

**Understanding the disclosure of mental health problems by mental health
professionals.**

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This thesis set out to further understanding of mental health disclosure decision-making amongst UK-based mental health professionals. Part one is a conceptual introduction looking at the factors associated with the disclosure of mental health problems amongst this population, including a literature review of research published in the past decade. Part Two consists of an empirical paper in which the Disclosure Process Model (DPM) is applied to baseline data collected from the *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) pilot randomised controlled trial (RCT) – a guided self-help intervention designed to aid mental health professionals with mental health problems with disclosure decision-making. This is part of a joint project carried out by two trainee clinical psychologists. The paper outlines the researcher’s role in the development and running of the pilot RCT and details the application of the DPM to elucidate the disclosure experiences of participants.

Part three is a critical appraisal of the research undertaken in this thesis, presenting personal reflections on the research process and discussing the challenges involved in researching disclosure-decision making amongst mental health professionals. It concludes with a reflection on the implications of the study.

Impact statement

The mental health of health care professionals has come under scrutiny in recent years, partly in response to evidence of the financial cost of untreated mental health problems. The UK National Health Service employs some 1.4 million people, with mental health problems estimated to cost the organisation £1,794 - £2,174 per NHS employee per year (Deloitte UK, 2017). Evidence suggests that mental health professionals, a sub-group of health care professionals, are as vulnerable to mental health problems as the general population (Horsfall, Cleary, & Hunt, 2010; Tay, Alcock, & Scior, 2018). Yet research suggests that they are hesitant about disclosing their mental health problems due to fear of discrimination and stigma, which can limit help-seeking (see for example, Health Education England, 2019; Tay et al., 2018; Zerubavel & Wright, 2012). Little is known about the relationship between disclosure decision making and outcomes amongst this group of health care professionals. Extant research had focused predominantly on disclosure beliefs and factors influencing disclosure decision making, but not on disclosure decision making processes and resulting outcomes and how these are connected.

Part One reviews research over the past decade into the factors associated with the disclosure of mental health problems by mental health professionals. Part Two, the empirical paper, aims to address the gap in the existing disclosure research, applying the Disclosure Process Model (Chaudoir & Fisher, 2010) – a framework for understanding when and why disclosure may be beneficial – to data collected at baseline in the *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) pilot Randomised Control Trial (RCT).

There is significant clinical value in understanding when and why disclosure might be beneficial for mental health professionals. Selective disclosure could help

mental health professionals access support and treatment, alleviating the numerous negative consequences associated with the burden of secrecy and concealment including increased self-stigma and poorer mental health (Pachankis, 2007).

Understanding disclosure and related dilemmas could also support health care service providers to better facilitate and support the mental health professionals in their workforces, particularly in relation to managing their mental health and wellbeing. This could help to create a more resilient workforce, reducing the financial cost of staff mental ill health.

Vitaly, supporting mental health professionals to understand when and why disclosure might be beneficial, could over time help to reduce mental health stigma and discrimination by breaking down the dominant institutional discourse within health services which locates mental distress in patients and sanctifies professionals as 'well healers', as such 'normalising' mental health problems.

Outcomes from this study are exploratory and not conclusive, and analysis of data from a larger sample is needed to allow a more thorough assessment of the applicability of the DPM to further understanding of disclosure decision making and outcomes. The empirical paper makes recommendations, which may be important to take into consideration for future research seeking to elucidate disclosure process amongst mental health professionals. Not only could this help support mental health professionals think about disclosure, increasing options for support and help-seeking and reducing self-stigma and fear of discrimination, but it could also contribute to reducing mental health stigma and discrimination more widely.

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Part 1: Conceptual Introduction

Factors associated with the disclosure of mental health problems by mental health professionals.

1. Introduction

Globally, mental health problems are the main cause of the overall disease burden worldwide (Vos et al., 2015). It is estimated that one in six people in England have experienced a mental health problem in the past week (McManus, Bebbington, Jenkins, & Brugha, 2016), and that 41% of UK adults have experienced a mental health problem at some point in their lives (Mental Health Foundation, 2016). More recent research has evidenced the prevalence of mental health problems amongst mental health professionals, with some suggesting a greater prevalence compared to the general population (Department of Health, 2010; Tay, Alcock, & Scior, 2018).

