early intervention is not possible, help-seeking is still essential in fostering a good quality of life. Even though seeking help is key to recovery from a mental disorder, many people do not seek help. Stigma is the number one reason people do not seek help; therefore, efforts to reduce stigma are crucial to increasing people's help-seeking behaviors (Heath, Brenner, Lannin, & Vogel, 2018a).

Mindfulness may provide a protective factor during this formation of self-stigma, which in turn could impact one's willingness to seek help. The attitudes of nonjudgment and nonreactivity in mindfulness may interrupt the process of forming stigmatizing judgments about oneself. When an individual responds with nonjudgment and nonreactivity to uncomfortable feelings that emerge during self-stigma formation, the internalization of self-stigma might be halted or slowed. If self-stigma is not internalized by those experiencing mental illness, they will be more likely to seek help. There is not much literature, however, connecting the concepts of self-stigma and help-seeking behaviors to mindfulness. The present study investigated the relationship between these three constructs. Do individuals who are more mindful experience less self-stigma about seeking help for mental disorders? And in turn, because they experience less self-stigma, are they more willing to seek help?

Seeking Help

In our everyday lives, we informally engage in help-seeking behavior, whether asking a loved one for help or venting to a friend (Cole & Ingram, 2019). Formal help-seeking behaviors, such as going to see a therapist, are often highly stigmatized, for several reasons. Self-stigma plays a significant role in creating this barrier to getting help (Hammer & Vogel, 2017). People believe that if they ask for professional help, they are inadequate or weak in some way (2010). In addition to stigma, there are other barriers to help-seeking, such as cost, availability, gender roles, and cultural expectations. Still, the most commonly cited factor for not seeking help is stigma (Corrigan et al., 2006).

Many potential behaviors could be considered help-seeking, and these behaviors are not always directly related to mental wellness. Asking friends and family for help when they are in trouble or need financial help is one example of help-seeking not related to mental illness. Asking others for advice about personal or work problems is another example of help-seeking behavior. Both of these examples are classified as informal help-seeking because a professional is not involved. Even informal help-seeking is avoided because of the fear of social rejection or embarrassment (Juhl, Wildschut, Sedikides, Xiong, & Zhou, 2020). More formal help-seeking behaviors can be talking to a doctor about health concerns, including mental wellness. These behaviors can also be talking to a therapist or counselor about whatever has been causing distress or engaging in other treatment services. Many actions can be considered help-seeking, but ultimately, help seeking involves an individual turning to another person and expressing that they need something from them.

Measuring Help-Seeking

It is typical in research on help-seeking to measure intentionality, rather than actions. The theory of planned behavior states that intentions are effective predictors of actual behavior, so to measure help-seeking behaviors, the intention to seek help can be utilized as a proxy (Ajzen, 1991). These measures typically ask how likely a person would be to seek counseling if they were experiencing a specific problem. The participant is often presented with a variety of potential issues (e.g., substance abuse, relationship issues, sleep disturbance). They are then asked to indicate if they would seek help if they experienced each of these conditions. It is essential to evaluate intention given that not all of the issues will be something that the participant has experience with, yet, by asking if they would seek help if they experienced these conditions, we can measure how the individual would most likely act.

Hammer and Spiker compared three different self-report help-seeking intention instruments: Intention to Seek Counseling Inventory (ISCI), General Help-Seeking Questionnaire (GHSQ), and the Mental Help-Seeking Intention Scale (MHSIS) (Hammer & Spiker, 2018). This analysis supports that the ISCI was reliable and valid when utilizing it as a multi-dimensional scale instead of a unidimensional one. The GHSQ did not demonstrate acceptable internal consistency, and while the MHSIS showed good predictive validity, it is a lesser-known scale with only three items. The current study employed the ISCI and the MHSIS.

The ISCI lists a series of 17 potential issues that people bring to counseling such as excessive alcohol use, depression, speech anxiety, inferiority feelings, etc. and asks participants to rate how likely they would be seek counseling if they were experiencing the problems (Cash, Begley, McCown, & Weise, 1975). The 17 issues are the items of the scale. There are three subscales within the ISCI for interpersonal problems, academic problems, and drug/alcohol problems, into which these 17 issues are categorized. Since this scale does not offer a global

measure of intent to seek mental health help, the three-item MHSIS was included in the current study. The MHSIS simply asks participants if they had a mental health concern, how likely would they be to intend, try, and plan to seek help from a mental health professional.

Understanding Self-Stigma

Even though seeking help is key to recovery from mental illness, many people do not seek help when they need it. The Substance Abuse and Mental Health Services Administration reports only 43% of adults with mental illness get treatment in a given year (2019). One reason why people do not seek help is stigma.

There are multiple types of stigma, such as public stigma and self-stigma; however, the present study is focused on self-stigma. Much of our identity, specifically the way we perceive ourselves, is socially constructed (Lucksted & Drapalski, 2015). When negative stereotypes held by society become internalized within this construction, self-stigma occurs. Research has shown many deleterious effects of self-stigma: lower self-esteem and self-efficacy, lower personal empowerment and life satisfaction, and increased depression symptoms (Chan, Mak, & Lam, 2018; Corrigan et al., 2006; Livingston & Boyd, 2010).

Although the present study focuses on self-stigma, public stigma is key to understanding the formation of self-stigma. Public stigma refers to the negative views that are held by the wider society (Mackenzie, Heath, Vogel, & Chekay, 2019). The more individuals endorse these negative views in general, the more likely they are to internalize or believe these thoughts about themselves. Once public stigma has been internalized, it becomes self-stigma.

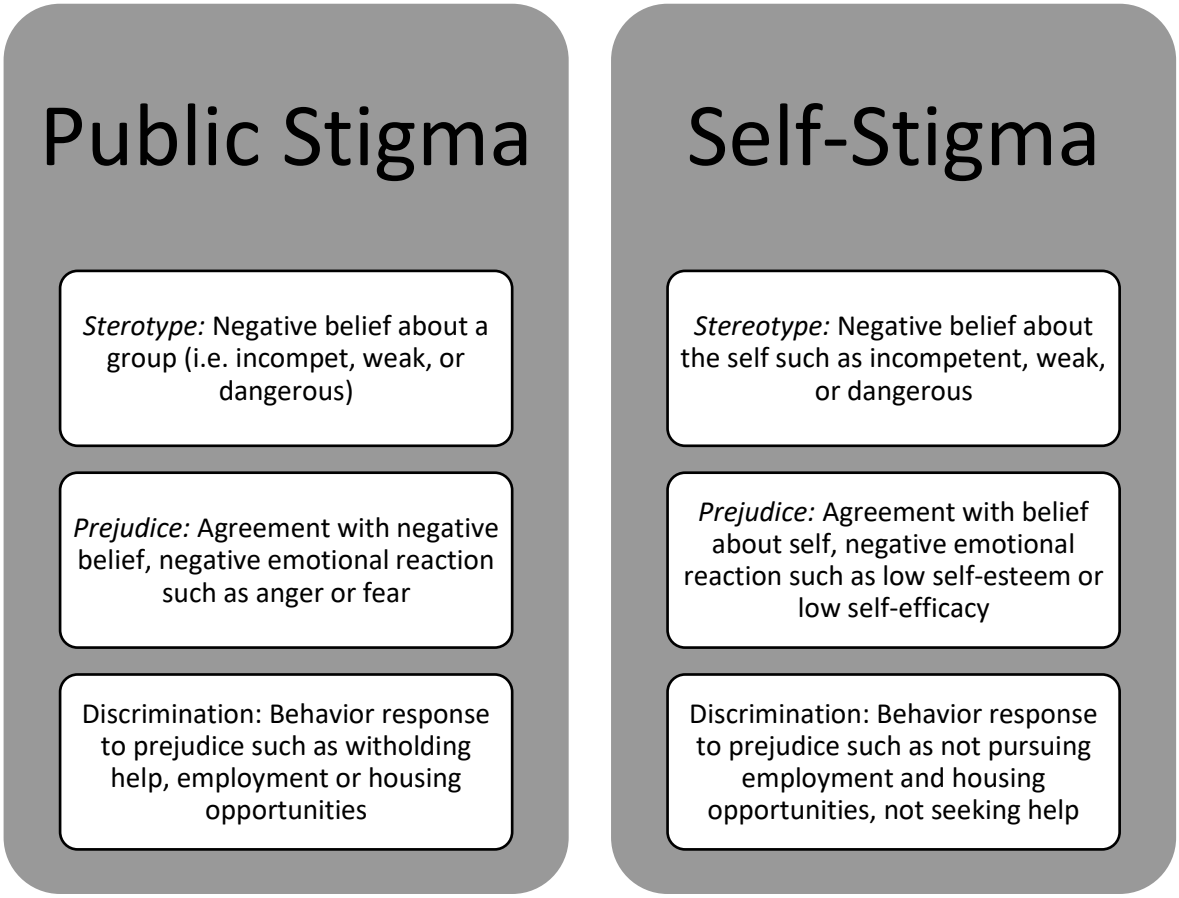

Figure 1. Comparing public stigma and self-stigma

The Formation of Self-Stigma

There is a range of possible stigmatizing attitudes that exist in broader society. A stigmatizing attitude is one that attaches labels to others or oneself, based on certain shared traits (Curcio & Corboy, 2020). These attitudes create in-groups and out-groups based on these shared traits and, particularly surrounding those with mental illnesses, include dangerousness, unpredictability, incompetence, and a "weak-not-sick" perception (Corrigan, 2004). The "weak-not-sick" narrative implies that the mental illness is not a medical problem and that if the person just tried hard enough, they would be able to overcome it (Wright, Jorm, & Mackinnon, 2011).

Holding this belief often leads to observable behavioral markers, such as social distance (Curcio & Corboy, 2020). Social distance is one's self-reported willingness to make contact and interact with a person with a mental illness and often only perpetuates negative stereotypes (2019).

Through discriminatory experiences in society, individuals become aware of negative stereotypes associated with a part of their identity. For example, they might hear that people with mental illnesses are dangerous and might find themselves being treated differently because they have a mental illness. If the individual agrees with this inaccurate stereotype, they self-concur. Self-concurrence is the initial formation of a self-stigma (Chan & Mak, 2017). After this initial formation of self-stigma, habitual self-stigma often occurs. When an individual expects and anticipates stigmatization, they repeat this initial self-concurrence throughout their life (Lucksted & Drapalski, 2015). Habitual self-stigma is responsible for many of the deleterious effects of stigma because it perpetuates a negative self-image (Chan & Mak, 2015).

Corrigan and colleagues proposed a progressive, or trickle-down, model for the formation of self-stigma (2002). This model was based on an earlier one by Link and colleagues (Link, 1987; Link & Phelan, 2001). The original model conceptualized stigma as "the co-occurrence of its components—labeling, stereotyping, separation, status loss, and discrimination" (Link & Phelan, 2001, p. 363). Labeling is when people recognize human differences and develop labels for them while stereotyping occurs when labeled people are lumped together and linked to negative characteristics. Separation places these labeled groups apart in distinct categories. People who are labeled experience status loss and discriminatory outcomes. When the five components all occur together, a person experiences self-stigma.

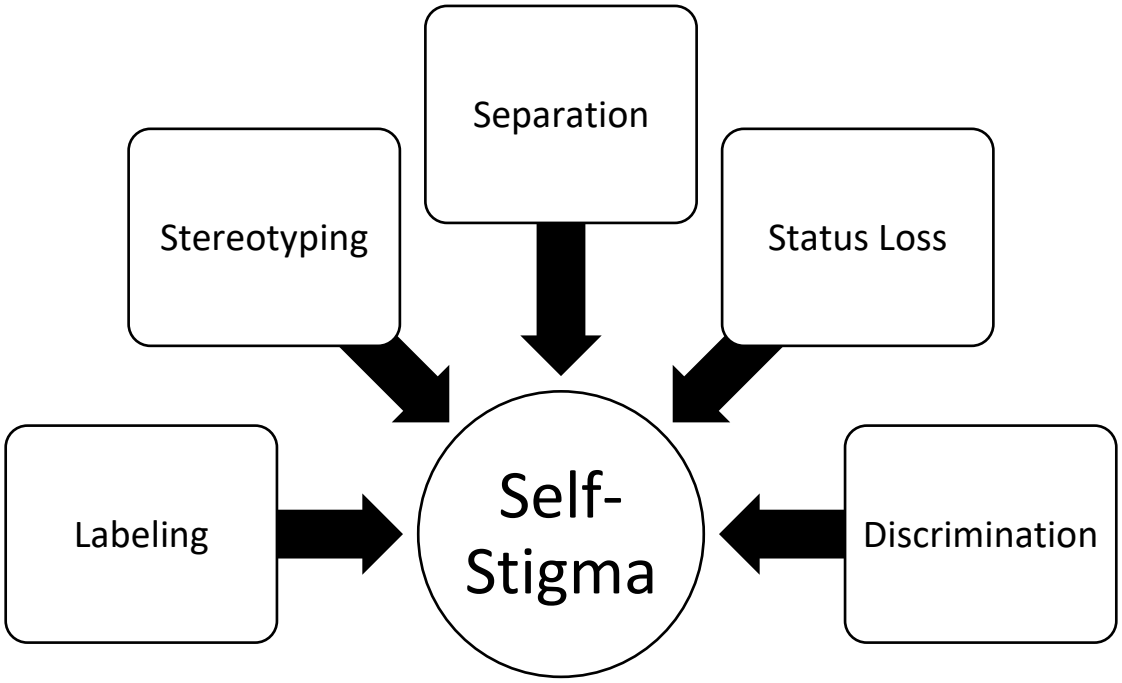

Figure 2. The experience of self-stigma

Note. The model of self-stigma as proposed by Link and Phelan (1987).

