

Research Paper

Effectiveness of a Single Session Workshop using Principles of Acceptance and Commitment Therapy in Reducing Mental Health Stigma among Higher Education Students: Preliminary Report

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ABSTRACT

Background: Mental health stigma continues to be a significant barrier to accessing psychological help among higher education students, particularly in collectivist cultures like India. Internal stigma and concern about social judgment dissuade students from approaching support services despite reporting high levels of psychological distress. Acceptance and Commitment Therapy (ACT), emphasising psychological flexibility and value-guided action, can potentially reduce stigma in brief, scalable interventions. **Objective:** This research evaluated the efficacy of a single-session ACT-based workshop in minimising mental health stigma and enhancing help-seeking behaviour and psychological flexibility in higher education students. **Methods:** A single-group pretest-posttest-follow-up design was used with 281 students from various higher education institutions in eastern India. Participants received a 90-minute Acceptance and Commitment Therapy (ACT) workshop on six core processes. The outcome measures were the Self-Stigma of Seeking Help Scale (SSOSH), Perceived Stigmatization by Others Scale (PSOSH), Attitudes Toward Seeking Professional Psychological Help (ATSPPH), and the Acceptance and Action Questionnaire-II (AAQ-II). Data were analysed using descriptive statistics and repeated measures ANOVA. **Results:** Statistically significant improvements were seen on all outcome variables from pre-test to follow-up ($p < .001$) with large effect sizes ($\eta^2 = .26-.31$). Reductions in self-stigma and perceived stigma and improvement in help-seeking attitudes and psychological flexibility, were sustained at 30-day follow-up assessment. **Conclusion:** A single ACT intervention effectively reduced stigma and increased psychological openness among Indian college students. Its brevity and flexibility make it suitable for application in educational settings.

Keywords: *Acceptance and Commitment Therapy (ACT), Single session, stigma, help-seeking, psychological flexibility, higher education*

The stigma of mental illness remains a powerful obstacle to the use of psychological help, especially among young adults in institutions of higher education. Everywhere in the world, and India in particular, an incredibly large percentage of college

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students suffering from psychological distress do not seek the help of professionals. This is most frequently because of the widespread power of stigma (Corrigan, 2004; Eisenberg, Downs, Golberstein, & Zivin, 2009). In this situation, stigma refers to self-stigma, internalisation of negative social stereotypes, perceived stigma, or perceived expectation of judgment or discrimination by others (Vogel et al., 2006). The college experience is a critical developmental milestone characterised by identity exploration, academic strain, and profound life change. These processes make students extremely susceptible to tension, anxiety, and numerous other mental health issues (Arnett, 2000). Despite heightened policy and advocacy for mental health improvement in India (Ministry of Health and Family Welfare, 2017), contact between students and psychological services is despondently low (Gopalakrishnan & Babacan, 2015). The gap between perceived and actual use of mental health care is maintained by deeply entrenched cultural, social, and psychological obstacles, with stigma being the most dominant barrier.

The Nature of Stigma in Indian Higher Education

In India, stigma towards mental health is supported by collectivist cultural values, fear of damaging the reputation of the family, and low mental health literacy (Raguram et al., 2004). Students are afraid of being stigmatised as "mentally weak" or "unstable" if they seek psychological counselling (Mascayano et al., 2015). Such stigmatising attitudes not only discourage seeking professional help but also promote maladaptive coping strategies such as avoidance, affective repression, and hyper-academic compensation (Loganathan & Murthy, 2011). Chandra et al. (2018) showed that a high percentage of Indian students would prefer to talk to friends or family members about their problems rather than seek advice from mental health professionals, even when they were suffering from intense psychological distress. Such avoidance of professional services can worsen symptoms, result in academic problems, and, in the extreme, result in suicide. With India's vast youth population and the vital role that higher education plays in the country's progress, there is a need to introduce brief, scalable, and culture-sensitive stigma-reducing interventions.

Psychological Interventions for Stigma Reduction

Various psychological interventions have been used to counteract mental health stigma, including psychoeducation, cognitive-behavioural, and contact interventions (Corrigan et al., 2012). These interventions are usually resource-intensive, taking multiple sessions and expert staff, and are, therefore, challenging to implement in low-resource academic environments (Patel et al., 2007). Acceptance and Commitment Therapy (ACT) is one possible alternative. ACT is a third-wave behavioural therapy that promotes psychological flexibility—the ability to stay involved in valued life activities in the presence of complex thoughts and feelings (Hayes et al., 1999).