The UK National Health Service (NHS) employs some 1.4 million people. In recent years concern has been expressed about who cares for these health care professionals, culminating in a call for evidence and the production of a wide-ranging report by Health Education England (HEE, 2019) into NHS learners and staff wellbeing. Drawing on existing research, the report highlights worrying trends in the health and wellbeing of NHS staff including high levels of distress, burnout, self-harm and suicidality (Stevenson & Farmer, 2017). Some 15% of staff are cited as reporting symptoms of mental health problems, and staff with mental health problems were reported as twice as likely to lose their jobs as colleagues with no mental health problems, estimating that the poor mental health of NHS staff costs the organisation £1,794 - £2,174 per NHS employee per year. In contrast, the return on investment in workplace mental health interventions was reported at £4.20 for every £1 spent (Deloitte UK, 2017). A survey of NHS staff found that one in three had felt unwell due to work-related stress and that one in two went to work despite feeling unwell due to work pressures (NHS Survey Coordinating Centre, 2017).

Furthermore, death amongst female healthcare workers is reported as 24% higher than the national average (Office for National Statistics, 2017).

Public campaigns designed to encourage awareness and openness about mental health problems, such as *Time To Change*, have flourished in the past decade. Highlighting how mental health issues affect individuals and society, these initiatives, including the recent British Broadcasting Corporation's (BBC) mental health season, which saw well-known British public figures talking about their own mental health problems, have begun to shift public attitudes towards people with mental health problems (Henderson & Thornicroft, 2013). However, despite these significant advances, anticipated and experienced stigma and discrimination within the workplace, and self-stigma, remain barriers to help seeking amongst NHS staff and learners, with the ongoing reality of stigma stated to be "deep-seated and profound" in the aforementioned HEE report (p.69) which notes that:

The trust and confidence needed in ensuring confidentiality was expressed by some staff as a barrier to seeking work-based support. If general stigma reduction remains the objective, the Commission feels it important to break down barriers to emotional support and enhance the sense of community to respond immediately to the presenting situation (HEE, 2019, p.69).

Thus staff and learners are in the unenviable position of advocating and providing support for people with mental health problems within a system whose culture may dichotomise the patient-professional relationship, thereby discouraging disclosure of problems and help-seeking by the very professionals who work in it.

The exploration of disclosure of mental health problems amongst mental health professionals is a relatively new focus within disclosure research. Research has predominantly focused on the prevalence of mental health problems and factors

associated with disclosure, rather than the disclosure process, and understanding when and why disclosure may be beneficial. The current study therefore aimed to explore the disclosure of mental health problems amongst UK based mental health professionals taking part in a pilot randomised controlled trial (RCT) of the *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) intervention. The Disclosure Process Model (DPM; Chaudoir & Fisher, 2010), a comprehensive theoretical framework to understand when and why disclosure may be beneficial and the impact of disclosure on wellbeing, will be applied to explore the data from said study. The DPM is expounded on in section 5. The aim of this conceptual introduction is to outline the key concepts integral to this research, summarise research on the disclosure of mental health problems amongst mental health professionals, and set out the motivations for the current study.

2. Key Concepts

2.1 Stigma

Goffman's (1963) pioneering work on stigma drew insight from the ancient Greek practice of burning or cutting marks into the skin of slaves or criminals to identify them as different or tainted. He defined stigma as an individual attribute or characteristic which is viewed negatively by society and used to discredit an individual, leading to what he referred to as a 'spoiled identity'. This results in status loss and discrimination for the stigmatised individual (Link & Phelan, 2001).

In both Goffman's and subsequent research, there is a differentiation between visible stigmatised identities, for example physical disability, and concealable stigmatised identities which can be hidden from others. The latter covers a range of identities, for example substance use problems, sexual identity, mental health problems, experiences of abuse or sexual assault, and an HIV+ diagnosis (Pachankis,

2007; Quinn & Chaudoir, 2009). As with visible stigmatised identities, concealable ones, once exposed, lead to a process by which the individual is cognitively ascribed a set of negative characteristics which are devalued, setting them apart from others. An individual might possess multiple stigmatised identities, both visible and concealable, for example, a visible physical disability and substance use problems, or multiple concealable identities, for example, a mental health problem and a minority sexual identity (Chaudoir et al., 2010).

