Kwantlen Psychology Student Journal
Issue 8, September 2026
Kwantlen Polytechnic University

Gender Identity in Mental Health Stigma

Angelica Nakamura-Mendivil[1] Hue Linh (Emily) Thai[2] Alexander Culshaw, Troy Langtry, Gurveen Kaur

Abstract

This study aimed to investigate how a character's gender, male or female, and type of mental disorder, depression or schizophrenia, influence stigma perceptions. Understanding these factors is important because stigma can affect individuals with mental health diagnosis experiences and willingness to seek treatment. Stigma experiences may vary depending on intersecting social identities such as gender. The study included approximately 93 participants who rated stigma toward four-character conditions intersecting gender and disorder type. Statistical analysis confirmed equal variances across groups. Results indicated that character gender alone did not significantly affect stigma scores, while the type of mental disorder significantly affected stigma levels. The interaction between gender and disorder was not significant, although male characters with schizophrenia received the highest average stigma scores. These findings suggest that mental disorder type plays more of a role than gender in shaping stigma perceptions, but the intersection of these factors should still inspire further research. The results highlight the complexity of stigma and the importance of incorporating intersectional factors which are important to consider when designing intervention strategies.

[1] angelica.nakamuramendivil@student.kpu.ca; Thank you, Instructor Amanda Champion, for your recommendation and assistance.

Introduction/Literature Review

Mental illness stigma is a complex social process that operates differently between every individual (Simmons et al. 2017). Mental illness stigma is a major barrier to the well-being of individuals with mental health diagnoses, affecting their self-esteem, increasing symptom severity, and contributing to feelings of isolation and discrimination (Fox et al., 2018). Kiaos' (2023) research indicates that public attitudes toward mental illness remain largely negative, with many individuals still holding harmful stereotypes. This can lead to discrimination in necessities such as employment, housing, and healthcare access (Fox et al., 2018). Understanding and addressing mental illness stigma is crucial for developing effective treatment interventions; a framework for evaluating stigma can advise better educational programs, policies, and advocacy efforts for mental health awareness (Fox et al., 2018).

To understand stigma, Fox et al. (2018) created a model based on a systematic review of past mental health stigma measures, called the Mental Illness Stigma Framework, that helped categorized the complexities of stigma. This model outlines diverse stigmas from individuals being stigmatized such as discrimination, stereotypes, and prejudice, and those stigmatizing others, such as internalized stigma, experienced stigma, and anticipated stigma, while also acknowledging intersectional characteristics such as gender (Fox et al. 2018). Many individuals experience compound stigma, where multiple marginalized identities, such as mental illness, gender, race, or cultural background overlap and intensify the negative stigma (Fox et al., 2018). This layer of stigma can differ in treatment-seeking and amplify social exclusion, particularly among groups like men with mental health conditions, who face both illness-related stigma and societal expectations of stoicism (Chatmon, 2020).

Pescosolido et al. (2021) found that perceived stigma toward individuals diagnosed with depression has decreased over time, while individuals with schizophrenia have stayed consistent, which highlights the complexity of stigma and the necessity for disorder-specific research. Over 40% of people with schizophrenia feel highly stigmatized and even consider stigma as a "second illness" (Valery & Prouteau, 2020). Samson & Wong's (2015) research clarifies shared negative symptoms among those with schizophrenia or depression, such as a lack of interest, drive, or initiative, a decrease in

vocalization, and social withdrawal. Yet, depression is often more forgiving, and others may hold more compassion for this diagnosis (Pescosolido et al. 2021). This could be influenced by the more visible and disruptive symptoms of schizophrenia, such as hallucinations and aggression (Griffiths et al., 2014).