Acceptance and Commitment Therapy (ACT): Conceptual Overview

Acceptance and Commitment Therapy (ACT) is mainly based on Relational Frame Theory (RFT), which emphasises that human suffering tends to result from linguistic and cognitive processes (Hayes et al., 2006). Psychological inflexibility—experiential avoidance and cognitive fusion with negative cognitions—in ACT is a primary source of the development of emotional distress. As a counter to this, ACT is trained to produce six basic processes: acceptance, cognitive defusion, mindfulness, self-as-context, values clarification, and committed action.

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Stigma, particularly self-stigma, is sustained by cognitive entanglement and experiential avoidance. For instance, the student who believes, "If I go for therapy, I must be weak," does not seek counselling due to cognitively entangled thoughts and the consequent emotional distress. Acceptance and Commitment Therapy (ACT) allows one to unhook from such thoughts (e.g., "I have the thought that I am weak") and to act in ways that are aligned with their core values, e.g., seeking help for self-improvement. There is extensive research that indicates ACT has a substantial decrease in internalised stigma across various populations, including psychosis, chronic illness, and substance abuse disorders (Masuda, Hayes, Fletcher, Seignourel, & Bunting, 2007). The flexibility of ACT for short interventions further contributes to its applicability in educational environments (Levin, Haeger, Pierce, & Cruz, 2017).

In the Indian context, Acceptance and Commitment Therapy (ACT) is significantly underdeveloped, even among non-clinical student populations. While studies have supported ACT's efficacy among Indian clinical populations (Singh et al., 2020), there is not much evidence of its effectiveness in reducing stigma among students. As a model based on value-guided action and experiential learning, ACT is a suitable culturally adapted model for empowering students to overcome internalised stigma and seek psychological assistance.

This study addresses several gaps in the literature. While stigma has been thoroughly identified as a hindrance to the use of mental health services, few Indian studies have tested the impact of short, guided psychological interventions in lowering stigma in non-clinical student populations. Further, while ACT is effective worldwide, its application in Indian higher education has not yet been adequately tested. Since most stigma-reduction interventions are not scalable and require frequent visits and trained professionals—resources not commonly found in Indian universities—there is a demand for an alternative. A one-session ACT-based workshop presents a feasible solution. It is low-cost, easy to disseminate, and can be integrated into existing campus mental health programs.

The first aim of this research is to assess the efficacy of a one-session, culturally adapted ACT intervention in decreasing perceived stigma and self-stigma among Indian university students. The secondary aim is to test whether the intervention increases psychological flexibility and improves professional psychological help-seeking attitudes.

The study draws on the Acceptance and Commitment Therapy (ACT) theory of psychological flexibility (Hayes et al., 2006). According to this theory, individuals suffer from distress when they become over-engrossed in negative thoughts and avoid painful internal events, which restrains adaptive action. Stigma can be considered an expression of cognitive fusion and experiential avoidance. For example, internalised cognitions like "I am weak if I ask for help from others" lead to the suppression of distress as well as the avoidance of therapeutic help. The ACT theory seeks to counteract these pathological processes by applying metaphors, mindfulness exercises, and experiential practices, which allow individuals to disengage from stigmatising thoughts, accept painful feelings, and approach valued actions. In return, the theory proposes that increased psychological flexibility will reduce stigma and enhance help-seeking behaviour (Levin et al., 2017). While there has been growing awareness of mental health issues among Indian youth, empirical studies evaluating interventions to reduce stigma from the context of higher education settings are scarce. Available interventions suffer from methodological weaknesses, such as the lack of randomised controlled trials and follow-up assessments.

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Moreover, the application of culture-validated scales to assess psychological flexibility, stigma, and attitudes towards seeking help is scarce.

This study has policy applications for policymakers, mental health professionals, and educators. For schools, it offers an evidence-based and scalable model for fostering student well-being. For clinicians, it adds to the literature on ACT's cultural adaptability and efficacy. For policymakers, it demonstrates the promise of low-cost, preventive mental health interventions that can be integrated into national education systems. Successful delivery of the one-session ACT workshop can be used as a model for large-scale stigma reduction programs across India, ultimately creating a more supportive climate for mental health in Indian higher education.