Drawing together recent advances in stigma research, Bos, Pryor, Reeder, & Stutterheim (2013) posit that stigma occurs on public, interpersonal and individual levels, and resides not in the individual but within social contexts. They advance that stigmatisation serves to keep people down in order to maintain social dominance by a dominant group; to enforce social norms and encourage conformation to in-group norms. Stigmatisation is also thought to provide an evolutionary means to protect society from destruction, for example, through the spread of infectious diseases (Major & O'Brien, 2005; Neuberg, Smith, Hoffman, & Russell, 2007). Bos et al. (2013) further observe that stigma can be experienced as both overt – for example avoidance, social rejection and dehumanisation – and covert – more subtle displays of discomfort, such as avoiding eye contact resulting in uncomfortable social interactions. They elaborate four dynamically interrelated types of stigma (Figure 1): structural, public and self-stigma, and stigma by association.

Public stigma, “the consensual understanding that a social attribute is devalued” (Bos et al., 2013, p. 2), is located at the core of the model and encompasses the cognitive, emotional and behavioural reactions of those who stigmatise individuals with a perceived stigmatised condition. Triggers for these reactions may include whether an individual is perceived as responsible for the

stigmatised condition, for example, smokers diagnosed with lung cancer; the perceived severity of the condition which might elicit both anxiety and sympathy, leading to difficult social interactions; the perceived dangerousness of the condition, which might elicit fear or avoidance as often seen in relation to certain mental health problems such as psychosis; and finally, the degree to which the stigmatised individual is thought to have violated cultural or social norms which are positively associated with anger and social exclusion and negatively associated with sympathy, for example, the stigmatisation of people who have contracted HIV due to perceived promiscuity or associations with devalued sexual identities.

Self-stigma refers to both the way in which individuals who possess stigmatised characteristics may internalise negative beliefs and emotions associated with that identity, as well as their anticipation of stigma. Where stigmatised identities are concealable, individuals are confronted with decisions about whether to disclose these identities, and to whom, and research indicates heightened levels of fear at being discovered, both of which heighten psychological distress. Problem-focused coping strategies might be employed to mitigate the negative effects of stigmatisation including selective-disclosure and adapting behaviour in social settings, for example, avoiding stigmatising situations. Emotion-focused strategies might include downward social comparison, attributing stigmatised behaviours to ignorance, minimisation (Bos et al., 2013), and attempts to distance or detach oneself from the stigmatised identity, often referred to as disidentification (Major et al., 2005).

Stigma by association, which Goffman referred to as ‘courtesy stigma’ (1963), comprises the psychological and social reactions to people associated with an individual possessing a stigmatised identity (for example, family, friends and

professionals), and the reactions of those individuals to being associated with a stigmatised person. Finally, structural stigma refers to the way in which a society's institutions and structures legitimise, reinforce and maintain stigmatising beliefs and behaviours (Bos et al., 2013). Link et al. (2001) advocate for the centrality of structural stigma, noting that stigma exists and thrives in the convergence of numerous processes: where individual differences are labelled and these differences are culturally prescribed negative stereotypes and devalued, where individuals with stigmatised characteristics are categorised into distinct groups to produce social separation (them and us), where those associated with negative characteristics or identities experience loss of status and discrimination leading to inequality, and finally that these all occur within social, economic and political contexts which perpetuate and encourage these processes. They further refer to external stigma as prejudice and discrimination towards individuals with a stigmatised identity.