Research shows that gender stereotypes contribute to mental health stigma. Men often face stigma for expressing vulnerability due to societal expectations, while women are known to be more emotionally expressive (Pattyn et al., 2015). Li et al. (2016) found that women with schizophrenia were more likely to show symptoms such as irritability and mood disturbance while men with schizophrenia were more likely to show symptoms, such as social withdrawal and substance abuse. A study conducted by Kiaos (2023), found male roles influenced individuals with mental health diagnoses by expecting quick resolution of their grief, suppressing emotions, and adhering to societal expectations to avoid stigma. Men were less likely to seek treatment due to the internalized shame they feel when associated with mental illness (Pattyn et al. 2015).

Kaitz et al. (2021) examined mental illness stigma in medical professionals. They found male providers were found to hold significantly more stigmatizing views towards individuals with schizophrenia than female providers. Factors such as negative societal attitudes, internalized shame, and professional bias also contribute significantly to mental health stigma, which discourages men from expressing emotions and seeking help (Chatmon, 2020). This social construct could influence how both men and women seek treatment.

In conclusion, stigma in mental health disorders and gender identity create barriers to treatment and acceptance by society (Pattyn et al., 2015). Simmon et al. (2017) indicate that individuals often hold stigmatizing views because of a lack of mental health knowledge, negative experiences, and societal perceptions. Williston et al. (2020) argues that an increase in mental health literacy and educational intervention can help lower mental health stigma. Despite extensive research on mental illness stigma, there remains a need to understand how gender intersects with specific mental health diagnoses, particularly in populations other than those from Eurocentric systems. This study aims to examine the relationship between gender and stigma toward different mental health diagnoses, including schizophrenia and depression. Specifically, we investigate whether

male and female individuals differ in their stigma levels and how these differences may vary by diagnosis. Researching the intersectionality of gender on mental health stigma can provide more insight into gender-specific experiences and treatments and create specific interventions to reduce future stigma. Based on this past research we predicted that men with mental health diagnosis would report higher stigma than women (H1), schizophrenia would be subjected to higher stigma compared to depression, regardless of gender (H2), and men with schizophrenia would have the highest stigma scores followed by men with depression, women with schizophrenia, women with depression (H3).

Method

Research Design

This study utilized a 2 (Diagnosis: Schizophrenia vs. Depression) × 2 (Gender: Man vs. Woman) between-subjects factorial design to investigate how mental health stigma varies based on the gender of the individual and the type of mental health diagnosis d. The independent variables were diagnosis type and gender, while the dependent variable was the mental illness stigma level, measured using the Attribution Questionnaire-27 (AQ-27).

Participants

Participants were undergraduate students recruited from Kwantlen Polytechnic University (KPU) through the SONA participant pool. A G*Power analysis (Faul et al., 2009) was conducted to determine the ideal sample size for adequate statistical power. Using an alpha level of .05, a medium effect size ($f = 0.25$), and a power level of 0.90, it was determined that a minimum of 350 participants would be necessary, with approximately 88 participants per condition.

Eligibility criteria included being at least 18 years of age and currently enrolled at KPU. All participation was voluntary and anonymous. Participants received course credit for completing the study. Demographic information was collected, including age, gender, ethnicity, and educational background, to better understand the sample and explore potential covariates.

Materials

The primary materials used in this study were four written vignettes and the Attribution Questionnaire-27 (AQ-27). The vignettes described a 21-year-old university student, either “Harry” or “Sarah” experiencing symptoms consistent with either

schizophrenia or depression. The vignettes were designed to be realistic and empathetic, based on information adapted from peer-reviewed literature (Chatmon, 2020; Mannarini et al., 2022). The vignettes depicted common negative symptoms shared between both conditions such as anhedonia, abulia, alogia, and social withdrawal (Samson et al., 2015) in controlled settings to isolate the effects of diagnosis and gender.