Corrigan and colleagues' (2006) model is similar, but instead of the co-occurrence of these five components, they proposed a four-stage progressive model. The process begins with stereotype awareness or the perception of the public's stigma towards mental illness. The second stage is stereotype agreement, followed by self-concurrence. The final stage is harm to self, particularly harm to self-esteem. This model was tested with a sample of people with mixed diagnoses and did indeed show a trickle-down effect from the first stage to the third stage (Corrigan, Watson, & Barr, 2006). In other words, self-reports showed a higher correlation between proximal stages (such as stereotype awareness and stereotype agreement) as compared to distant stages (stereotype awareness and self-concurrence), with people in the stereotype awareness stage agreeing the least with stereotypes and those in the self-concurrence stage agreeing the most with stereotypes. However, there was no significant difference (in agreement

with the stereotypes) between self-concurrence and self-harm. Since this study, more research has been conducted to understand better the internalization of self-stigma and the harm caused by the process.

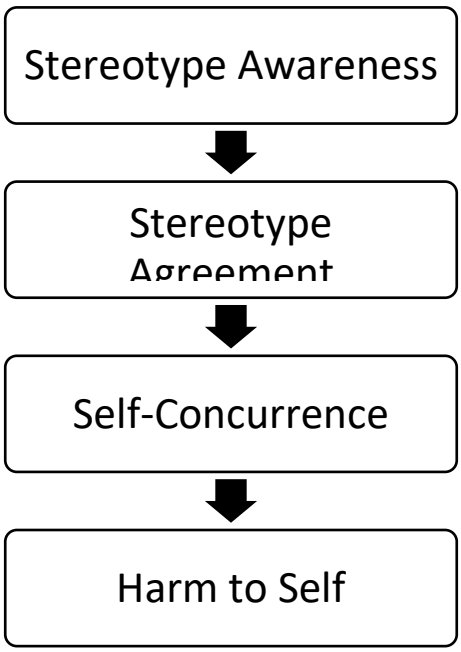

Figure 3. The formation of self-stigma

Note. The model for the formation of self-stigma as proposed by Corrigan, Watson, & Barr (2006).

Self-stigma has been associated with lower self-esteem and lower self-efficacy in people with mental illnesses (Corrigan, Watson, & Barr, 2006). Self-esteem is one's overall sense of personal value or how much someone likes or appreciates themselves. Self-efficacy is an individual's belief in their ability to complete a task or achieve a goal. These constructs are essential when considering a person's general psychological well-being, and low levels are associated with disorders like depression. Corrigan and colleagues found that when people

indicated high levels of self-concurrence, they also experience lower levels of self-esteem and self-efficacy (2006). However, other stages of the trickle-down model were not significantly associated with self-esteem and self-efficacy. It is not enough to be aware of or to agree with a stereotype. One must believe that the stereotype is true about themselves, or internalize it, for the harmful effects of self-stigma to be observed.

A more recent study examined this process in a population of people with depression (Gopfert, von Heydendorff, DreBing, & Bailer, 2019). Using the same model proposed by Corrigan, a trickle-down effect was only observed in the first stage, that is, stereotype awareness had higher endorsement (i.e., stronger agreement with the stereotypes) than the other two stages. People in the self-concurrence stage agreed more with stereotypes than the stereotype agreement stage, which is in contradiction with results from Corrigan and colleagues' study; however, the statistical tests used by Gopfert and colleagues are highly sensitive to sample size. This could account for the apparent contradiction given the difference in sample sizes between the two studies. Additionally, the sample composition differed between the two studies. Gopfert and colleagues tested participants with depression solely, while Corrigan and colleagues' sample was a mixed clinical population (2019; 2006). Gopfert and colleagues' differences in results could also indicate that people with depression experience a slightly different process of self-stigma formation (2019). Most importantly, Gopfert and colleagues utilized serial mediation analysis to understand the process of moving through these stages.

The proximal stages mediated associations of distant stages; for example, high levels of stereotype awareness were associated with high endorsement of stereotype agreement, which in turn was associated with higher levels of self-concurrence and, subsequently, lower levels of self-esteem (Gopfert, et al., 2019). Ultimately, this study supports the model initially proposed

by Corrigan and colleagues, but it does raise questions about the relationship between self-concurrence and personal agreement. Self-concurrence is a crucial stage where the harmful effects of self-stigma seem to occur, so interventions, such as mindfulness, may need to impact the process of internalizing self-stigma at this stage.

Self-Stigma of Having a Mental Illness and Self-Stigma about Seeking Help

Within the context of mental health, self-stigma emerges as two different forms: the self-stigma of seeking help and the self-stigma of having a mental illness (Tucker et al., 2013). The significant role that self-stigma plays in an individual's perception of seeking mental illness help makes it challenging to determine the differences between self-stigma associated with having a mental illness and the self-stigma associated with seeking help (2013). Self-stigma research began with patients in 1987 and combined the concept of stigma surrounding having a mental illness with the stigma of seeking psychological help. However, these two concepts are distinct, and both impact the behavior of actually seeking help (2013).

Tucker and colleagues hypothesized that these two types of self-stigma would be empirically distinct, as shown through confirmatory factor analysis (2013). To identify the stigma associated with seeking help, the researchers utilized the Self-Stigma of Seeking Help (SSOSH) questionnaire (Vogel, Wade, & Haake, 2006). The Self-Stigma of Mental Illness Scale was used to identify the stigma associated with having a mental illness, which was a scale developed from the SSOSH by replacing "seeking help" references to "having a mental illness" (Tucker et al., 2013). Tucker and colleagues found that the two concepts of self-stigma were indeed distinct since confirmatory factor analysis identified two factors.

Other differences between the two constructs of self-stigma were found regarding shame, self-blame, and social inadequacy (Tucker et al., 2013). Both self-stigmas predicted shame, but

self-blame was predicted more strongly by the self-stigma of seeking help. This could be because having a mental illness is seen as uncontrollable, but seeking help is perceived as more of a choice. The stigma of having a mental illness was the only significant predictor of social inadequacy. Those with a mental illness often see themselves as less valuable, but seeking help does not necessarily affect social standing. In the current study, self-stigma regarding seeking help was the focus.

Measuring Self-Stigma about Seeking Help

When investigating the relationship between mindfulness, self-stigma, and help-seeking behaviors, it is vital to have an instrument that accurately represents these constructs. For the present study, the SSOSH scale was employed to measure the self-stigma associated with seeking help. This 10-item scale asks participants about their reactions when they seek help for any problem they may face. This is a one-dimensional scale used to measure the construct of the self-stigma regarding seeking help.

Self-Stigma as a Barrier for Seeking Help

For the current study, it is essential to differentiate between self-stigma of mental illness and the stigma associated with seeking help. However, public stigma is still a key element in understanding self-stigma. As a part of the internalization of self-stigma, individuals must be aware of public stigma (Vally, Cody, Albloshi, & Alsheraifi, 2018). Vally and colleagues analyzed the relationship between public stigma, self-stigma, and psychological help-seeking. They found that the relationship between public stigma and help-seeking was fully mediated by self-stigma. Individuals with higher levels of public stigma awareness have higher self-stigma levels, which is associated with a more negative attitude towards seeking help. When individuals

have a negative attitude towards seeking help, they are less likely to do so if they would need to. This demonstrates one way that self-stigma acts as a barrier to seeking help for mental illness.

Exploring Mindfulness

Mindfulness is an intentional way of paying attention to one's present moment experience without judgment. Mindfulness originated in the Buddhist tradition, but over time, it a Westernized version has emerged as scientists began investigating the numerous benefits of mindfulness (Shapiro, Carlson, Astin, & Freedman, 2006).

There has been a wide variety of research supporting the beneficial effects of consistently practicing mindfulness. Studies demonstrate decreased perceived stress, increased resiliency, improved working memory, and fewer sleep issues, to name a few (Dvorakova et al., 2017; Mzarek et al., 2013; Vidico & Cherup, 2019). Also, mindfulness practice has become an essential component of some psychotherapies: mindfulness-based stress reduction, acceptance and commitment therapy, and dialectical behavior therapy. While much research focuses on mindfulness as a practice, it is also a way of being or a disposition. This is referred to as trait mindfulness. In contrast, state mindfulness is often conceptualized as occasions when one intentionally engages in mindfulness practice, such as meditation.

Mindfulness as a Practice or a Disposition

Trait mindfulness (TM) can be developed through mindfulness-based interventions. Jon Kabat-Zinn, the founder of mindfulness-based stress reduction therapy, refers to mindfulness practices as "scaffolding" used to develop the trait of being mindful (Kabat-Zinn, 2003).

Regular practice of mindfulness demonstrates improvements in both state and trait mindfulness, as results from a brief mindfulness training program for psychotherapists show (Swift et al., 2017). The training program was brief, lasting five weeks and consisting of 30-

minute weekly meetings and mindfulness exercise assignments. Trait mindfulness was assessed with the Five-Factor Mindfulness Questionnaire, while state mindfulness was evaluated with the Toronto Mindfulness Scale (FFMQ; Baer, Smith, Hopkins, Krietmeyer, & Toney, 2006; TMS Lau et al., 2006). The FFMQ was administered before and after the program to examine general mindfulness traits across five dimensions. The TMS was administered after mindfulness exercises to evaluate the activity's immediate experience (Swift, Callahan, Dunn, Brecht, & Ivanovic, 2017). A significant linear trend in increase in state mindfulness was found. As the therapists moved through the training, they reported that they were better able to engage in a mindful state during the exercises. Additionally, an increase in trait mindfulness after the training program was observed, meaning that the therapists also lived their lives with a more mindful disposition after completing the program. While this study does not show that increases in state mindfulness are directly related to increases in trait mindfulness, these two concepts are certainly related and are developed through mindfulness practice.

In addition to mindfulness training, personality may play a role in whether someone has higher levels of trait mindfulness (Mather, Ward, & Cheston, 2019). Studies have shown that certain factors of the Big Five personality traits like neuroticism are inversely related to trait mindfulness. Individuals with high neuroticism levels tend to experience anxiety, worry, self-criticism, moodiness, and insecurity—concepts that are in direct contrast with the nonjudgmental and nonreactive nature of mindfulness.

Low trait mindfulness is associated with mental health symptoms and substance use (Shorey et al., 2014). Shorey and colleagues coded treatment records from patients at a residential substance use treatment center using the following measures: Mindful Attention Awareness Scale, Psychiatric Diagnostic Screening Questionnaire, and Drug Use Disorders

Identification Test. Low levels of trait mindfulness were associated with more severe levels of substance use, depression, and PTSD. Interestingly, patients who were probable cases of depression or PTSD had significantly lower levels of trait mindfulness. This study indicates that lower levels of trait mindfulness may be a risk factor for developing substance use disorders and other comorbid disorders. These results are echoed in other studies that demonstrate the protective factors of high levels of trait mindfulness.

Trait mindfulness has been shown to serve as a limiting or protective factor for depressive, anxiety disorders, impulse control disorder, substance use disorders, and general distress (Beshai & Parmar, 2019; Radford et al., 2014; Rasmussen & Pidgeon, 2011). Resilience, or the ability to "bounce back" after a failure or setback, is a skill that is linked to trait mindfulness (Pidgeon et al., 2014). Resiliency is an essential protective factor in the development of mental illness, so more resilient individuals are less likely to develop a mental illness like depression. In those that do develop such a mental illness, the symptoms are more easily treatable.

Mechanisms of Mindfulness

Shapiro and colleagues proposed three axioms that make up the key components of mindfulness: intention, attention, and attitude (2006). They proposed that a meta-mechanism, reperceiving, was responsible for a shift in perspective integral to the positive effects of mindfulness.

Intention, ultimately, is *why* someone is mindful. The intention of mindfulness practices, according to the original Buddhist traditions, was enlightenment and developing compassion for all things. Since becoming Westernized, this intention has shifted to self-regulation, self-

exploration, and self-liberation (Shapiro, 1992). Shapiro also found that intention was a crucial component in determining the outcome of mindful practices.

Attention is another key component of mindfulness. Present moment awareness of one's internal and external experiences is a skill developed through mindfulness practice. This raised awareness creates a distance from the experiences, as the individual attends to their conscious experience rather than interpreting it.