Research has evidenced negative associations with anticipated and experienced mental health stigma and discrimination across the globe (Lasalvia et al., 2013), including associations with being less likely to access help for mental and physical help problems, reduced life expectancy, limitations on education and employment, increased risk of contact with the criminal justice system, victimisation, poverty, homelessness and the disruption of personal lives and relationships (Clement et al., 2015; Corrigan, Druss, & Perlick, 2014; Gronholm, Henderson, Deb, & Thornicroft, 2017; Thornicroft, 2003). Public stigma and discrimination are thought to heighten self-stigma and its numerous negative consequences (Corrigan & Watson, 2002; Rüsçh et al., 2009), including identification with a mental health problem, shame, reduced self-esteem, eroded life goals, avoidance of effective help-seeking and a reduction in the efficacy of

evidence-based practices – these can in turn lead to worsening mental health (Corrigan, Larson, & Rüsch, 2009; Schomerus & Angermeyer, 2008).

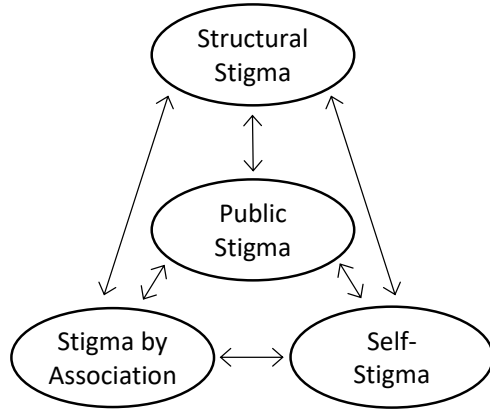


Figure 1: Four dynamically interrelated types of stigma advanced by Bos et al., 2013.

2.2 Disclosure

Disclosure of a mental health problem – a concealable stigmatised identity – is commonly termed ‘self-disclosure’ and refers to the intentional verbal sharing of information about oneself with another (Brohan et al., 2012; Chaudoir et al., 2010). Self-disclosure is a central component of social interaction, thought to facilitate emotional expression, build intimacy within personal relationships and provide an opportunity to develop a sense of self (Greene, Derlega, & Mathews, 2006). However, for those living with a concealable stigmatised identity, decisions about disclosure can be complex (Pachankis, 2007; Quinn et al., 2009) as individuals balance the potential benefits of disclosure, such as a reduction in anxiety associated with keeping an identity concealed, with potential harms, for example, in disclosing a minority sexual identity individuals may be subject to discrimination (Chaudoir et al., 2010). As such, individuals might feel significant pressure to keep information

they fear might lead to negative evaluation secret, often referred to as self-concealment (Masuda, Boone, & Timko, 2011).

Research suggests that people living with mental health problems disclose selectively, with some 10% not disclosing to any family member, and less than 40% seeking help, despite evidence of the efficacy of psychological treatments for a range of mental health problems (Bos, Kanner, Muris, Janssen, & Mayer, 2009). Pachankis (2007) advances that concealability of mental health problems, far from protecting individuals from stigma, exposes them to considerable stressors and psychological challenges including heightened vigilance and suspiciousness, anxiety, depression, increased social avoidance and isolation, difficulties in close relationships, reduced self-efficacy and identity ambivalence. Lowered self-esteem (Hinshaw, 2007) reduced psychological flexibility (Masuda et al., 2011), shame and self-stigma (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2011) and overall heightened psychological distress (Quinn et al., 2009) have also been cited as consequences of concealment. Those who conceal are furthermore thought to hold less positive attitudes to help seeking (Vogel, Wade, & Haake, 2006) and are more likely to employ harmful coping strategies, for example, the use of drugs or alcohol to manage mood (Thomas, Caputi, & Wilson, 2014). Conversely, it is suggested that selective disclosure can help alleviate these difficulties, creating a greater congruence between private and public selves, reducing self-stigma (Corrigan, Kosyluk, & Rüsçh, 2013; Corrigan et al., 2010), increasing emotional and social support (Weisz, Quinn, & Williams, 2016), improving overall psychological wellbeing and quality of life (Rüsçh, Brohan, Gabbidon, Thornicroft, & Clement, 2014), and helping to shift public views, thus reducing stigmatisation and discrimination (Corrigan & Matthews, 2003).