METHODOLOGY

Research Design

The present study employed a prospective exploratory trial with a one-sample, quantitative, pretest-posttest-follow-up design to evaluate the effects of a one-session Acceptance and Commitment Therapy (ACT) workshop on stigma reduction among higher education students. This design was employed because it is suitable for natural teaching environments and amenable to first-intervention studies (Creswell & Creswell, 2018). The intervention was directly aimed at core ACT processes for the sake of modifying stigma-related and psychological flexibility.

Participants

Using purposive sampling, 281 student participants were recruited from various higher education institutions in eastern India. The inclusion criteria were as follows: (a) a student in a higher education institution, (b) aged between 18 and 30 years, and (c) willing to participate voluntarily. To constitute a non-clinical population, participants with psychiatric disorders or those receiving psychological therapy during the study were not included. Participants' demographic details were collected, such as gender, course of study (science, arts, commerce), nature of institution (public/private), nature of family (nuclear/joint), and residence (rural/urban). These variables were then used for subgroup analysis.

Instruments

To assess the impact of the ACT workshop, the following standardised and psychometrically validated instruments were used:

- **Self-Stigma of Seeking Help Scale (SSOSH-10):** This 10-item scale measures the internalised stigma of seeking psychological help (Vogel et al., 2006). It has demonstrated good internal consistency ($\alpha = .86$) and test-retest reliability.
- **Perceptions of Stigmatization by Others for Seeking Help (PSOSH):** This 5-item scale assesses perceived public stigma associated with psychological help-seeking (Vogel et al., 2009).
- **Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPH-SF):** A 10-item measure evaluating participants' openness and value placed on professional psychological services (Fischer & Farina, 1995).
- **Acceptance and Action Questionnaire – II (AAQ-II):** A 7-item measure assessing psychological inflexibility, a central ACT construct (Bond et al., 2011).

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- **Satisfaction Questionnaire:** Developed for this study to measure participants' perceived satisfaction and utility of the ACT workshop. It included both Likert-scale and open-ended items.

All instruments were administered in English, and the facilitator explained a few complex terms to ensure uniform comprehension. Cronbach's alpha coefficients for the scales ranged from .78 to .88 in the current study, indicating good internal consistency.

Intervention

Single-Session Acceptance and Commitment Therapy (SSACT) based intervention was applied with students as a therapeutic module, adapted from Thomas's (2021) One-Session, Brief Acceptance and Commitment Therapy Workshop. The module has been adopted for the current study. However, few therapeutic techniques had been tailored to meet their need and a better understanding of the students to meet the treatment efficacy. This adapted and culturally relevant therapeutic module has been approved by the university ethics committee. The details of the Single-Session Acceptance and Commitment Therapy Workshop is presented in Table 1.

Table 1: Single-Session Acceptance and Commitment Therapy

Module	Content
Cognitive Fusion	Definition of cognitive fusion, thought evolution, defusion exercise (e.g., leaves on a stream), defusion task (e.g., observing thoughts), defusion exercise (e.g., hands as thoughts).
Acceptance	Definition of acceptance, willingness video, metaphor (e.g., passengers on the bus) and related task, acceptance exercise (e.g., struggle switch), metaphors (e.g., unwanted party guest), benefits of practicing acceptance.
Mindfulness and the Observer Self	Mindfulness definition, formal and informal mindfulness task, video on presence, tasks (e.g., practicing mindfulness), metaphor (e.g., classroom metaphor), observing self-video, observer self-exercise (e.g., relaxation observation exercise).
Values and Committed Action	Definition of values, working towards values video, values exercises (e.g., contemplating what is important in your life, 80-year-old birthday speech, values drop), committed action exercise (e.g., SMART goal training), troubleshooting (e.g., FEAR and DARE).

Procedure

After obtaining written informed consent, 50 students (33 male and 17 female) participated in this pilot study. The pre-intervention assessment was completed using the ATSPPH-SF, PSOSH, SSOSH, and AAQ-II scales. Following the assessment, a proposed intervention session has been conducted. After completing the intervention, post-assessment was completed on all the tools mentioned in the preassessment administered.