Attitude refers to *how* someone attends to their experiences. A mindful attitude is nonjudgmental, openhearted, and curious. This curiosity enables the observer to experience interest in the different components of their present moment experience and continued exploration without judgment. These three axioms are essential to understanding what mindfulness is, but Shapiro also proposed a mechanism by which mindfulness practice brings about the changes that researchers have observed: reperceiving (1992).

Reperceiving allows us to take a step back from our feelings by detaching. For example, when one gets angry, we often feel as if we *are* the anger that we are feeling, due to the intense emotions and strong physiological reaction. We become unaware that we are experiencing anger because we are so tangled up in the feelings associated with the emotion. Instead, if one were to reperceive the situation, we could take a step back and recognize that we are experiencing this emotion, but we do not have to overcome it. Reperceiving could help explain why mindfulness might impact stigma. According to Corrigan's progressive model, self-stigma becomes internalized through four different stages (2002). During this internalization process, if individuals were to reperceive the stereotypes they are becoming aware of and recognize that just because they have a mental illness, they do not fit that stereotype, mindfulness may interrupt that process.

Shapiro proposed this meta-mechanism of reperceiving, a concept with three components: decentering, detachment, and deautomation (2006). Individuals engaged in reperceiving choose to shift their perspective by making something that was once a "subject" an "object". In other words, they recognize other perspectives exist besides their points of reference, and this results in a change—perhaps the same change seen through the practice of mindfulness.

This concept of reperceiving was further investigated by Carmody and colleagues (2009). They expected a significant overlap between the constructs of mindfulness and reperceiving, and their results supported this hypothesis. Reperceiving is not mindfulness, but it was theorized to be a mechanism by which mindfulness might operate. That is, reperceiving is how someone can be mindful. This shift in perspective is key to being mindful. The researchers tested for mediation in a sequential model in which improvements in mindfulness would lead to improvements in reperceiving throughout the course of a mindfulness-based stress reduction class and found no significant indicators of mediation. The researchers expected reperceiving to mediate the relationship between mindfulness and improvements in a few dependent variables (self-regulation, cognitive, behavioral, and emotional flexibility, values clarification, and exposure), but they did not find this to be the case. Instead, both mindfulness and reperceiving significantly predicted the improvements in the variables, indicating an overlap between these two constructs.

However, other interesting results were found regarding the relationship between mindfulness and psychological symptoms/distress. Based on results from the Five-Factor Mindfulness Questionnaire, the Purpose in Life Scale, and the Environmental Mastery Scale, this relationship was mediated by values clarification and emotional flexibility (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Carmody, Baer, Lykins, & Olendzki, 2009).

Additionally, intention to be mindful was measured and found not to be a strong predictor of any study variables, including decreased psychological symptoms/distress, suggesting that having a mindful disposition could have similar effects to active mindfulness practice.

Measuring Mindfulness

As defined by Baer and colleagues, there are five facets of mindfulness: nonreactivity, observing, acting with awareness, describing, and non-judging (Baer et al., 2006). These five factors were identified through a factor analysis conducted on several existing scales that measured the general tendency to be mindful.

Observing is our ability to take a step back from our experiences and notice them, such as becoming aware of a smell or a sound. This involves paying attention to the input from our five senses as well as internal sensations and thoughts. In mindfulness-based therapies, this is sometimes called our "observer self", which involves taking a step back from one's experiences to see them from an outside perspective.

Describing is often the next step after one has observed their experiences. Using words to describe or label our thoughts and emotions is key to this facet of mindfulness. For example, if one were experiencing anxiety about an upcoming exam, being able to describe those anxious feelings and the internal sensations that go along with those feelings, such as one's heart racing and sweaty palms, would be considered this facet of mindfulness (Baer et al., 2006).

Acting with awareness is perhaps best understood by what it is not. People often live their lives on "autopilot" mode without paying attention to their daily actions and allowing their brains to complete tasks automatically. When someone acts with awareness, they pay attention to whatever the task is at hand, without distractions and with total concentration (Baer et al. 2006).

Acceptance is vital to understand two facets of mindfulness. This concept sometimes has negative implications because some see this as an act of passivity in response to negative situations; however, both nonreactivity and non-judging give a different context to acceptance (Baer et al., 2006). Accepting a feeling, like exam-related anxiety, involves not making self-judgments or criticisms in response to the anxiety or reacting impulsively, such as procrastinating studying—which is a type of avoidance.

Certain facets were found to positively correlate with other constructs, such as openness to experience (observing), emotional intelligence (describing) positively, and self-compassion (nonreactivity) (Baer et al., 2006). Other constructs were negatively correlated like psychological symptoms (non-judging) and difficulties regulating emotions (non-judging). This sheds light on the importance of non-judging and nonreactivity when examining our internal experiences of negative experiences. Suppose one were to have a negative experience, such as being discriminated against due to a mental illness. In that case, there are many different possible reactions, but an individual who is non-judging and nonreactive might respond with acceptance towards the negative feelings that situation may create. Acceptance does not imply passivity; rather, it means accepting the reality as it is and not judging or being self-critical about how one experiences life.

The FFMQ measures both an overall mindfulness construct consisting of these five factors of mindfulness: describing, acting with awareness, nonjudgment, nonreactivity, and observing. Each facet is assessed through a subscale, and overall mindfulness is the total score on the questionnaire. Baer and colleagues tested this hierarchical model and found that all of these five factors loaded significantly onto the overall mindfulness score (observe = .34, describe

= .57, awareness = .72, nonjudgment = .55, nonreactivity = .71; CFI = .96, NNFI = .94, and RMSEA = .07).

Other studies continue to test this assessment's validity and reliability (Dundas, Vøllestad, Binder, & Sivertsen, 2013). Versions of the FFMQ were adapted for use in Norway, Sweden, and Denmark, to name a few countries (Dundas, Vøllestad, Binder, & Sivertsen, 2013; Lilja et al., 2011; Jensen, Krogh, Westphael, & Hjordt, 2019). These studies mostly support the initial five-factor structure but also present the possibility of a four-factor model as a more accurate representation of the overall mindfulness construct (Curtiss & Klemanski, 2014; Lilja et al., 2011). Baer and colleagues also observed a similar pattern with the Observing factor having the lowest loading score compared to the other factors, although it was still significant (2006). The Observing factor fits into their mindfulness model best when the population had previous exposure to meditation, indicating that it likely is an aspect of mindfulness that is quite sensitive to practice. Similarly, Lilja and colleagues found that the observing factor was not significant for their population with little meditation experience (2011). When people without meditation experience attend to or observe their experiences, they tend to judge them, meaning that observation plays a different role based on the amount of meditation experience an individual has.

Relating Mindfulness, Self-Stigma, and Help-Seeking Behaviors

Mindfulness and Help-Seeking

Little research has been done directly linking mindfulness with help-seeking behavior, but some aspects of mindfulness can still be related to an individual’s intention to seek help. One such study examined whether mindfulness was able to predict veterans’ mental health service utilization.

In Barr and Kintzle's study, mindfulness was examined for its ability to predict the likelihood of veterans' utilization of mental health services (Barr & Kintzle, 2019). Veterans and service members face many challenges due to the nature of their work, including challenges that could be overcome by utilizing mental health services. Post-traumatic stress disorder is estimated to have a prevalence rate of 23% within those that use Veterans Health Administration Services (Fulton et al., 2015). Depression also has a potentially high prevalence rate of 21%, although some studies cite it as around 11-16% (Vaughan, Scheel, Tanelian, Jarcox, & Marshall, 2014). However, self-stigma is consistently cited as one of the most significant barriers to service utilization within this population (Barr & Kintzle, 2019). In Barr and Kintzle's study, an interaction between mindfulness and PTSD was found. Increased PSTD symptoms were associated with more mental health services utilization, and increased self-stigma was associated with less utilization. However, for lower levels of mindful (below the mean level of mindfulness in the sample), increases in PTSD symptoms were not associated with increased utilization. Above the mean mindfulness score, the likelihood of utilization increased as PTSD symptoms increased. This interaction suggested that mindfulness provides a "buffering" effect, in which past the sample mean of mindfulness, the probability of utilizing mental health services increased as PTSD symptoms increased.

Mindfulness and Self-Stigma

One of the critical aspects of mindfulness is a nonjudgmental attitude. The current study proposes that there is an inverse relationship between trait mindfulness and self-stigma due to this nonjudgmental attitude—because, at the core of stigma is making judgments about oneself. Other studies have shown a connection between trait mindfulness and making judgments about oneself.

One study demonstrated a robust, inverse relationship between trait mindfulness and early maladaptive schemas (EMS) in women seeking substance use treatment (Shorey, Anderson, & Stuart, 2015). Women with high trait mindfulness had lower endorsement of EMS. EMS can be defined as a "broad, pervasive theme or pattern comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationships with others… that are dysfunctional to a certain degree" (Young, Klosko, & Weishaar, 2003, p. 7). EMS are used by people to interpret their world and process their lives and typically underlie the development of psychopathology. There are several schemas that an individual can hold, but examples include emotional deprivation, abandonment, and mistrust/abuse. Schemas such as these are theoretically inversely related to mindfulness along two dimensions: present moment awareness and nonjudgment. While this does not directly relate stigma to trait mindfulness, there is indeed a connection that can be made between stigma and EMS. When someone develops an EMS (or multiple ones), they make judgments about themselves and the world around them. Although these judgments are perhaps more pervasive than self-stigmas, both EMS and self-stigma negatively impact how someone interprets their experiences (Shorey, Anderson, & Stuart, 2015). The researchers also suggest that the dimensions of awareness and nonjudgment will be most strongly associated with the development of self-stigma because EMS is composed of negative, self-defeating views and beliefs, so the increase in awareness and acceptance will empower people to be aware of the automatic process behind their EMS and be more accepting of their struggles. Shorey and colleagues measured mindfulness with a unidimensional measure, so this relationship remains theoretical, but they did find that participants with more EMS also had lower levels of trait mindfulness.

Due to institutionalized stigma in the military (despite destigmatization efforts), veterans who met the criteria for mental health problems were substantially more likely to endorse internalized mental health stigma (Barr et al., 2019). Barr and colleagues investigated the relationship between mindfulness, PTSD, depression, and self-stigma in veterans to better understand why this internalized self-stigma is prevalent in this population (2019). Higher levels of mindfulness were associated with less PTSD and depression symptoms, and PTSD symptoms were associated with higher levels of self-stigma. Barr and colleagues suggest that the mechanisms of action for mindfulness affecting self-stigma also lies in nonjudgment and nonreactivity, similar to the results found by Shorey, Brasfield, Anderson, and Stuart (2014). This is because inherent in the process of self-stigma is making judgments about oneself and others, so the attitude of nonjudgment and acceptance key to mindfulness may be a protective factor in developing self-stigma. Unfortunately, in Barr and colleagues' study, a unidimensional model of mindfulness was employed, but insights into the pathway that relates mindfulness and self-stigma were still uncovered (2019).

Barr and colleagues found that mindfulness had a negative direct effect on PTSD and depression symptoms, but there was no significant direct effect on self-stigma, which was not what Barr and colleagues hypothesized (2019). PSTD symptoms were predictive of depression and self-stigma, meaning that more PSTD symptoms were associated with more depressive symptomology and higher levels of self-stigma.

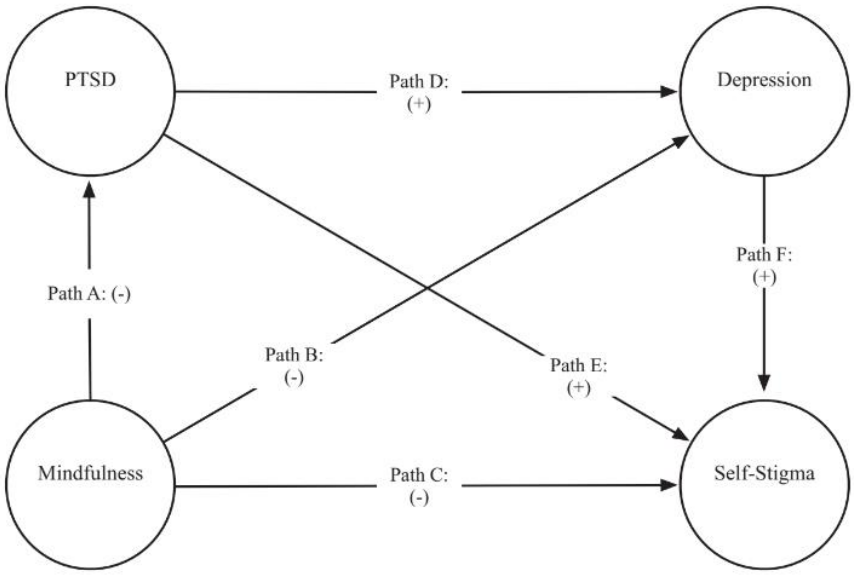

Figure 4. The relationship between mindfulness, PTSD, depression, and self-stigma

Note. This figure was adapted from Barr and colleagues (2019).