The Attribution Questionnaire-27 (AQ-27) is a validated self-report instrument designed to measure public stigma toward mental illness (Fridberg & Ahmed, 2013). The AQ-27 includes 27 items that assess stigma across nine subscales, such as Fear, Dangerousness, Help/Interact, Responsibility/Blame, Forcing Treatment, Empathy, Negative Emotions, and Coercion. Responses are recorded on a 9-point Likert scale, ranging from 1 (Not at all) to 9 (Very much), with higher scores indicating greater levels of perceived stigma. For example, participants might be asked how dangerous they believe the person in the vignette is or how likely they are to interact with them (see Appendix B). Subscale scores are calculated by summing the scores of the items within each subscale. A total score for mental health stigma is also calculated by summing the scores of all items across the subscales (as cited in Fridberg & Ahmed, 2013). In this study only the total score was analyzed.

Procedure

The study was conducted entirely online using Qualtrics, a secure, web-based survey platform. Participants accessed the study link via the KPU SONA system and were first presented with a consent form outlining the purpose of the study, confidentiality measures, and their rights as participants (see Appendix C). Upon consenting, they were randomly assigned one of four vignette conditions: (1) a man with schizophrenia, (2) a woman with schizophrenia, (3) a man with depression, or (4) a woman with depression (see Appendix A).

Participants were instructed to carefully read a short vignette that described a university student exhibiting symptoms consistent with either schizophrenia or depression. After reading the vignette, participants completed the Attribution Questionnaire-27 (AQ-27), a standardized instrument comprised of nine subscales. Participants were instructed to base their responses solely on the vignette provided. Also, participants completed a short

demographic questionnaire, which included items on age, gender identity, ethnicity, andeducation level.

Participation was entirely anonymous and took approximately 15 minutes to complete. Participants were debriefed immediately upon finishing the survey through a debriefing form that clarified the study's true purpose (see Appendix D). All collected data were stored securely and later analyzed using SPSS statistical software, with one-way ANOVA employed to examine the effects of diagnosis and gender on mental health stigma scores.

Results

A total of 93 participants completed the survey, 19 men and 74 women. Participants were randomly assigned to one of four possible vignette categories: man diagnosed with schizophrenia ($N = 23$), female diagnosed with schizophrenia ($N = 23$), man diagnosed with depression ($N = 22$), and female diagnosed with depression ($N = 25$).

A 2 x 2 between subjects ANOVA was conducted to examine the effects of character gender and mental diagnosis type on mental illness stigma scores. The evene's test was non-significant, showing that the assumption of homengenity of variance was met.

As shown in table 1, there was no significant main effect of character gender in stigma scores, $F(1,89) = 2.96$, $p = .089$, $\eta p^2 = .032$. Although male characters received slightly higher stigma scores ($M = 100.22$; $SD = 24.93$) than female characters ($M = 91.17$; $SD = 24.38$), this difference was not statistically significant. There was a significant main effect of mental diagnosis type, $F(1,89) = 6.02$, $p = .016$, $\eta p^2 = .063$. Characters diagnosed with schizophrenia received higher stigma scores ($M = 102.13$; $SD = 22.07$) than characters diagnosed with depression ($M = 89.56$; $SD = 26.12$), thus failing to reject the null hypothesis (H2).

The interaction between character gender and diagnosis type was not significant, $F(1,89) = .06$, $p = .805$, $\eta p^2 = .001$. Although the descriptive pattern showed the highest scores for men with schizophrenia ($M = 105.74$; $SD = 22.04$) and the lowest scores for women with depression ($M = 84.84$; $SD = 25.01$). This suggests people may judge men with schizophrenia and depression more compared to women with schizophrenia and depression. However, the non-significant interaction shows that the effect of diagnosis on

stigma did not significantly differ by character gender, therefore H1 and H2 were not supported.

Discussion

This study aimed to examine how stigma varies across mental health diagnoses, specifically between depression and schizophrenia, and whether gender influences stigma levels. We hypothesized that participants would report more stigma toward men with mental illness than women (H1) and rejected the null hypothesis. We hypothesized that schizophrenia would be associated with more stigma than depression regardless of gender (H2) and failed to reject the null hypothesis. We also hypothesized that the highest stigma would be directed at men with schizophrenia, followed by men with depression, women with schizophrenia, and finally women with depression (H3), and rejected the null hypothesis.