Statistical Analysis:

Statistical analysis was completed using the Statistical Package for the Social Sciences Software for Windows IBM version 25. The primary analysis involved Repeated Measures

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ANOVA to examine changes across pre-test, post-test, and follow-up scores on SSOSH, PSOSH, ATSPPH, and AAQ-II. Bonferroni post hoc tests were used for pairwise comparisons. MANOVA was conducted to explore the influence of demographic variables (gender, academic stream, family type, habitat) on intervention outcomes. Effect sizes (Cohen’s d and partial eta squared) were calculated to interpret the magnitude of change. All statistical tests were two-tailed, with a significance level set at $p < .05$.

RESULTS

A total of 281 participants completed all three phases of data collection: pre-intervention, post-intervention, and 30-day follow-up. The descriptive statistics of the primary outcome variables—Self-Stigma of Seeking Help (SSOSH), Perceived Stigmatization by Others (PSOSH), Attitudes Toward Seeking Professional Psychological Help (ATSPPH), and Psychological Inflexibility (AAQ-II)—are given in the following tables.

Table - 2: Sociodemographic Characteristics of Participants (N = 281)

Variable	Category	n	%
Gender	Male	125	44.5
	Female	156	55.5
Age Group (years)	18–20	98	34.9
	21–23	143	50.9
	24 and above	40	14.2
Academic Stream	Arts/Humanities	85	30.2
	Science	102	36.3
	Commerce/Management	94	33.5
Habitat	Urban	173	61.6
	Rural	108	38.4
Type of Institution	Government	117	41.6
	Private	164	58.4
Family Type	Nuclear	178	63.3
	Joint/Extended	103	36.7

% = percentage, n = total sample

The study sample included 281 participants, with a slight overrepresentation of females, as 55.5% were female and 44.5% were male. The age group of 21–23 years represented the highest percentage of the sample (50.9%), followed by 18–20 years (34.9%), with 14.2% being older than 24 years, reflecting an extremely young adult sample. In an educational context, the participants were relatively evenly distributed across different streams of study, with 36.3% of the participants studying in scientific streams, 33.5% in commerce or management, and 30.2% in arts or humanities. Most participants lived in urban areas (61.6%), as opposed to 38.4% from rural areas, reflecting a slight urban bias in the sample. Regarding institutional affiliation, a higher percentage of participants were from private institutions (58.4%) compared to those affiliated with government institutions (41.6%). Finally, the greater majority of participants (63.3%) reported having come from nuclear family systems, as 36.7% reported being from joint or extended family systems.

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Table 3: Means and Standard Deviations of Outcome Variables Across Timepoints (N = 281)

Variable	Pre-test (M ± SD)	Post-test (M ± SD)	Follow-up (M ± SD)
SSOSH	25.84 ± 5.11	22.13 ± 4.76	21.80 ± 5.01
PSOSH	14.62 ± 3.45	12.91 ± 3.29	12.73 ± 3.37
ATSPPH	27.15 ± 4.98	30.84 ± 4.67	30.51 ± 4.95
AAQ-II (Inflexibility)	22.37 ± 6.02	18.45 ± 5.51	18.62 ± 5.66

SSOSH = Self-Stigma of Seeking Help, PSOSH = Perceived Stigmatisation by Others, ATSPPH = Attitudes Toward Seeking Professional Psychological Help, AAQ-II = Acceptance and Action Questionnaire – II, M = Mean, SD = Standard deviation

Table 3 shows the mean (M) and standard deviation (SD) scores on four psychological measures: Self-Stigma Concerning Seeking Help (SSOSH), Perceived Stigmatisation by Others for Seeking Help (PSOSH), Attitudes Concerning Seeking Professional Psychological Help (ATSPPH), and Psychological Inflexibility (AAQ-II). These were measured at three-time points: pre-test, post-test, and follow-up.

Self-Stigma of Seeking Help (SSOSH): Participants decreased self-stigmatisation from the pre-test (M = 25.84, SD = 5.11) to the post-test (M = 22.13, SD = 4.76), with an additional modest decrease at the follow-up (M = 21.80, SD = 5.01). The trend of decrease that is apparent suggests that the intervention effectively reduced self-stigma about seeking psychological help, and that the gains were sustained over time.