Since they did not find a significant direct effect of mindfulness on self-stigma, the indirect pathways were explored. Barr and colleagues also examined the indirect effects of mindfulness on self-stigma through PSTD and depressive symptoms pathways (2019). They hypothesized that mindfulness could decrease self-stigma levels when veterans experienced higher levels of PSTD and depression. Results showed that mindfulness had a significant negative effect on self-stigma through the PTSD pathway (paths A and E): when mindfulness increases and subsequently, PTSD symptoms decrease, self-stigma also decreases. This was not the case for depressive symptoms (paths B and F). While Barr and colleagues' research focuses on a single population with fairly severe mental illness, due to the extremely high levels of stigmatization inherent in the military, this relationship between mindfulness and self-stigma may still be present with less severe symptoms (2019). These results indicate that the relationship between mindfulness and self-stigma may depend upon the presence of mental

illness, so it is important to take into account the mental health of participants when investigating the relationship between these constructs.

For someone to seek help for psychological problems, self-compassion may be another mitigating factor. Heath and colleagues investigated whether self-compassion moderated the relationship of perceived public and anticipated self-stigma of seeking help (2018). The researchers defined self-compassion as "viewing oneself with kindness and nonjudgement in the face of personal suffering, perceived failure, or feelings of inadequacy" (Heath, Brenner, Lannin, & Vogel, 2018, p 65). They theorized that self-compassion could act as a protective factor toward an individual endorsing stigmatizing beliefs about themselves. This buffer could enable individuals to still seek help when experiencing a need. The results of Heath and colleagues' study show that self-compassion was negatively correlated with self-stigma, suggesting that self-compassion may be related to lower-self-stigma by buffering against the negative self-judgments inherent in self-stigmatization (2018). Self-compassion is an aspect of mindfulness because it encourages nonjudgment towards oneself; therefore, mindfulness may also act as a protective factor in that self-compassion interrupts the internalization of self-stigma.

Present Study

Self-stigma is internalized through a process that involves becoming aware of stereotypes that apply to one's identities, then agreeing with that stereotype. The individual then believes that the stereotype applies to them in a step called self-concurrence. Then, the self-stigma negatively impacts the individual in some way. In the context of mental health, self-stigma regarding seeking help for mental issues could decrease the likelihood that individuals reach out and seek help for their mental illness. Mindfulness, a nonjudgmental, present-moment focused awareness, may interrupt this process or provide a buffer for self-stigma formation because it encourages

non-judgment and acceptance of negative experiences. Non-judgment and nonreactivity in mindfulness buffers against the negative judgments made about oneself during the internalization of stigma. By interrupting self-stigma formation, one of the barriers to seeking help may be overcome, which could foster the utilization of mental health services. The purpose of the current study was to examine if mindfulness increases one's willingness to seek help for mental health issues by reducing the chances of forming self-stigma regarding seeking mental health help. Little research has been done to investigate the relationships between these three factors of mindfulness, self-stigma, and seeking help.

Research Question 1

Does mindfulness foster a willingness to seek help for mental illness? It was predicted that mindfulness (as an overall construct) will positively correlate with a willingness to seek help because the nonjudgmental and acceptance-based nature of mindfulness should reduce internal barriers to seeking help. This question was investigated with both the Intention to Seek Counseling Inventory (ISCI) and the Mental Help Seeking Intention Scale (MHSIS).

Research Question 2

Which of the five facets of mindfulness facilitate a willingness to seek help for mental illness? It was hypothesized that each of the five facets of mindfulness would positively correlate with willingness to seek help because if the overall construct of mindfulness is positively related to a willingness to seek help, each individual facet should also be positively correlated. This question was also analyzed with both the ISCI and the MHSIS.

Research Question 3

Does mindfulness inhibit the formation of self-stigma regarding seeking help? It is predicted that mindfulness (as an overall construct) will negatively correlate with experiencing

self-stigma regarding seeking mental health help. The nonjudgmental and nonreactive nature of mindfulness may provide a buffer to limit the internalization of self-stigma.

Research Question 4

Which of the five facets of mindfulness are likely to inhibit the formation of self-stigma concerning seeking mental health help? It is predicted that non-judgment and nonreactivity will be negatively correlated with experiencing self-stigma. A key step in the internalization of self-stigma is agreeing with negative stereotype and concurring that those stereotypes apply to oneself—not being reactive to experiences and adopting a nonjudgmental perspective may prevent self-concurrence.

Research Question 5

Does having a self-stigma about seeking help for mental illness reduce the willingness to seek help? This question was also answered with both the ISCI and the MHSIS.

Research Question 6

Does mindfulness facilitate willingness to seek help for mental illness by providing a protective factor in self-stigma formation regarding seeking help? In other words, will mindfulness prevent self-stigma, and will this, in turn, facilitate seeking help? A mediation analysis is expected to show that when mindfulness (as an overall construct) is negatively correlated with experiencing self-stigma, this reduced likelihood of forming self-stigma will, in turn, increase the intention to seek help for mental illness. Again this question was investigated with both the ISCI (6a) and the MHSIS (6b).

Research Question 7

Which of the five facets of mindfulness will provide a protective factor for the formation of self-stigma concerning seeking help, and will, in turn, facilitate someone's

willingness to seek help for a mental illness? With a mediation analysis, it is hypothesized that non-judgment, as well as nonreactivity, will each negatively correlate with self-stigma, and this, in turn, will increase the intention to seek help. This question was also explored with the ISCI (7a) and MHSIS (7b).

Method

Participants

Participants were recruited using Amazon's Mechanical Turk (MTurk) service. MTurk is an online crowdsourcing service that allows people to complete tasks, such as surveys, for payment. This allows for a large pool of data to be gathered, although there are some concerns with the sample's characteristics. Since the payment for the tasks is fairly minimal, questions may be raised about who is completing the tasks (Paolacci & Chandler, 2014). However, the sample pool is wide, consisting of more than 500,000 workers in 2014 in 190 countries. Although there is a large labor force, it is not necessarily representative of the broader populations.

As of 2014, workers on MTurk tend to be under thirty, overeducated, unemployed, and potentially less emotionally stable (Paolacci & Chandler, 2014). Some research shows that workers on MTurk are no more likely to show clinically significant distress compared to the general population (Shapiro, Chandler, & Mueller, 2013). With the current global pandemic and lower employment in 2020, these demographics may have changed to become more representative of the wider population.

There are also potential sampling issues due to the self-selection nature of the tasks. Workers are presented with several alternative tasks that they are qualified to complete.

Requestors of tasks can choose what qualifications they would like for their workers to have. Additionally, other factors such as timing, pay, task complexity, and the posting's recency can all impact whether a worker chooses to complete a task (Paolacci & Chandler, 2014).

With all these considerations, research on the data quality on MTurk still demonstrates that worker samples are reliable (Paolacci & Chandler, 2014). Studies show few differences between MTurk workers and other participants' attention and that MTurk workers are truthful when completing self-report measures (Paolacci et al. 2010; Shapiro et al. 2013). Although the sample gathered on MTurk may not be as diverse as the wider population, it will be closer to being representative than a college sample would be.

In total, 200 participants were recruited for this study using Amazon Mechanical Turk. Eleven of these responses were not utilized for final analyses because they did not complete all four measures. Therefore, a total of 189 scores were analyzed for each measure. This is well over the minimum sample size suggested of 116 to conduct multiple regression analyses at a desired power of .80, an anticipated moderate effect size, and an alpha level of .05.

The majority of participants were male, with 119 (63%) males and 70 (37%) females. The average age of this sample was 35.75 (*SD* = 10.84, range 21-68). Seventy-eight percent of participants identified as White, 6% identified as Black, 5 % identified as Hispanic, and 7 % identified as Asian. Also, 4% of participants identified as a combination of Caucasian and another ethnicity.

Procedure

Participants completed the study measures through an online survey system, Qualtrics. Participants began with reading a statement of informed consent, then completing a series of

demographic questions (age, ethnicity, gender, etc.). After this, the participants completed a battery of measures consisting of the scales mentioned previously and further described below. The scales were counterbalanced to control for order effects. Once the scales are completed, participants were presented with a debriefing and thanked for the participation. Participants were compensated $0.50 once their participation was verified by checking their Mechanical Turk ID.

Materials

Five-Facet Mindfulness Questionnaire (FFMQ)

The FFMQ has an overall score and individual scores for five subscales that measure different aspects of mindfulness by asking participants to rate how much an item is generally true for them. The overall score was obtained by adding all the items together and then dividing by the total number of items, thirty-nine. The five subscales are: observe (8 items), describe (8), act with awareness (8), nonjudgment (8), and nonreactivity (7). For example, an item in the observing subscale is “When I’m walking, I deliberately notice the sensations of my body moving”. An item on the describing subscale is “I’m good at finding words to describe my feelings”. The Cronbach alphas of the subscales are: observe = .34, describe = .57, awareness = .72, nonjudgment = .55, nonreactivity = .71; other psychometric properties are CFI = .96, NNFI = .94, and RMSEA = .07. The total score for each subscale was derived by adding each item's numeric responses and then dividing by the total number of items in the subscale to find the average score for each scale. Both the overall and subscale scores can range from 1 (minimum) to 5 (maximum). The higher the score on the FFMQ, the higher the participant’s mindfulness.

Self-Stigma of Seeking Help

This scale has ten items that ask participants to rate how

they feel their reactions would be in a situation, such as having a mental illness, where they would need to seek mental health help (5 = strongly agree, 1 = strongly disagree). A sample item is “I would feel inadequate if I went to a therapist for psychological help”. This is a unidimensional scale, and the total score is the sum of the participants’ responses. Items 2,4,5,7 and 9 are reverse scored. Scores can range from 10-50, with a lower score indicating less self-stigma towards seeking help. This scale demonstrates a cross-cultural reliability alpha of .83 (Tucker et al., 2013).

Intention to Seek Counseling Inventory

This scale has 17 items that ask participants to indicate how likely they would be to seek counseling if they were experiencing the issue listed in the item. The scores can range from 17-68, with scores between 17-42 indicating a lower likelihood of seeking services and scores above 43, indicating a higher likelihood of seeking services. There are three subscales: interpersonal problems, academic problems, and drug/alcohol problems. The ISCI shows internal consistency estimates for its three subscales measuring .90 for Interpersonal Problems, .86 for Drug/Alcohol Problems, and .71 for Academic Problems. For example, an item from the Interpersonal Problems subscale is “conflict with parents” and an item from the Academic Problems subscale is “test anxiety”. Scores from each item awee added together and then averaged to create a total score and/or the subscale scores. In the current study, the total score was used during the analyses.

Mental Help-Seeking Intentions Scale

This scale only has three items that produce a single mean score. All the scores for each item are added together and then divided by three. Scores could range from 1 (minimum) to 7 (maximum). Factor analysis of this scale shows a unidimensional factor (R^2 = 85%, 83%, and

84%). A higher score on this inventory indicates a higher willingness to seek help. A sample item from this scale is "If I had a mental health concern, I would try to seek help from a mental health professional."

Results

Internal Consistency Analyses of the Measures

Negatively worded items were reverse-scored in the FFMQ and SSOSH scales before analyses. As measured by Cronbach's alphas, internal consistency exceeded .70 for all measures except the FFMQ describing subscale and Self-Stigma of Seeking Help Scale (.46 and .64, respectively). Cronbach's alpha values for the FFMQ subscale nonreactivity (.85), the Intention to Seek Counseling Inventory (.87), and the Mental Help-Seeking Scale (.84) indicated good internal consistency. The FFMQ subscales of acting with awareness (.91) and nonjudging (.91) subscales had excellent internal consistency. Appendix E has a further discussion of how the internal consistencies compare to other studies.

Table 1

Internal Consistency of the Measures (N = 189)

Measure		Cronbach's alpha
Five-Factor Mindfulness Questionnaire (FFMQ)		
	Sum	.77
	Observing	.72
	Describing	.46
	Acting with Awareness	.91
	Nonjudging	.91
	Nonreactivity	.85
Self-Stigma of Seeking Help (SSOSH)		.64
Intention to Seek Counseling Inventory (ISCI)		.87

Mental Help-Seeking Scale (MHSIS)	.84

Characteristics of the Study Sample

Mindfulness was scored as an overall, one-dimensional construct, and each facet subscale score was also obtained. Mean scores and standard deviations of each measure are found in Table 2.

Table 2

Means and Standard Deviations (N = 189)

Measure		*M*	*SD*	Possible Range of Scores	Sample Range of Scores
FFMQ					
	Sum	122.83	12.84	39-195	92-173
	Observing	28.53	5.68	8-40	11-40
	Describing	26.16	3.66	8-40	11-39
	Acting with Awareness	22.25	7.61	8-40	8-40
	Nonjudging	20.98	6.80	8-40	8-40
	Nonreactivity	24.94	5.00	9-35	9-35
SSOSH		28.83	5.55	5-50	10-50
ISCI		32.26	11.77	4-68	16-68
MHSIS		16.12	3.32	3-21	3-21

Note. Five-Factor Mindfulness Questionnaire = FFMQ, Self-Stigma of Seeking Help Scale = SSOSH, Intention to Seek Counseling Inventory = ISCI, Mental Help Seeking Intention Scale = MHSIS.