Our main results lead to mental illness diagnosis type playing a more significant role than gender in influencing mental health stigma, with schizophrenia consistently producing a higher level of stigma than depression across both genders. We observed a general trend of higher stigma directed at male characters; however, the effect of gender was not statistically significant. Similarly, the interaction between diagnosis and gender was not significant. Therefore, our findings support H2 but not H1 or H3.

These findings align with earlier research showing that schizophrenia is typically more stigmatized than depression, especially among mental health professionals (Valery & Prouteau, 2020). Schizophrenia is often associated with stereotypes of unpredictability, danger, and social avoidance (Mannarini et al., 2022), which likely contribute to higher stigma scores. In contrast, depression is more commonly discussed among the general population. Evidence suggests that interventions designed to reduce stigma associated with depression are effective (Griffiths et al., 2014). This trend was reflected in our results, as both male and female characters with depression received lower stigma ratings.

Although our results did not confirm a significant effect of gender, previous research has shown that men face unique stigma when dealing with mental illness, often due to cultural norms surrounding masculinity and emotional suppression (Chatmon, 2020). The lack of a statistically significant effect in our study may stem from an underpowered sample size or our sample demographic, primarily composed of university

students who may be more progressive or empathetic regarding mental health. Additionally, most of our participants were female, who on average emote more empathy and nurturing behaviors than male identifying persons (Christov-Moore et al., 2014). While the *p*-value for gender approached significance ($p = .089$), it fell short of the threshold, suggesting that a larger sample might reveal a stronger effect.

The non-significant interaction effect between gender and diagnosis challenges our third hypothesis. While the descriptive statistics suggested the pattern we hypothesized (the highest stigma toward men with schizophrenia and the lowest toward women with depression), the interaction was not significant. This could imply that stigma associated with schizophrenia may overshadow gender-related biases, flattening the differences we expected to find.

One limitation of our study is the generalizability of our sample, which consisted mostly of undergraduate students and females. Past research has indicated that stigma levels can vary by age, education, and cultural background (Pescosolido et al., 2021). Our sample's relatively young average age (22.56) and shared educational environment may not reflect broader sociodemographic characteristics, which limits the real-world application. Additionally, social desirability bias may have influenced responses, especially due to the increasing public awareness surrounding mental health. The study also failed to meet the required number of participants as calculated using G*Power resulting in an underpowered sample.

Future research could benefit from larger and more diverse samples, including participants from various cultural, socioeconomic, and educational backgrounds, as well include more categories to be more inclusive of diverse genders and mental health diagnosis. It would also be useful to incorporate qualitative methods to better understand the reasons behind participants' stigma-related attitudes and create more authentic vignettes. A longitudinal design similar to Pescosolido et al.'s (2021) study could also explore whether stigma levels shift over time, specifically in response to the spread of mental health education or contact with individuals with a mental diagnosis.

In conclusion, while our study confirmed that schizophrenia is more stigmatized than depression, it did not find significant effects for gender or the interaction between gender and diagnosis. These findings underscore the continued stigma surrounding severe

mental illnesses, regardless of gender. They also highlight the importance of ongoing stigma reduction efforts, such as interventions and awareness campaigns, specifically aimed at increasing empathy toward individuals with schizophrenia. Our results contribute to the growing literature on mental illness stigma and may offer insights for future investigations into the complicated intersection of gender, mental illness, and public perception.