Perceived Stigmatisation by Others for Seeking Help (PSOSH) also reduced in the same way from the pre-test (M = 14.62, SD = 3.45) to the post-test (M = 12.91, SD = 3.29), with a further slight reduction at the follow-up (M = 12.73, SD = 3.37). This suggests that the intervention positively affected participants' views about societal stigma regarding seeking help, with these views being stable over the longer term relative to the higher scores at baseline.

Attitudes Toward Seeking Professional Psychological Help (ATSPPH): In contrast to the measures of stigma, the ATSPPH scores significantly rose from pre-test (M = 27.15, SD = 4.98) to post-test (M = 30.84, SD = 4.67), and the scores remained relatively stable on follow-up (M = 30.51, SD = 4.95). This indicates a substantial shift in attitudes toward help-seeking immediately after the intervention, which was maintained in the long term, pointing to the long-term rise in the participants' direction towards seeking psychological services.

Psychological Inflexibility (AAQ-II): A notable reduction in psychological inflexibility was seen, indicated by the pre-test scores (M = 22.37, SD = 6.02), which reduced to post-test scores (M = 18.45, SD = 5.51) and remained stable at follow-up (M = 18.62, SD = 5.66). This pattern indicates that the intervention effectively enhanced psychological flexibility, a key aspect targeted in Acceptance and Commitment Therapy (ACT), with these improvements sustained at the follow-up evaluation.

Table 4: Repeated Measures ANOVA Results for Primary Outcomes (N = 281)

Outcome Variable	F	p-value	Partial η ²
SSOSH	112.45	< .001***	.29
PSOSH	98.72	< .001***	.26
ATSPPH	125.39	< .001***	.31
AAQ-II	107.16	< .001***	.28

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SSOSH = Self-Stigma of Seeking Help, PSOSH = Perceived Stigmatisation by Others, ATSPPH = Attitudes Toward Seeking Professional Psychological Help, AAQ-II = AAQ-II = Acceptance and Action Questionnaire – II,

Table – 4 shows the results of the repeated measures ANOVA revealed a statistically significant change in all four outcome measures—Self-Stigma of Seeking Help (SSOSH), Perceived Stigmatization by Others for Seeking Help (PSOSH), Attitudes Toward Seeking Professional Psychological Help (ATSPPH), and Psychological Inflexibility (AAQ-II)—following the intervention. For SSOSH, there was a significant time effect, $F(2, pdf) = 112.45$, $p < .001$, with a large effect size (partial $\eta^2 = .29$), showing that the intervention accounted for 29% of the variance in self-stigma scores. Likewise, PSOSH scores decreased significantly over time, $F = 98.72$, $p < .001$, partial $\eta^2 = .26$, showing a significant decline in perceived public stigma. The greatest change was observed in attitudes toward seeking professional psychological help (ATSPPH), which enhanced significantly, $F = 125.39$, $p < .001$, partial $\eta^2 = .31$, showing a very large effect and that the intervention accounted for 31% of the variance in attitudes toward help-seeking. As measured by the AAQ-II, psychological inflexibility also demonstrated a significant decline over time, $F = 107.16$, $p < .001$, with a partial η^2 of .28, showing that the intervention accounted for 28% of the change in inflexibility. Overall, these findings strongly support the intervention's efficacy in reducing both perceived and internalised stigma, facilitating greater openness to psychological help and fostering enhanced psychological flexibility.

Outcomes show that the single-session ACT workshop significantly decreased self-stigma and perceived public stigma, enhanced attitudes toward consulting a psychologist, and decreased psychological inflexibility. The large effect sizes (η^2 ranging from .26 to .31) demonstrate the high intervention effect. Stigma-specific measures evidenced statistically and clinically significant post-intervention change, and these were well maintained at 30-day follow-up, confirming short-term efficacy and long-term maintenance of the one-session ACT model. The decreases in psychological inflexibility (an ACT process central to the model) also affirm the theoretical mechanisms of change embedded in ACT models (Hayes et al., 2012).