Dundas and colleagues (2013) reported a slightly higher level of mindfulness as measured by the FFMQ, with a mean of 128.74 for a sizeable sample size of 792 participants. However, these participants were from Sweden. Likewise, the subscales showed similarities: observing (27.24), describing (29.27), acting with awareness (24.91), nonjudging (26.45), and nonreactivity (20.97).

Participants in the current study have a similar, although slightly higher, mean score of self-stigma of seeking help than participants in Barr and colleagues' study with a mean of 26.04 and a standard deviation of 6.40 (2019). Barr and colleague's study utilized a sample of U.S. veterans. Another study utilized two different samples (university students and patients at a health care clinic) and found similar mean values: 27 (students) and 23 (patients) (Wallin et al., 2017).

The current study's ISCI score is significantly higher than those measured by Tucker and colleagues (2013) who only report a mean of 24, although they report a lower standard deviation of 6.98. This study utilized a population of college undergraduates experiencing significant psychological distress levels, so this is a fairly different population. Another study by Cepeda-Benito and Short also utilized a sample of undergraduate students (not in distress) and obtained a higher mean ISCI score of 45.86 with a relatively high standard deviation of 16.45 (1998).

Relating Mindfulness, Self-Stigma, and Help-Seeking

Before examining if self-stigma is a mediating factor in the relationship between mindfulness and help-seeking behaviors, zero-order correlations were examined. Most correlations were statistically significant. See Table 3 below for details. As expected, nearly all of the five facets of mindfulness were significantly positively correlated with the unidimensional construct of mindfulness: observing (.19), describing (.60), acting with awareness (.66), and nonjudging (.61). Nonreactivity was the only facet that was not significantly correlated with unidimensional mindfulness (.12), but it wasin the predicted direction. However, the facets were not all positively correlated with each other. Observing was significantly negatively correlated with acting with awareness and nonjudging (-.42, -.50) and significantly positively correlated with describing and nonreactivity (.30, .62). Describing was significantly correlated with

nonreactivity (.23) and observing (.30). Acting with awareness was positively correlated with nonjudging (.84) and negatively correlated with observing and nonreactivity (-.46, -.55).

It is unusual that there is a difference in the directions of the correlations. A higher score on the FFMQ indicates a higher level of mindfulness, so all facets should be positively correlated with each other and with the sum FFMQ score (Goldberg et al., 2017). Interestingly, all five facets do positively correlate with the sum FFMQ score, even though they were not all positively correlated with each other. This inconsistency is likely due to the characteristics of the sample. In studies by (Gu et al., 2016), whether or not a sample was a meditating sample had a significant effect on the relationships between the subscales of the FFMQ. This lack of a unitary pattern in the correlations was observed in nonmeditating samples, while samples that practiced regular meditation demonstrated the expected correlations pattern. This shows that sample demographics can affect the scores of this study.

Table 3

Correlations Between Variables (N = 189)

Variable	FFMQ (Sum)	Observing	Describing	Acting with Awareness	Nonjudging	Nonreactivity	SSOSH	ISCI	MHSIS
FFMQ (Sum)	--	.19*	.60**	.66**	.61**	.12	-.35**	-.19*	-.04
Observing		--	.30**	-.46**	-.54**	.67**	-.06	.52**	.53**
Describing			--	.11	.09	.23**	-.18*	.11	.16*
Acting with Awareness				--	.84**	-.55**	-.25**	-.55**	-.42**
Nonjudging					--	-.54**	-.24**	-.57**	-.45**
Nonreactivity						--	.03	-.50**	-.46**
SSOSH							--	.09	-.28**
ISCI								--	.56**
MHSIS									--

Note. Five-Factor Mindfulness Questionnaire = FFMQ, Self-Stigma of Seeking Help Scale = SSOSH, Intention to Seek Counseling Inventory = ISCI, Mental Help Seeking Intention Scale = MHSIS.

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

Relationship between Mindfulness and Help-Seeking Intentions

Research Question 1

Does mindfulness foster a willingness to seek help for mental illness? It was predicted that mindfulness (as an overall construct) would positively correlate with a willingness to seek help because the nonjudgmental and acceptance-based nature of mindfulness should reduce internal barriers to seeking help. However, Table 3 indicates a significant inverse correlation between mindfulness (FFMQ Sum) and seeking help (measured by the ISCI), $r = -.19$, $p = .001$. As mindfulness increased, help-seeking behaviors decreased. When the MHSIS measured help-seeking, there was no significant relationship between these two constructs, $r = -.04$, $p > .05$.

Research Question 2

Which of the five facets of mindfulness facilitate a willingness to seek help for mental illness? It was hypothesized that each of the five facets of mindfulness would positively correlate with willingness to seek help. If the overall construct of mindfulness is positively related to a willingness to seek help, each facet should also be positively correlated.

When help-seeking intention was measured using the ISCI, only the facet of observing was positively correlated with willingness to seek help (see Table 3), $r = .52$, $p < .001$. Following the inverse correlation between mindfulness as an overall construct and help-seeking (ISCI) (see Research Question 1 results), acting with awareness, nonjudgment, and nonreactivity were each negatively correlated with help-seeking ($r = -.55$, $r = -.57$, $r = -.50$, for all correlations, $p < .001$). The facet of describing was not associated with help-seeking.

When help-seeking intention was measured using the MHSIS, a similar correlation pattern was observed (see Table 3). Observing was also positively correlated with willingness to

seek help, $r = .53$ $p < .001$. Likewise, acting with awareness, nonjudgment, and nonreactivity were each negatively correlated with help-seeking ($r = -.42$, $r = -.45$, $r = -.46$, for all correlations, $p < .001$). In addition, however, the facet of describing was positive though weakly correlated with help-seeking as measured by the MHSIS, $r = .16$, $p = .03$.

Relationship between Mindfulness and Self-Stigma

Research Question 3

Does mindfulness inhibit the formation of self-stigma regarding seeking help?

It was predicted that mindfulness (as an overall construct) would negatively correlate with experiencing self-stigma regarding seeking mental health help. The nonjudgmental and nonreactive nature of mindfulness may provide a buffer to limit the internalization of self-stigma. The results in Table 3 confirmed this. As mindfulness increased (FFMQ Sum), self-stigma (SSHOS) decreased, $r = -.35$, $p = .001$; people reporting more mindfulness reported less self-stigma towards seeking help.

Research Question 4

Which of the five facets of mindfulness are likely to inhibit the formation of self-stigma concerning seeking mental health help? It was predicted that non-judgment and nonreactivity would be negatively correlated with experiencing self-stigma. A key step in the internalization of self-stigma is agreeing with negative stereotypes and concurring that those stereotypes apply to oneself—not being reactive to experiences and adopting a nonjudgmental perspective may prevent self-concurrence. As hypothesized, self-stigma was negatively correlated with non-judgment, $r = -.24$, $p = .001$, but was not associated with nonreactivity (see Table 3). It was also negative though weakly correlated with describing, $r = -.18$, $p = .02$.

Relationship between Self-Stigma and Help-Seeking Intentions

Research Question 5

Does having a self-stigma about seeking help for mental illness reduce the willingness to seek help? Table 3 shows no significant relationship between self-stigma (SSHOS) and help-seeking intentions (measured by the ISCI), $r = .09$, $p = .23$ However, since mindfulness was significantly correlated with self-stigma (see Research Question 3 results) and help-seeking (see Research Question 1 results), a partial correlation was performed. When mindfulness as an overall construct was controlled, there was a significant negative correlation between self-stigma and help-seeking (ISCI), $r = -.18$, $p = .001$; as self-stigma decreased, willingness to seek help increased. When the MHSIS measured willingness to seek help, a similar result was obtained, $r = -.28$, $p = .001$, even when mindfulness was not controlled.

Self-Stigma as a Mediator in the Relationship between Mindfulness and Help-Seeking Intentions (ISCI)

Research Question 6a

Does mindfulness facilitate willingness to seek help for mental illness by providing a protective factor in self-stigma formation regarding seeking help? In other words, will mindfulness prevent self-stigma, and will this, in turn, facilitate seeking help? To investigate whether self-stigma mediates the relationship between mindfulness as an overall construct and help-seeking intentions (using the ISCI), a Baron and Kenny test for mediation (2014) was performed. Step 1 of this procedure requires a significant relationship between the hypothesized causal (mindfulness) and outcome (help-seeking) variables. A multiple regression analysis indicates that as mindfulness levels increased, help-seeking (as measured by the ISCI) decreased, $\beta = -.19$, $p = .009$.

Step 2 examines the relationship between the causal variable and the potential mediator (self-stigma). Another multiple regression analysis was performed, and as mindfulness increased, self-stigma towards seeking help decreased, $\beta = -.35$, $p < .001$.

Step 3 tests if there is a relationship between the potential mediator and the outcome variable while controlling the causal variable. Results indicate that as self-stigma increased, help-seeking decreased, $\beta = -.18$, $p = .02$.

Finally, Step 4 investigates whether the relationship between the causal and the outcome variables is fully (when $\beta = 0$) or partially mediated (when $\beta \neq 0$). This mediation is partial (β was not zero), $\beta = -.25$, $p < .001$. As mindfulness increased, help-seeking decreased while controlling the potential mediator (self-stigma). The amount of mediation (the indirect effect) is $\beta = .06$. According to a Sobel's test, this partial mediation was statistically significant, ($Z = 2.12$, $p = .02$ (one-tailed)).

Table 4

Summary of the Multiple Regression Analysis for Variables Predicting Help-Seeking Intentions as Measured by the ISCI (N = 189).

Variable	*B*	*SE B*	*β*
Unidimensional Mindfulness	-.23	.07	-.25
Self-Stigma of Seeking Help	-.37	.16	-.18

Note. $R^2 = .063$; adjusted $R^2 = .053$

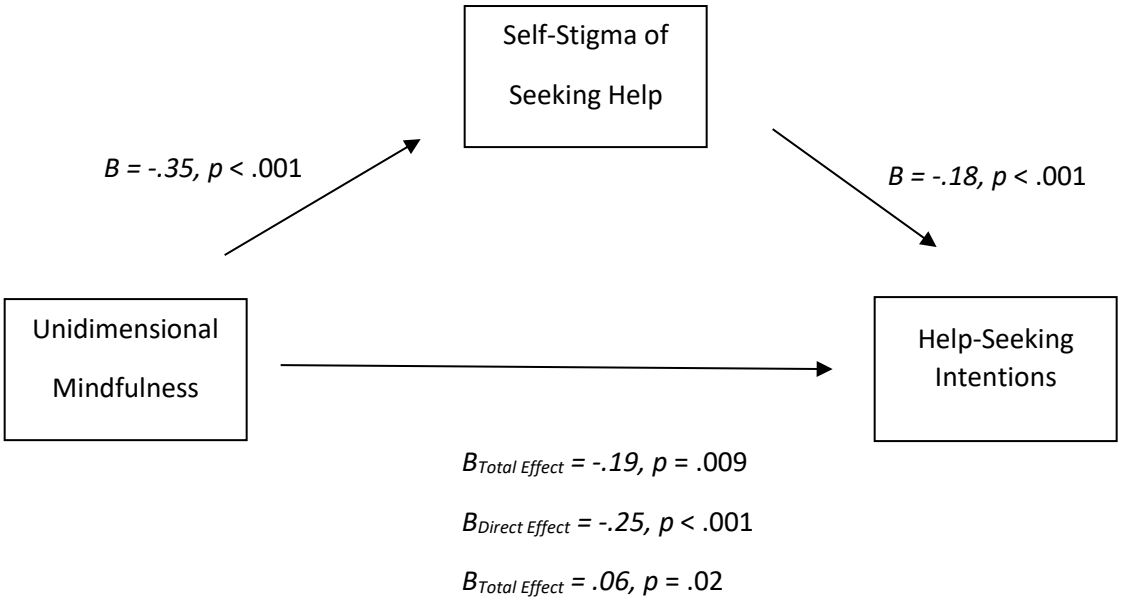

Figure 5. Relationship between mindfulness and help-seeking intentions as partially mediated by self-stigma of seeking help.

Self-Stigma as a Mediator in the Relationship between Mindfulness and Help-Seeking Intentions (MHSIS)

Research Question 6b

Since there was no significant relationship between mindfulness and help-seeking when measured using the MHSIS (see Research Question 1 results), a mediation test is not warranted.

Identifying the Facets of Mindfulness for Tests of Mediation

Research Question 7

Which of the five facets of mindfulness will provide a protective factor for the formation of self-stigma concerning seeking help, and will, in turn, facilitate someone's willingness to seek help for a mental illness? A test of mediation involving a facet of mindfulness is only justified

if the specific facet (the hypothesized causal variable) is correlated with both help-seeking intentions (the outcome variable) and self-stigma (the potential mediator). The table below summarizes the results of Research Questions 2 and 4. When measuring help-seeking with the ISCI, the following two facets can be tested for mediation: acting with awareness and nonjudgment. When the MHSIS was used to measure help-seeking, mediation analyses can be conducted for the following three facets: describing, acting with awareness, and nonjudgment. The results of these five tests of mediation are presented in the subsequent sections of the results section.