References

Chatmon, B. N. (2020). Males and mental health stigma. *American Journal of Men's Health, 14*(4). https://doi.org/10.1177/1557988320949322

Christov-Moore, L., Simpson, E. A., Coudé, G., Grigaityte, K., Iacoboni, M., & Ferrari, P. F. (2014). Empathy: Gender effects in brain and behavior. *Neuroscience & Biobehavioral Reviews*, *46*, 604–627. https://doi.org/10.1016/j.neubiorev.2014.09.001

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*(4), 1149-1160. https://doi.org/10.3758/BRM.41.4.1149

Ferrari, S., Bressi, C., Busnelli, E., Mattei, G., Pozzoli, S., Oliva, A., Galeazzi, G. M., & Pingani, L. (2020). Stigma on mental health among high school students: Validation of the Italian version of the Attribution Questionnaire-27 (AQ-27-I) in a high school student population. *International Journal of Environmental Research and Public Health, 17*(14), 5207. https://doi.org/10.3390/ijerph17145207

Fox, A. B., Earnshaw, V. A., Taverna, E. C., & Vogt, D. (2018). Conceptualizing and measuring mental illness stigma: The mental illness stigma framework and critical review of measures. *Stigma and Health, 3*(4), 348-376. https://doi.org/10.1037/sah0000104

Fridberg, D. J., & Ahmed, A. O. (2013). Critical synthesis package: Attribution Questionnaire-Short Form (AQ-27). *MedEdPORTAL*. https://doi.org/10.15766/mep_2374-8265.9532

Griffiths, K., Carron-Arthur, B., Parsons, A., & Reid, R. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World Psychiatry, 13*(2), 161-175. https://doi.org/10.1002/wps.20129

Kaitz, J. E., Steinhilber, K. M., & Harris, J. I. (2021). Influence of provider gender on Mental Health Stigma. *Community Mental Health Journal, 58*(3), 536–540. https://doi.org/10.1007/s10597-021-00849-y

Kiaos, T. (2023). Stop being a wuss: People's perceptions of men experiencing grief in Australia. *Health Promotion Journal of Australia, 35*(3), 713–723. https://doi.org/10.1002/hpja.794

Li, R., Ma, X., Wang, G., Yang, J., & Wang, C. (2016). Why sex differences in schizophrenia? *Journal of translational neuroscience, 1*(1), 37-42.

Mannarini, S., Taccini, F., Sato, I., & Rossi, A. A. (2022). Understanding stigma toward schizophrenia. *Psychiatry Research, 318*, 114970. https://doi.org/10.1016/j.psychres.2022.114970

Pattyn, E., Verhaeghe, M., & Bracke, P. (2015). The gender gap in Mental Health Service use. S*ocial Psychiatry and Psychiatric Epidemiology, 50*(7), 1089–1095. https://doi.org/10.1007/s00127-015-1038-x

Pescosolido, B. A., Halpern-Manners, A., Luo, L., & Perry, B. (2021). Trends in public stigma of mental illness in the US. 1996-2018. JAMA Network Open. 4(12). https://doi.org/10.1001/jamanetworkopen.20

Samsom, J. N., & Wong, A. H. (2015). Schizophrenia and depression co-morbidity: What we have learned from animal models. Frontiers in Psychiatry. 6. https://doi.org/10.3389/fpsyt.2015.00013

Simmons, L., Jones, T., & Bradley, E. (2017). Reducing mental health stigma: The relationship between knowledge and Attitude Change. European Journal of Mental Health. 12(1). 25– 40. https://doi.org/10.5708/ejmh.12.2017.1.2

Valery, K.-M., & Prouteau, A. (2020). Schizophrenia stigma in mental health professionals and associated factors: A systematic review. Psychiatry Research. 290. 113068. https://doi.org/10.1016/j.psychres.2020.113068

Williston, S., Bramande, E., Vogt, D., Iverson, K., & Fox, A. (2020). An examination of the roles of mental health literacy, treatment-seeking stigma, and perceived need for care in female veterans' service use. Psychiatric Services. 71(2). 144-150. https://doi.org/10.1176/appi.ps.201800405

Appendices

Appendix A

Vignettes

Four vignettes, each describing a scenario involving an individual diagnosed with either Schizophrenia or Depression. Each vignette will be assigned men or women:

1. A man diagnosed with schizophrenia

Harry, a 21-year-old university student, usually sits at the back of the class, avoiding eye contact with others. He often appears distracted, looking around the room as if he hears things that no one else does. During group discussions, Harry struggles to follow the conversation. Sometimes, he speaks softly to himself or reacts to something that others cannot see. One day while working on a group project, Harry mentions that the classroom walls are moving and that he is hearing voices talking to him. You learn that Harry was diagnosed with schizophrenia.