DISCUSSION

The present study evaluated the efficacy of an ACT single-session workshop in reducing help-seeking stigma and enhancing psychological flexibility in higher education students. Statistically significant and clinically significant pre-test to post-test enhancements in all of the primary outcome measures, such as lower self-stigma (SSOSH), reduced perceived public stigma (PSOSH), more positive attitudes toward seeking professional psychological help (ATSPPH), and reduced psychological inflexibility (AAQ-II) were found in a sample of 281 participants. The changes were mainly maintained at the 30-day follow-up.

Sociodemographic Profile

The current sample of the study consisted of 281 higher education level students, representing a balanced but slightly above-average number of female subjects (55.5%) over males (44.5%). The same gender distribution is reported in recent studies that indicate a greater participation of females in psychological research, particularly in mental health-related issues and seeking help (Komiya, Good, & Sherrod, 2000; Nam et al., 2010). Females have always been more willing to undergo psychological treatment. They are more

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likely to report the necessity of professional psychological treatment, which may be the reason for their majority participation in the study.

Most participants were aged 21-23 years (50.9%), so the sample was primarily made up of advanced undergraduate or early postgraduate students. This is a key phase of identity exploration, career exploration, and psychological vulnerability (Arnett, 2000). This phase in transition has been identified in earlier research to be the peak time in the emergence of mental health issues, yet ironically, a period of low help-seeking behaviour (Gulliver, Griffiths, & Christensen, 2010). They are, therefore, an appropriate target group for stigma-reduction and Acceptance and Commitment Therapy (ACT) interventions.

Academically, the participants were almost evenly divided across disciplines, with science (36.3%), commerce/management (33.5%), and humanities (30.2%) participants. This division by discipline is important because past research has indicated that humanities students are more likely to be open to psychological constructs and therapy input than their science and commerce counterparts, perhaps because they study a human-related and self-reflection-based curriculum (Rickwood et al., 2005). Help-seeking dispositions, however, are independent of academic background but transcend personal values, stigma perception, and mental health literacy.

The majority of the participants (61.6%) resided in urban settings. Urban students tend to have more access to mental health care and are more active on issues of psychological health and stigma (Gronholm et al., 2017). This trend may be at least partially responsible for their higher completion rate. Rural students, although underrepresented in this sample (38.4%), tend to have higher self and perceived stigma levels and lower numbers of mental health resources (Clement et al., 2015). Rural students are thus a crucial subgroup to target with future interventions.

Institutional affiliation was more likely to be private institutions (58.4%) than government institutions (41.6%). This may reflect broader trends in enrollment, availability of internet-based recruitment, or institutional prioritisation of mental health awareness. Private institutions are better resourced with well-designed wellness programs, which may encourage more engagement in psychological studies (Eisenberg, Hunt, & Speer, 2012).

Finally, the information regarding types of families revealed that 63.3% of the students came from nuclear families, and 36.7% came from joint or extended families. Family type can have a substantial effect on attitudes towards mental health. Past studies have indicated that extended families, commonly with collectivist orientations, can result in greater perceived stigma or hesitation in seeking mental health treatment from the perceived obligations of the family (Lauber & Rössler, 2007). Nuclear families, in contrast, may offer greater emotional autonomy, which may decrease internalised stigma and promote seeking help. This research population profile indicates the necessity of stigma-reduction interventions, like ACT-based workshops, to be tailored to the sociocultural contexts of the subjects. The observed heterogeneity in gender, field of study, setting, and family structure suggests that one-size-fits-all intervention may be inadequate. Future interventions must consider these demographic variables to be impactful and appropriate.

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Effectiveness of ACT in Reducing Stigma

The decrease in self-stigma reported in this study is consistent with earlier research that indicates Acceptance and Commitment Therapy (ACT)-based interventions decrease internalised negative thoughts through acceptance and defusion from self-criticism (Hayes et al., 2012; Levin et al., 2017). In the study, participants were exposed to ACT metaphors (e.g., "Passengers on the Bus") and participated in experiential exercises, demonstrating a significant reduction in self-stigma following the intervention. The findings are consistent with those of Yoon et al. (2019), who found that a brief ACT workshop significantly reduced stigma in Asian American college students. The long-term change over 30 days further speaks to the efficacy of ACT's focus on values and committed action in bringing about lasting psychological changes (Luoma et al., 2007). In addition to the decrease in internalised stigma, the intervention was also linked with a significant decrease in perceived public stigma. This agrees with earlier findings that demonstrate that changing people's perceptions of societal judgment can reduce the salience of external stigmatisation (Masuda et al., 2007). Through defusion and acceptance, students may have gained a more detached and less personally disturbing view of others' view of seeking psychological help.