Table 5

Relationships between the Facets of Mindfulness, Help-Seeking Intentions, and Self-Stigma

Mindfulness Facet	Correlation with Help-Seeking (ISCI) (Research Question 2)	Correlation with Help-Seeking (MHSIS) (Research Question 2)	Correlation with Self-Stigma (Research Question 4)
Observing	.52**	.53**	NS
Describing	NS	.16*	-.18*
Acting w/ Awareness	-.55**	-.42**	-.25**
Nonjudgment	-.57**	-.45**	-.24**
Nonreactivity	-.50**	-.46**	NS

* $p < .05$ ** $p < .01$ NS = not significant

Self-Stigma as a Mediator in the Relationship between Acting with Awareness and Help-Seeking Intentions (ISCI)

A Baron and Kenny test for mediation was performed on acting with awareness as the predictor variable, help-seeking (ISCI) as the outcome variable, and self-stigma as the potential mediator. For Step 1, the relationship between the predictor and outcome variables was investigated: as acting with awareness scores increased, help-seeking decreased, β = -.55, p < .001.

Step 2 examines the relationship between acting with awareness and the self-stigma of seeking help. As acting with awareness scores increased, self-stigma decreased, β = -.25, p = .001.

Step 3 investigates the relationship between self-stigma and seeking help while controlling acting with awareness. When controlling acting with awareness, as self-stigma increased, seeking help decreased, β = -.24, p < .001.

Step 4 explores whether the relationship between the predictor and outcome variables is partially ($\beta \neq 0$) or fully mediated ($\beta = 0$). The relationship between acting with awareness and help-seeking is partially mediated by self-stigma, β = -.61, p < .001. The amount of mediation (indirect effect) is β = .06 According to a Sobel's test, this partially mediated effect was statistically significant (Z = 2.60, p = .004 (one-tailed).

Table 6

Summary of the Multiple Regression Analysis for Variables Predicting Help-Seeking Intentions as Measured by the ISCI (N = 189)

Variable	*B*	*SE B*	β

Acting with Awareness	-.95	.09	-.61
Self-Stigma of Seeking Help	-.51	.13	-.24

Note. R^2 = .36; adjusted R^2 = .35

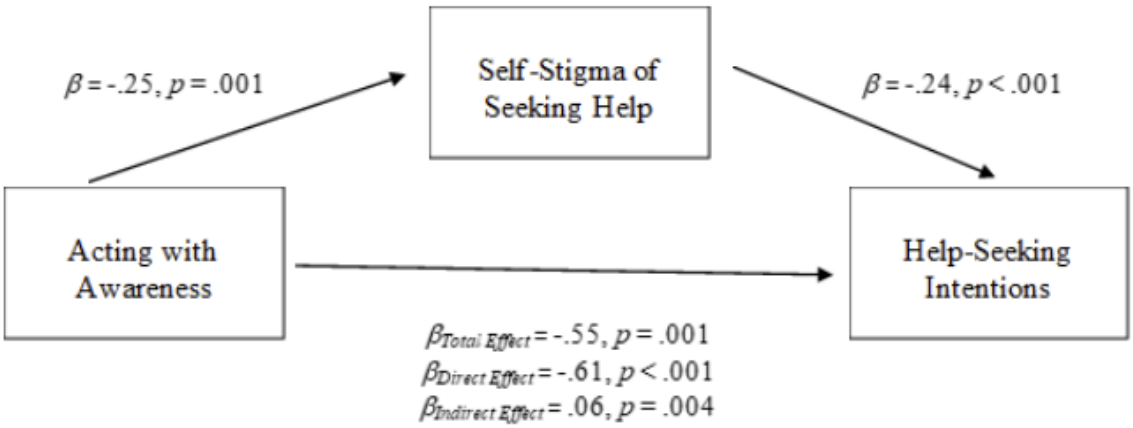

Figure 6. Relationship between acting with awareness and help-seeking intentions as partially mediated by self-stigma of seeking help.

Self-Stigma as a Mediator in the Relationship between Nonjudging and Help-Seeking Behaviors (ISCI)

Step 1 of the Baron and Kenny test for mediation showed that as nonjudging scores increased, help-seeking decreased, β = -.57, p < .001.

Step 2 examines the relationship between nonjudging and the self-stigma of seeking help. As nonjudging scores increased, self-stigma decreased, β = -.24, p = .001.

Step 3 investigates the relationship between self-stigma and seeking help while controlling nonjudging. When controlling nonjudging, as self-stigma increased, seeking help decreased, β = -.24, p < .001.

Step 4 examines whether the mediation is partial ($\beta \neq 0$) or full ($\beta = 0$). As nonjudging increased, help-seeking also decreased while controlling self-stigma, β = -.62, which was also a partial mediation. The amount of mediation (indirect effect) was β = .05. According to a Sobel's test, this mediation was statistically significant (Z = 2.58, p = .005 (one-tailed)).

Table 7

Summary of the Multiple Regression Analysis for Variables Predicting Help-Seeking Intentions as Measured by the ISCI (N = 189)

Variable	*B*	*SE B*	*β*
Nonjudging	-1.08	.10	-.62
Self-Stigma of Seeking Help	-.50	.13	-.24

Note. R^2 = .38; adjusted R^2 = .37

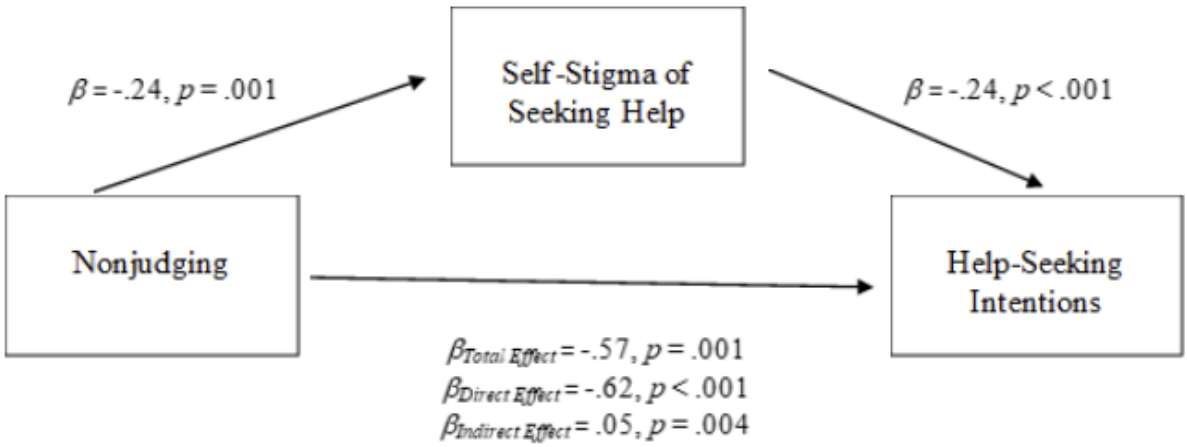

Figure 7. Relationship between nonjudging and help-seeking intentions as partially mediated by self-stigma of seeking help.

Self-Stigma as a Mediator in the Relationship between Describing and Help-Seeking Intentions (MHSIS)

Step 1 of the Baron and Kenny test for mediation found that as describing scores increased, the intention to seek mental health help as measured by the MHSIS increased, β = -

.16, p = .03. Step 2 examined the relationships between describing and the self-stigma of seeking help. As describing increased, self-stigma decreased, β = -.18, p = .02. For Step 3, when controlling describing, as self-stigma scores increased, seeking help decreased, β = -.26, p < .001.

Step 4 explored whether the relationship between describing and help-seeking is partially ($\beta \neq 0$) or fully mediated ($\beta = 0$). Results indicate a partial mediation, β = .12, p = .11. The amount of mediation (indirect effect) was β = .04. According to a Sobel's test, this partial mediation approached statistical significance, Z = 2.04 , p = .02 (one-tailed).

Table 8

Summary of the Multiple Regression Analysis for Variables Predicting Help-Seeking Intentions as Measured by the MHSIS (N = 189)

Variable	*B*	*SE B*	*β*
Describing	.10	.06	.12
Self-Stigma of Seeking Help	-.16	.04	-.26

Note. R^2 = .092; adjusted R^2 = .083

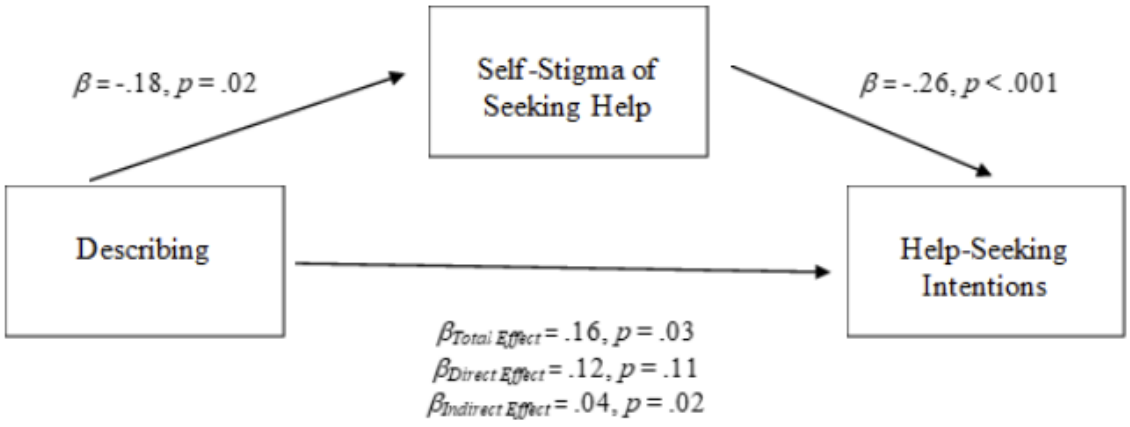

Figure 8. Relationship between describing and help-seeking intentions as partially mediated by self-stigma of seeking help.

Self-Stigma as a Mediator in the Relationship between Acting with Awareness and Help-Seeking Behaviors (MHSIS)

Step 1 of the Baron and Kenny test for mediation was performed with the acting with awareness scores and the MHSIS: as acting with awareness increased, the likelihood someone would seek help decreased, β = -.42, p < .001. Step 2 explored the relationship between acting with awareness and the SSOSH, and these were inversely related, β = -.25, p = .001. For Step 3, when controlling acting with awareness scores, as self-stigma increased, the likelihood people would reportedly seek mental health help decreased, β = -.41, p < .001.

In Step 4, acting with awareness had a β of -.52, p < .001—and since this value is not zero, self-stigma only partially mediated the relationship between acting with awareness and help-seeking. The amount of the indirect effect was β = .10. A Sobel's test was also conducted and indicated that this mediation was significant, Z = 3.07, p = .001 (one-tailed).

Table 9

Summary of the Multiple Regression Analysis for Variables Predicting Help-Seeking Intentions as Measured by the MHSIS (N = 189)

Variable	*B*	*SE B*	*β*
Acting with Awareness	-.23	.03	-.52
Self-Stigma of Seeking Help	-.25	.04	-.41

Note. R^2 = .33; adjusted R^2 = .33

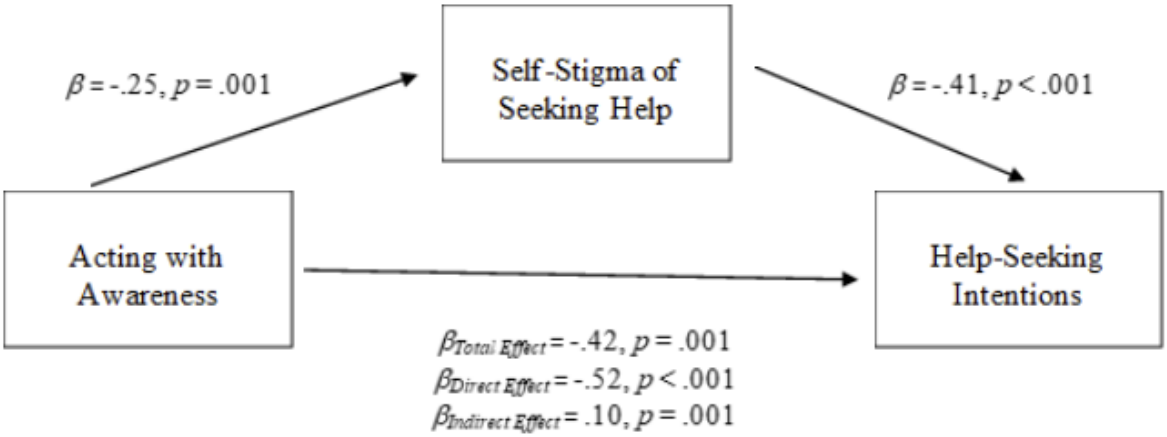

Figure 9. Relationship between acting with awareness and help-seeking intentions as partially mediated by self-stigma of seeking help.