2. A man diagnosed with depression

Harry, a 21-year-old university student, has been struggling more than usual lately. He often looks tired and does not seem interested in anything. He frequently misses classes or arrives late, and when he is in class, he rarely participates. During group discussions, he does not contribute much, and when he does speak, his voice sounds low and uninterested. One day, a classmate asks him if he is feeling okay. Harry responds slowly, saying that he feels exhausted all the time and he cannot find energy to do things. He explains that everything feels like it takes too much effort. You learn that Harry was diagnosed with depression.

3. A woman diagnosed with schizophrenia:

Sarah, a 21-year-old university student, usually sits at the back of the class, avoiding eye contact with others. She often appears distracted, looking around the room as if she hears things that no one else does.

During group discussions, Sarah struggles to follow the conversation. Sometimes, she is speaking softly to herself or reacts to something that others cannot see. One day while working on a group project, Sarah mentions that the classroom walls are moving and that she is hearing voices talking to her. Her classmates are unsure how to respond. You learn that Sarah was diagnosed with schizophrenia.

4. A woman diagnosed with depression:

Sarah, a 21-year-old university student, has been struggling more than usual lately. She often looks tired and does not seem interested in anything. She frequently misses classes or arrives late, and when she is in class, she rarely participates. During group discussions, she does not contribute much, and when she does speak, her voice sounds low and uninterested.

One day, a classmate asks her if she is feeling okay, Sarah responds slowly, saying that she feels exhausted all the time and she cannot find energy to do things. She explains that everything feels like it takes too much effort. You learn that Sarah was diagnosed with depression.

Appendix B

AQ-27

Factor 1 –Dangerousness – Fear and dangerousness of the mentally ill

1. I would feel threatened by Harry/Sarah.
2. How dangerous would you feel Harry/Sarah is?
3. I would feel unsafe around Harry/Sarah.

Factor 2 – Help/Interact – Willingness to help and interact with the mentally ill

4. How likely is it that you would help Harry/Sarah?
5. How certain would you feel that you would help Harry/Sarah?
6. I would be willing to talk to Harry/Sarah about his problems.

Factor 3 – Responsibility/Blame – Primarily responsible for their own mental illness

7. How responsible, do you think, is Harry/Sarah for his present condition?
8. I would think that it was Harry's/Sarah's own fault that he is in the present condition.
9. How controllable, do you think, is the cause of Harry's/Sarah's present condition?

Factor 4 – Forcing Treatment/Segregation– Forcing treatment on the mentally ill

10. How much do you think hospitalization, where Harry/Sarah can be kept away from his community, is the best place for him?

11. I think Harry/Sarah poses a risk to his community unless he is hospitalized

12. I think it would be best for Harry's/Sarah's community if he were hospitalized.

Factor 5 – Empathy – Empathy towards the mentally ill

13. How much sympathy would you feel for Harry/Sarah?

14. I would feel pity for Harry/Sarah.

15. How much concern would you feel for Harry/Sarah?

Factor 6 – Negative Emotions – Negative emotions towards the mentally ill

16. How irritated would you feel by Harry/Sarah?

17. I would feel aggravated by Harry/Sarah.

18. How angry would you feel at Harry/Sarah?

Factor 7- Fear

19. How frightened of Harry/Sarah would you feel?

20. Harry/Sarah would terrify me.

21. How scared of Harry/Sarah would you feel?

Factor 8 – Avoidance (scale reversed)