Improved Help-Seeking Attitudes

Students reported a significantly more positive attitude toward seeking psychological help after the ACT workshop. This finding is consistent with earlier studies suggesting that ACT enhances psychological openness and help-seeking thoughts (Levin et al., 2014; McCracken & Gutiérrez-Martínez, 2011). Through values clarification and reduction in avoidance of painful experiences (e.g., social judgment, shame), perhaps the workshop enabled students to view mental health care as being in line with their values and overall good. The significant increase in ATSPPH scores reflects a shift in cognitive and motivational frameworks—a chief therapeutic goal in courses aimed at reducing stigma (Rickwood et al., 2005). Unlike conventional psychoeducation, where the content of thoughts is addressed for modification, ACT provides for modification of the functional process of such thoughts by teaching students to notice them without immediate response, thus encouraging valued action in the face of discomfort.

Reduction in Psychological Inflexibility

Consistent with ACT's theoretical model, the reduction in psychological inflexibility on the AAQ-II indicates a core change mechanism. Psychological inflexibility is a transdiagnostic risk factor for a wide range of psychological disorders (Bond et al., 2011; Kashdan & Rottenberg, 2010), and its reduction is related to increased well-being and adaptive function. Through the practice of mindfulness exercise, defusion of cognition, and values-consistent action, participants likely became increasingly proficient at remaining in contact with painful experiences without avoiding them—thereby reducing the tendency to act on stigmatising cognition about themselves or others. This result is particularly noteworthy considering the brief duration of the intervention. Twohig et al. (2015) also found similar results, demonstrating that single-session ACT interventions effectively reduce experiential avoidance and stigma in non-clinical populations. This suggests that short intervention formats can be both time-effective and effective in college settings, where student participation in multi-session programs is typically short-lived.

Theoretical and Practical Implications

This study contributes to the evidence base supporting Acceptance and Commitment Therapy (ACT) as a useful model for reducing stigma in educational settings. It shows that

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even a well-designed session can yield significant cognitive, emotional, and behavioural changes concerning help-seeking and self-concept. The emphasis on experiential learning, as opposed to more pedagogical approaches, may be especially useful in addressing deeply entrenched beliefs that are not amenable to reason-based interventions (Hayes et al., 2012). In practice, the brevity of the workshop and low resource intensity enhance its scalability and transferability to alternative institutional settings. Therefore, it is an up-and-coming tool to enhance mental health in low- and middle-income countries like India. Integrating such evidence-based approaches into orientation programs or peer mentoring activities could be a preventive mechanism to overcome the barriers to help-seeking behaviour among student populations.

Limitations and Future Directions

Despite promising results, this study has some limitations. First, the absence of a control group prevents causal inference. While changes were observed at multiple time points, it cannot be definitively concluded that these changes were the direct consequence of the ACT workshop. Future research should apply randomised controlled trial (RCT) designs to verify efficacy. Second, self-report measures pose potential threats to social desirability bias. Despite the promise of anonymity, future research should include behavioural or physiological measures to evaluate stigma reduction more robustly. Third, the 30-day follow-up period, though useful to ascertain immediate effect, is too brief to ascertain long-term sustainability. Future research should apply outcome measurement at broader intervals (e.g., 3 or 6 months). Fourth, despite the intervention's high feasibility, implementation fidelity and cultural sensitivity issues are critical to replicating the program across different settings and locations. Local adaptations and feedback mechanisms should be incorporated to ensure relevance and engagement.

CONCLUSION

The research demonstrates that a short, single-session ACT-informed intervention had the potential to significantly decrease self-stigma and public stigma beliefs and increase psychological flexibility and help-seeking propensity among university students. The intervention demonstrated transformational psychological change through values-based action and experiential avoidance. The results indicate that such low-intensity, scalable interventions can be incorporated into university mental health programs to promote openness, resilience, and destigmatised campus culture.

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