Self-Stigma as a Mediator in the Relationship between Nonjudging and Help-Seeking Behaviors (MHSIS)

Finally, a Baron and Kenny test of mediation was conducted on the nonjudging facet, the MHSIS, and the SSOSH. In Step 1, as nonjudging increased, help-seeking intentions decreased, β = -.45, p < .001. In Step 2, as nonjudging increased, the self-stigma associated with seeking help decreased, β = -.24, p = .001. When nonjudging was controlled in Step 3, there was a negative relationship between self-stigma and seeking help, β = -.41, p < .001.

For the final step of the mediation test, nonjudging had a nonzero standardized β of -.55, p < .001, so this was a partial mediation with an indirect effect of .10. A Sobel's test indicates a significant effect, Z = 3.04, p = .001 (one-tailed).

Table 10

Summary of the Multiple Regression Analysis for Variables Predicting Help-Seeking Behaviors as Measured by the MHSIS (N = 189)

Variable	*B*	*SE B*	*β*

Nonjudging	-.27	.03	-.55
Self-Stigma of Seeking Help	-.25	.04	-.41

Note. R^2 = .36; adjusted R^2 = .35

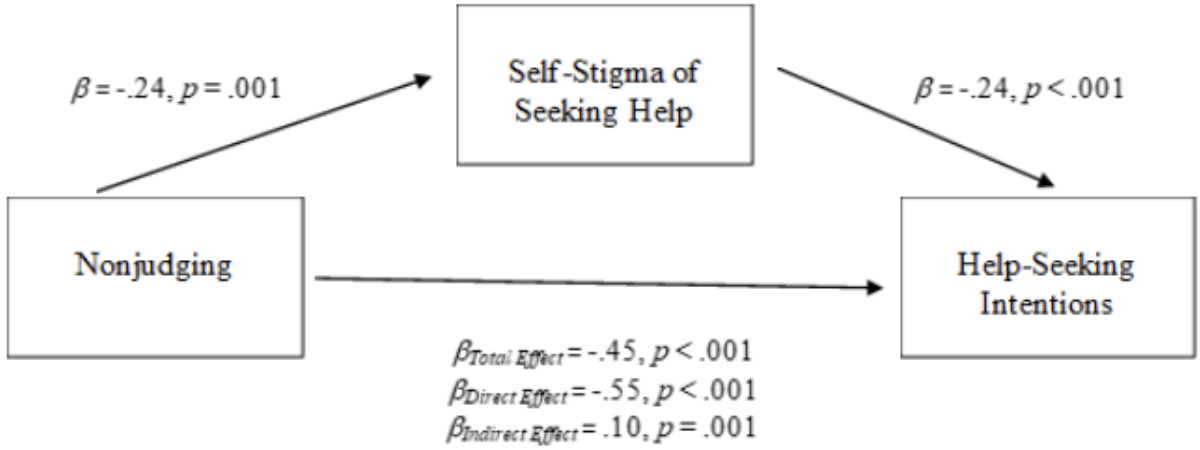

Figure 10. Relationship between nonjudging and help-seeking intentions as partially mediated by self-stigma of seeking help.

Summary of the Results of the Tests of Mediation

Table 11 below summarizes the results of the six Baron and Kenny tests of mediation results. Although the results indicate that the relationships between mindfulness (and some of its facets) and help-seeking intentions were partially mediated by self-stigma regarding seeking help, these mediated effects were much weaker than the direct effects of mindfulness on help-seeking. For example, when examining the relationship between overall mindfulness and help-seeking (using the ISCI), the mediated effect was .06 while the direct effect -.25. The direct effect of mindfulness on help-seeking was at least four times stronger than the effect of mindfulness when mediated by self-stigma.

Except for the facet of describing, overall mindfulness and its acting with awareness and nonjudging facets had negative direct effects on help-seeking. As overall mindfulness, acting

with awareness, and nonjudging increased, help-seeking intentions decreased. In contrast, the partially mediated effects of overall mindfulness and its facets of acting with awareness and nonjudging were positive. As mindfulness increased, self-stigma regarding seeking help decreased. In turn, this increased the intention to seek help.

Table 11

Summary of the Tests of Mediation Results

Variable Relationships	$\beta_{\text{Total Effect}}$	$\beta_{\text{Direct Effect}}$	$\beta_{\text{Indirect or Mediated Effect}}$	Sobel's *p*
Unidimensional Mindfulness and ISCI	-.19	-.25	.06	.02
Acting with Awareness and ISCI	-.55	-.61	.06	.004
Nonjudging and ISCI	-.57	-.62	.05	.005
Describing and MHSIS	.16	.12	.04	.02
Acting with Awareness and MHSIS	-.42	-.52	.10	.001
Nonjudging and MHSIS	-.45	-.55	.10	.001

Discussion

The present study investigated the relationship between mindfulness, help-seeking, and self-stigma to explore whether mindfulness acts as a buffer to the formation of self-stigma, in turn, increasing the likelihood that someone would be willing to seek help. Participants were recruited through Amazon Mechanical Turk and given a battery of assessments to measure their trait mindfulness, self-stigma towards seeking help, and intention to seek help.

Mindfulness and Willingness to Seek Help

Overall Mindfulness and Willingness to Seek Help

In the current study, mindfulness had a negative relationship with seeking help as measured by the ISCI. As mindfulness increased, willingness to seek help decreased. This result was in the opposite direction of the hypothesized results. Other studies, such as Barr and Kintzle's, demonstrated that as participants' mindfulness increased, so did their willingness to seek help (2019). Their study's population consisted of veterans with PTSD symptoms, and results showed that participants who had high levels of PTSD symptoms and high levels of mindfulness were more willing to seek help; however, when participants had lower levels of mindfulness and lower levels of PTSD, there was no significant relationship between mindfulness and help-seeking. Participants of the current study might have lower psychological distress levels, partly explaining the unexpected relationship between mindfulness and help-seeking. Future studies should take into consideration the participants' current state of mental health.

Additionally, these results occurred because if participants were naturally more mindful, they would have the inherent skills to handle a problem when it arose. For example, if someone were experiencing the onset of test anxiety (one of the items on the ISCI), they would have been equipped with skills such as present moment awareness that could help them handle test anxiety without outside help. If they were naturally mindful, they would likely be able to focus on the tasks at hand, thus improving test performance despite the presence of anxiety. If a person was experiencing PTSD symptoms such as flashbacks, one of the best interventions is grounding in the present moment by focusing on body sensations or the external environment. This practice is

often a way of practicing mindfulness by focusing on the present moment—so someone naturally more mindful could already possess this skill.

Likewise, those with higher levels of mindfulness tend to have higher resiliency levels (Pidgeon et al., 2014). Resiliency reflects our ability not to be as affected by challenges and bounce back after a challenge. This could similarly explain the lesser need for help, and thus a lesser willingness to seek help. Resilient people are less likely to seek help to recover from setbacks or other challenges because they can more easily get themselves back to everyday functioning (2014).

The other scale used to measure help-seeking intentions was the Mental Help-Seeking Intention Scale. This scale explicitly focused on whether someone would seek mental health help from a professional if they experienced a problem. It is a newer scale and not as widely utilized as the ISCI (Hammer & Spiker, 2018). There was no significant relationship between the MHSIS and mindfulness as an overall construct. This scale uses the term "mental health professional" in each item, while the ISCI only mentions "seeking counseling" in the instructions. Likewise, the ISCI presented the participants with a list of problems (e.g., excessive alcohol use, depression, etc.) and asked them to assess their likelihood of seeking help if they were confronted with those problems. In contrast, the MHSIS only mentions "a mental health concern." These differences in wording could have an impact on the participants' intentions to seek help. Future studies should consider the level of specificity in seeking help (e.g., who to seek help from, what to seek help for, etc.).

The Five Facets of Mindfulness and Willingness to Seek Help

Which of the five facets of mindfulness were specifically associated with willingness to seek help? Observing was positively correlated with willingness to seek help as measured by the

ISCI and the MHSIS. Describing was not significantly correlated with the ISCI, but it was also positively correlated with the MHSIS. In contrast, acting with awareness, nonjudging, and nonreactivity were all negatively correlated with the willingness to seek help as measured by both scales.

The difference in the directions of the correlations was unexpected. Observing and describing were correlated in the predicted positive direction. Baer and colleagues (2006) found that observing was positively correlated with openness to experience, which would certainly impact an individual's willingness to seek help. Additionally, the observer self allows one to take a step back from one's experience, which would help someone recognize the need to seek help. Baer and colleagues (2006) also found describing to positively correlate with emotional intelligence, which would also help someone recognize the need to seek help to work through their difficulties (2006).

Acting with awareness, nonjudging, and nonreactivity, on the other hand, were negatively correlated with self-stigma. These are facets that represent mindfulness skills that can be directly applied to help-seeking situations. It is possible that individuals who often act with awareness and without judgment already possess the skills needed in coping with mental health issues. If they already have these skills, they would be less likely to ask professionals for help when they notice a mental health issue. For example, suppose someone were to recognize they were depressed. In that case, if they had the skill of acting with awareness, they could recognize behaviors maintaining the depression and those behaviors that alleviated it. They would be less likely to impose judgment on their actions, and that lack of shame also helps with symptom relief. Baer and colleagues (2006) also found that these three mindfulness facets were negatively correlated with psychological symptoms and difficulties regulating emotions, supporting the

suggestion that these facets are skills that can be used to address difficulties without needing help.

Mindfulness and Self-Stigma of Seeking Help

Overall Mindfulness and Self-Stigma of Seeking Help.

As predicted, overall mindfulness had a significant negative relationship with the self-stigma of seeking help. Barr and Kintzle's (2019) study demonstrated this relationship in a population of veterans . Shorey, Anderson, and Stuart (2015) also found a similar relationship when examining early maladaptive schemas (EMS) and mindfulness. EMS involve making judgments about our world, relating them to self-stigma. Shorey and colleagues found that as mindfulness increased, the number of EMS held by participants decreased.

In the present study, as mindfulness scores increased, participants' self-stigma towards seeking help decreased. This suggests that mindfulness may play a part in the formation of self-stigma—perhaps by interrupting the internalization of the self-stigma process. To internalize self-stigma, someone must become aware of a stereotype, agree with that stereotype, and believe that stereotype applies to themselves (Corrigan et al., 2006). Although this study did not examine at which step of the internalization process mindfulness intervenes, this relationship suggests that mindfulness does relate to the self-stigma of seeking help. This is also a promising result as it suggests that mindfulness could indeed serve as a buffer for the formation of self-stigma.

The Five Facets of Mindfulness and Self-Stigma of Seeking Help

Which of the five facets of mindfulness were associated with self-stigma of seeking help? Three facets of mindfulness predicted the formation of self-stigma: describing, acting with awareness, and nonjudging. As these facets increased, participants reported less self-stigma. This was the hypothesized result, except that nonreactivity and observing were not significantly

correlated with self-stigma. As individuals experience higher levels of nonjudgment, it is less likely that they will believe that a stereotype applies to them (Baer et al., 2006). Acting with awareness and describing are facets that would enable individuals to develop a more accurate understanding of the world around them and how seeking help has positive benefits, despite the negative beliefs surrounding doing so.

Self-Stigma of Seeking Help and the Willingness to Seek Help

No significant relationship was found between self-stigma about seeking help and the willingness to seek help when measured by the ISCI, which was not as hypothesized. However, given that mindfulness was highly correlated with both the willingness to seek help and self-stigma, mindfulness was statistically controlled to examine the unique effect of self-stigma on seeking help, and a significant negative correlation between self-stigma and willingness to seek help emerged.

When help-seeking intentions were measured with the MHSIS, there was a significant negative relationship between the self-stigma of seeking help and intention to seek help. This is in keeping with the hypothesized results and with quite a bit of previous research (Vally et al., 2018). This means that the same result was found with both scales used to measure help-seeking intentions.

Self-Stigma Partially Mediated the Relationship between Overall Mindfulness and Willingness to Seek Help

Self-stigma mediated the relationship between overall mindfulness and willingness to seek help. As predicted, when mindfulness scores increased, self-stigma regarding seeking help decreased, which increased the intention to seek help scores. However, this mediated or indirect

effect of mindfulness was only partial. Mindfulness also directly affected intentions to seek help though in the opposite direction to what was hypothesized. As mindfulness increased, willingness to seek help decreased. As explained earlier, this finding suggests that mindfulness may impart skills problem-solving skills that reduce the need and desire to seek help.

In contrast, when mindfulness interrupts the formation of self-stigma regarding seeking help, this could lead to stronger intentions to seek help. In other words, although mindfulness directly diminishes intentions to seek help, it could also indirectly increase them (when it buffers against self-stigma formation). However, the direct effect of mindfulness on willingness to seek help was stronger in magnitude than its mediated/indirect effect. Future studies should explore the various conditions under which mindfulness strengthen or diminish help-seeking intentions.