22. I would share a carpool with Harry/Sarah every day.

23. If I were a landlord, I would rent an apartment to Harry/Sarah.

24. If I were an employer, I would interview Harry/Sarah for a job.

Factor 9- Coercion

25. If I oversaw Harry's/Sarah's treatment, I would force him to live in a group home.

26. How much do you agree that Harry/Sarah should be forced into treatment with his doctor even if he does not want to?

27. If I oversaw Harry's treatment, I would require him to take his medication.

For this study, we will combine all factor questions and analyze as mental health stigma. Higher numbers will indicate a higher level of mental health stigma expressed by the participant.

Appendix C

Informed Consent

77 NAKAMURA-MENDIVIL, A., THAI, H., CULSHAW, A., LANGTRY, T., KAUR, G.

Study Title: Gender Identity Stigma in Mental Health Diagnosis

Study Team: Stigma Studiers include student researchers Angelica Nakamura-Mendivil, Hue Linh (Emily) Thai, Alexander Culshaw, Troy Langtry, and Gurveen Kaur with principal investigator Amanda Champion. This study team is affiliated with Kwantlen Polytechnic University's department of Psychology.

Conflict of Interest: We determine that there is no conflict(s) of interest in this study.

Invitation & Purpose of the Study: This study is open to all individuals at least 18 years of age. The purpose of this study is to explore Stigma in mental health labels (i.e., Stereotypes, unfair beliefs, discrimination) and the intersectionality of gender identity.

Voluntary Participation: Your participation in this is voluntary. You may skip any questions without penalty and can withdraw at any time by closing your browser or navigating to the debriefing page for resources. If you prefer not to have your data included in the study, you can proceed to the end of the survey and select the option to withdraw your data. If you choose this option, your data will be deleted before analysis. However, once you submit the survey, you cannot withdraw your data because the responses are anonymous and cannot be identified.

Procedures: You will be presented with a short scenario and complete a questionnaire with some demographic questions (e.g., age, gender). This study should take approximately 20 minutes to complete.

Anonymity/Confidentiality: All data will be collected through Qualtrics anonymously. No identifying data will be collected through the survey. However, for KPU students, due to the nature of SONA's sign-up system, your name and email address will be visible to the researcher and SONA administration.
Because the Qualtrics account is a shared research account, we cannot guarantee full confidentiality of the data. However, all researchers with access to the account are aware of

the importance of confidentiality and have been instructed to only access their own research data. Your name will never be connected to the data you provide, and it should be made clear that the researchers are NOT interested in judging anyone or forming opinions - we are only interested in your honesty regarding this topic.
To further protect you, we will: download and store your data on a secure computer and then delete your responses from the online survey tool. The information collected from this study will be stored on Qualtrics servers in Canada until is downloaded at the conclusion of data collection and retained for 1 year. However, Qualtrics is U.S. owned and as such is subject to U.S. laws including the U.S. Patriot Act. These laws allow government authorities to access the records of host services and internet service providers. If you choose to participate in the survey, you understand that your responses to the survey questions will be stored and potentially accessed in the U.S. The security and privacy policy for Qualtrics can be found at the following link: https://www.qualtrics.com/privacy-statement/

Risks of Harm: There is no anticipated risk of harm associated with this study. However, the discussion of mental health conditions may cause discomfort for some participants.

Withdrawing from the Study: Participants may withdraw at any time without explanation or consequence.

Benefits: While there are no direct benefits to you, the findings from this study will enhance the academic community's knowledge of stigma associated with gender in mental health diagnosis. This research will advance mental health education and research, offering valuable insights that can guide future studies and efforts to reduce stigma.

Compensation: You may receive 0.5 credits towards an eligible KPU course for your participation in this study

Study Results & Disposal of Data: In the event this research is shared, potentially through class presentations, journal publications, or conferences, the data will be presented

in an aggregated format. This means that individual responses will not be viewed separately; instead, the data will always be analyzed and presented. Data will be kept on a password-protected account that only the research group members can access.