Self-Stigma Partially Mediated the Relationship between Two Mindfulness Facets and Willingness to Seek Help

Tests of mediation involving the mindfulness facets showed that self-stigma mediated the relationship between two of the five facets (acting with awareness and nonjudging) and willingness to seek help. As acting with awareness increased, self-stigma decreased, which increased willingness to seek help. This was also true for the facet of nonjudging. Similar to the observed mediated effect of overall mindfulness on intentions to seek help discussed earlier, the mediated or indirect effects of acting with awareness and nonjudging were partial. Both also directly and inversely affected willingness to seek help. As acting with awareness and nonjudging increased, help-seeking intentions decreased.

In contrast, the mediated/indirect effects of these two facets strengthen rather than diminish the willingness to seek help. When someone acts with increased awareness, they experience less self-stigma towards seeking help. Perhaps they can better recognize the effects

seeking help has on their feelings and behaviors, enabling them to understand better the benefits that occur (Baer et al., 2006). Because of this understanding, they are more willing to seek help.

When someone is nonjudging, they are going to be less likely to internalize experiences and label them as "good" or "bad" (Baer et al., 2006). This would, in turn, prevent the formation of self-stigma (Corrigan & Watson, 2002). Therefore, when someone needs help, they will be less likely to judge the action of seeking help and be more willing to follow through with seeking help. Nonjudging is a crucial aspect of mindfulness since it is related to examining our internal experiences (Baer et al., 2006). Instead of responding with negative or positive thoughts towards the need to seek help, the facet of nonjudging buffers against the effects of self-stigma.

Like the results involving overall mindfulness, however, the direct effects of acting with awareness and nonjudging on help-seeking intentions were stronger in magnitude than their mediated or indirect effects. Future studies should also examine the conditions under which the facets of mindfulness could facilitate or inhibit help-seeking.

Limitations and Future Directions for Research

There are, of course, limitations to this study. Amazon Mechanical Turk participants are motivated to complete many surveys with a small amount of money, so they likely went through the study quickly without spending much time on the questions. Additionally, this study was conducted in the Fall of 2020, which was amid the COVID-19 pandemic. This has resulted in high unemployment levels, especially for those in service industries who may have lower education levels. Many people have turned to crowdsourcing platforms for an alternate form of income. This may have increased the sample's diversity regarding educational attainment, income, personality, mental health, experience with counseling or mental health help, etc., which could have contributed to the observed non-unitary psychometric properties of mindfulness.

However, it does seem that some of the study results are still consistent with those from samples that did not use MTurk.

In future studies, however, more information about the sample demographics should be obtained to examine which characteristics impact the measurement of mindfulness—such as educational attainment, meditation experience, etc. (Baer, Walsh, & Sauer, 2008; Gu et al., 2016). These characteristics have previously shown different mindfulness patterns and could have resulted in the observed non-unitary configuration of the five facets of mindfulness in this study. Gu and colleagues (2016) found that meditation experience impacts one's ability to observe in a way that is consistent with mindfulness, that is, in a nonjudgmental and nonreactive fashion.

Two scales demonstrated low internal reliability: the describing facet of mindfulness and the self-stigma of seeking help scale. Both had much lower internal reliability than in other studies; however, the means for both scales were not that different from the means of other studies. The MHSIS is a newer, less supported scale, but the results from the MHSIS were similar to those obtained from the ISCI.

Given that the study is correlational, the hypothesized direction of the relationships may not be accurate. It was predicted that mindfulness would prevent the formation of self-stigma, which would then enhance help-seeking. It is also possible that as people experience less self-stigma, they become more mindful. When someone avoids engaging in self-stigma, they would likely experience less subjective distress and harm to self, making it easier to look inward and examine the present moment.

Future research should engage in a more in-depth exploration of mindfulness's role in inhibiting self-stigma. A few self-stigma models (such as Corrigan's (2006) outline the different

stages of self-stigma formation. Future studies could examine at which stage describing, acting with awareness, and nonjudgment intervene. Since these three facets affect self-stigma and help-seeking in different directions, the facets may halt or inhibit self-stigma's internalization at different stages. For example, nonjudging was found to correlate negatively with self-stigma, so this facet of mindfulness could intervene at the self-concurrence stage (where one decides that a stereotype applies to oneself) (Baer et al., 2006; Corrigan & Watson, 2002). Nonjudgment may help a person think about their experiences without placing negative values normally associated with a stereotype.

Moreover, mental health symptoms should be inquired about in future studies. Some studies, such as Barr and colleagues (2019), found that mindfulness impacted help-seeking differently in veterans with lower and higher levels of PTSD symptoms. A general scale that asks about mental health symptomology could help explain the observed differences in the valences of the indirect (positive) and direct (negative) effects of mindfulness on help-seeking. Barr and colleagues had similar differences in the direct and indirect pathways of mindfulness—contingent on the severity of PTSD symptoms and the level of mindfulness of their participants (2019). Mindfulness affects people differently based on their experience with mental health disorders, and this may help explain why sometimes mindfulness encourages help-seeking behaviors and sometimes discourages them. If someone experiences more self-stigma, they likely have a mental disorder that impacts their life, and thus mindfulness may be beneficial for that individual. On the other hand, if one does not have a mental disorder and does not experience self-stigma, mindfulness may not encourage help-seeking because it provides resiliency skills. This echoes what Barr and colleagues found when participants with more severe

symptoms and higher levels of mindfulness were more likely to seek help than their peers with less severe symptoms and lower mindfulness levels.

Clinical Implications

Mindfulness is already a part of many third-wave behavior therapies like dialectical behavior therapy and acceptance and commitment therapy (Shapiro, et al., 2006 ;Swift, et al., 2017). However, these therapies can, of course, only be received by people who have already sought help. To increase engagement in mental health services, mindfulness could be taught to the public through schools, social media, or other outreach outlets.

In addition to increasing engagement in mental health services, mindfulness could be used with clients engaged in services who are still experiencing self-stigma regarding seeking help. It is not uncommon for someone to continue making judgments about their need to seek help, even after engaging in services. Mindfulness could be incorporated into treatment to reduce the self-stigma clients may be experiencing, decreasing drop-off rates.

Certain facets could be specifically targeted, particularly nonjudging and acting with awareness. A crucial part of acceptance and commitment therapy is acceptance, of which nonjudgment is a vital aspect. One accepts their present reality, including pain, to minimize their suffering. Nonjudgment is useful in this process by helping an individual recognize that there does not need to be positive or negative values placed on experiences. For example, if someone was anxious about an upcoming event, they may be upset with themselves for being anxious, which increases their distress. Instead, practicing a nonjudgmental attitude may decrease the suffering because the individual could reduce how upset they were with themselves by accepting that they are feeling anxious about the upcoming event. This could also apply to someone experiencing self-stigma about seeking help. Accepting that one needs help, without placing a

judgment on that need, might reduce their suffering and have better clinical outcomes. Acting with awareness could also enable clients to recognize better the changes that occur from seeking help because when acting with awareness, people notice changes in behavior. Usually, part of mental health treatment includes change, whether in behavior or thought processes. By acting with awareness, clients could notice how these changes benefit them, making them more likely to continue being engaged in services. Both of these facets of mindfulness can be built up through regular mindfulness practice. Mindfulness exercises are often assigned as treatment homework for other reasons, but now, when processing a client's practice, it may be beneficial to focus on these facets to improve retention in services specifically.

Conclusion

The present study's goal was to examine whether self-stigma mediated the relationship between mindfulness and one's intention to seek help. In other words, mindfulness was hypothesized to buffer against the formation of self-stigma, which would increase one's willingness to seek help. While the current study had some unexpected results, overall mindfulness and some facets of mindfulness (nonjudging and acting with awareness) decreased the amount of self-stigma experienced regarding seeking help, which increased the likelihood of someone willing to ask for help. This suggests that interventions that increase individuals' mindfulness could be utilized to increase the willingness to seek help by decreasing self-stigma generally. However, more research is needed to determine in what situations mindfulness encourages or inhibits help-seeking because the direct effect of mindfulness on help-seeking intentions was inverse. Nevertheless, this study adds to the current literature by showing relationships between mindfulness, self-stigma, and help-seeking intentions and opens the doors for future research into how these constructs influence each other.

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Appendix A

Five-Facet Mindfulness Questionnaire
(Baer et al., 2006)

INSTRUCTIONS: Please rate each of the following statements using the scale provided. Write the number that best describes your own opinion of what is generally true for you.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

1. When I'm walking, I deliberately notice the sensations of my body moving.
2. I'm good at finding words to describe my feelings.
3. I criticize myself for having irrational or inappropriate emotions.
4. I perceive my feelings and emotions without having to react to them.
5. When I do things, my mind wanders off and I'm easily distracted.
6. When I take a shower or bath, I stay alert to the sensations of water on my body.
7. I can easily put my beliefs, opinions, and expectations into words.
8. I don't pay attention to what I'm doing because I'm daydreaming, worrying or otherwise distracted.
9. I watch my feelings without getting lost in them.
10. I tell myself I shouldn't be feeling the way I'm feeling.
11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
12. It's hard for me to find the words to describe what I'm thinking.
13. I'm easily distracted.
14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
15. I pay attention to sensations, such as the wind in my hair or sun on my face.
16. I have trouble thinking of the right words to express how I feel about things.
17. I make judgments about whether my thoughts are good or bad.
18. I find it difficult to stay focused on what's happening in the present.
19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.

20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
21. In difficult situations, I can pause without immediately reacting.
22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.
23. It seems I am "running on automatic" without much awareness of what I'm doing.
24. When I have distressing thoughts or images, I feel calm soon after.
25. I tell myself that I shouldn't be thinking the way I'm thinking.
26. I notice the smells and aromas of things.
27. Even when I'm feeling terribly upset, I can find a way to put it into words.
28. I rush through activities without being really attentive to them.
29. When I have distressing thoughts or images I am able just to notice them without reacting.
30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.
32. My natural tendency is to put my experiences into words.
33. When I have distressing thoughts or images, I just notice them and let them go.
34. I do jobs or tasks automatically without being aware of what I'm doing.
35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.
36. I pay attention to how my emotions affect my thoughts and behavior.
37. I can usually describe how I feel at the moment in considerable detail.
38. I find myself doing things without paying attention.
39. I disapprove of myself when I have irrational ideas.

Appendix B

Self-Stigma of Seeking Help.
(Vogel et al., 2006)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.
1= Strongly Disagree 2= Disagree 3 = Agree nor Disagree 4= Agree 5= Strongly Agree

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

Appendix C

Intention to Seek Counseling Inventory
(Cash et al., 1975)

INSTRUCTIONS: Below is a list of issues people commonly bring to counseling. How likely would you be to seeking counseling if you were experiencing these problems? Please circle the corresponding answer.

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

17.	Loneliness	1	2	3	4

Appendix D

Mental Help-Seeking Intention Scale
(Hammer & Spiker, 2018)

INSTRUCTIONS: For the purposes of this survey, “mental health professionals” include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, “mental health concerns” include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression).

Please circle the number that best represents your opinion (1—extremely unlikely; 7—extremely likely).

If I had a mental health concern, I would intend to seek help from a mental health professional.
1 2 3 4 5 6 7

If I had a mental health concern, I would try to seek help from a mental health professional.
1 2 3 4 5 6 7

If I had a mental health concern, I would plan to seek help from a mental health professional.
1 2 3 4 5 6 7

Appendix E

A Discussion of Internal Consistencies

The measures of internal consistency are similar to results found in other studies. Goldberg and colleagues completed a study examining the different psychometric properties of the FFMQ with general participants recruited for a "health and well-being" study (2017). The Cronbach's alphas for the FFMQ subscales acting with awareness, nonjudging, nonreactivity were fairly similar: .89, .89, and .79, respectively. The sum of the FFMQ, observing, and describing scales all had higher internal consistency values in Goldberg and colleagues' study: .92, .80, and .92, respectively, with the most significant difference found in the describing subscale scores, which is .46 in the current study. Some of these differences may be due to differences in how the study was administered. The current study was administered through MTurk, and the scales that had the lowest internal consistency were the scales that included reverse items. Six of the eight items in the describing subscale had item-to-total correlations that were weak and below .30. The scales that did not include any reverse items demonstrated similar internal consistencies to other studies that were not administered through MTurk.

The SSOSH scale does show low internal consistency, compared to other studies that report internal consistencies of .84, .85, .80 (Wallin et al., 2018; Barr et al., 2019). Again, these differences may be due to study administration, as the SSOSH scale has reverse-scored items. Item-to-total correlations were weak to moderate, ranging from .14 to .43.

Using the ISCI in a unidimensional manner gives a similar internal consistency in the current study (alpha = .87). Another study by Wallin and colleagues (2018) also utilized the ISCI as a unidimensional construct and obtained a similar internal consistency of .86 and .88 in different samples.

The MHSIS scale had high internal consistency, which is in keeping with previous studies' report of an alpha of .87 (Hammer & Vogel, 2013). One study found a very high Cronbach's alpha for the MHSIS at .94 (Hammer & Spiker, 2018). Even though this study demonstrates a lower consistency, it is still acceptable (above .70) for subsequent analyses.