Contact for Information about the Study: If you have any questions or concerns related to this study, please feel free to contact any of the listed student researchers: Angelica Nakamura-Mendivil angelica.nakamuramendivil@student.kpu.ca, Hue Linh (Emily) Thai emily.thai@student.kpu.ca, Alexander Culshaw alexander.culshaw@student.kpu.ca, Troy Langtry troy.langtry@student.kpu.ca, or Gurveen Kaur gurveenkaur2@student.kpu.ca. You may also contact the Principal Investigator Amanda Champion amanda.champion@kpu.ca.

Contact for Complaints/Ethics Concerns: If you have any questions or concerns regarding ethics or complaints about your experience as a participant in this study, please contact amanda.champion@kpu.ca or KPU's Research Ethics Board at 604-599-3163; reb@kpu.ca.

Future Use of Data: In the future data collected in this study may be presented at the Connecting Minds conference where it will be shown to other researchers and people in the psychology field. Furthermore, it has the possibility of being published in the Kwantlen Psychology Student Journal (KPSJ). Additionally, the results will be presented in class.

Comprehension check: How old do you need to be to join this study?

☐At least 18 years of age

☐ Under the age of 18 years

I understand that I must be at least 18 to take part in this study

☐Yes, I understand and consent

☐ No, I do not consent to participate in this study

Appendix D

Debrief

We would like to thank you for your participation in our study "Gender Identity Stigma in Mental Health Diagnosis." This study depends on the willingness of participants. We thank you for joining and volunteering your time to help collect data on our subject. Your contribution to this study will help further the understanding of stigma related to mental health and its correlation to gender.

State the Purpose of the Study: This study aims to unpack the stigma of mental health diagnosis (schizophrenia and depression) and understanding the links to binary genders (men and women).

The Importance of Study Results: We hope this study's results will help reduce the stigma surrounding mental health related to gender. Stigma often leads to delayed treatment seeking and lowered overall well-being. Our intent is to add to the understanding of mental health stigma to improve social well-being of those affected, encourage public policy support, and improve mental health treatment.

KPU Participants: If you are a student seeking bonus marks for eligible psychology courses at KPU, your credits will be granted automatically. Please check to ensure they have been granted. If you have any questions or concerns regarding your credits, please contact psychresearchpool@kpu.ca.

Persons to Contact: If you have any questions or concerns about this study, or would like more information upon its conclusion, you may contact the course instructor at Kwantlen Polytechnic University, Amanda R. Champion; amanda.champion@kpu.ca or the student researchers: Angelica.nakamuramendivil@student.kpu.ca , Emily.thai@student.kpu.ca , Alexander.culshaw@student.kpu.ca , Troy.langtry@student.kpu.ca ,Gurveenkaur2@student.kpu.ca. Furthermore, if you want to talk to anyone about this research study because you think you have not been treated fairly, or think you have been hurt by joining the study, or you have concerns or complaints, you

can email the KPU Research Ethics Board (reb@kpu.ca) or call 604-599-3163.

Contact for Mental Health Support: TELUS Health Student Support: 1(844)-451-9700 (Available 24/7 - Canada & U.S)

Figure 1

Line graph depicting the difference in stigma between men and women with schizophrenia and depression

Tables

Table 1

Means and Standard Deviations of Total Stigma Scores by Character Gender and Disorder Type

Character Gender	Disorder Type	*M*	*SD*	*n*
Man				
	Depression	94.70	26.87	23
	Schizophrenia	105.74	22.04	23
	Total	100.22	24.93	46
Woman				
	Depression	84.84	25.01	25
	Schizophrenia	98.36	21.97	22
	Total	91.17	24.36	47
Total				
	Depression	89.56	26.12	48
	Schizophrenia	102.13	22.07	45
	Total	95.65	24.93	93

Figures

Figure 1