Research points to numerous factors that influence self-disclosure decision making, including previous experiences of discrimination (Ragins, Singh, & Cornwell, 2007), anticipated future stigma and fear of social rejection as well as the disclosure target (Grice, Alcock, & Scior, 2018), with high levels of self-stigma found to be associated with lower disclosure rates. In relation to workplace disclosure, Brohan et al. (2012) found that individuals often weighed up the anticipated costs of disclosure, including fears of workplace discrimination and being unable to secure a job, against potential benefits of disclosure, including gaining adjustments and being a role model.

Existing research therefore suggests that indiscriminate disclosure may be less helpful (Bos et al., 2009) than selective disclosure – disclosure to those who are anticipated by the person disclosing to be supportive and understanding (Corrigan & Rao, 2012). Chaudoir et al. (2010) in their aforementioned model of disclosure advance that the perceived benefits of disclosure depend on numerous factors, including the reaction of the disclosure confidant (the person disclosed to), with findings indicating that negative or neutral responses are not associated with beneficial outcomes. Furthermore, they argue that an individual's goals when entering the disclosure process, shape how the disclosure event unfolds, and subsequent outcomes, as does the communication style of the discloser. This is explored further in section 5.

3. Mental health professionals with mental health problems, stigma and disclosure

Evidence suggests that mental health professionals are as vulnerable to mental health stigma as the general population (Horsfall, Cleary & Hunt, 2010; Tay et al., 2018), and therefore face the same disclosure-concealment dilemma. This can

be worsened by an institutional culture that colludes with mental health stigma, and negative beliefs held by professionals about mental health and recovery (Zerubavel & Wright, 2012). Additionally, research suggests that mental health professionals may hold more pessimistic views than the wider public regarding the possibilities of recovery from mental health problems (Hugo, 2001).

The 2017 British Psychological Society (BPS) and New Savoy Partnership staff wellbeing survey found that 40% of mental health professionals surveyed ($n = 1,678$, predominantly NHS staff) reported feelings of depression or failure, and increased pressure to reach what were seen as unachievable targets (BPS, 2018). This follows their 2015 survey of predominantly NHS staff (88% of the 1106 respondents), which reported that 46% of psychological practitioners surveyed had struggled with depression and 50% reported feeling like a failure, with reports of high levels of work-related stress (70% of those surveyed; BPS, New Savoy Conference, & Public Health England, 2015).

In 2015, University College London (UCL) ran two comprehensive surveys of personal experiences of mental health problems and views on disclosure and help seeking among UK-based qualified and trainee clinical psychologists in collaboration with the Division of Clinical Psychology of the British Psychological Society (DCP, BPS) and with support from 19 UK Clinical Psychology Doctoral Training courses (Grice et al., 2018; Tay et al., 2018). Of the 348 trainee clinical psychologists anonymously surveyed, 67% said that they had personal experience of significant mental health problems, with 29% reporting current problems (Grice et al., 2018). Similarly, of the 678 qualified psychologists surveyed, 63% had lived experience, and of these 11% had not disclosed their problem, with 26% reporting disclosure to an employer, 38% to colleagues and peers and 68.2% to family (Tay et

al., 2018). Furthermore, many of those surveyed expressed concern about the possible negative consequences of professional disclosure for fear of unsympathetic and discriminatory responses (Tay et al., 2018).

As with the general population, concealment can limit help-seeking and the provision of support. Fears regarding disclosure in the workplace seem to mirror findings relating to the population in general, notably expectations and experiences of stigma and discrimination, fear of unfavourable treatment or being devalued at work, and fear of being rejected or excluded by colleagues (Brohan et al., 2012). In not acknowledging their own mental health difficulties, professionals are thought to contribute to the perpetuation of the polarisation of service users and professionals, encouraging disidentification and reinforcing public, structural and self-stigma (Zerubavel et al., 2012).

4. Review of the literature

A literature search was conducted to identify research into beliefs and behaviours of mental health professionals with mental health problems (hereafter referred to as lived experience) in relation to disclosure of these problems.

4.1 Search strategy

A literature search was conducted using PubMed (<https://www.ncbi.nlm.nih.gov/pubmed/>). The search was restricted to articles published in English between August 2010 and January 2019 on the basis that the most recent systematic review of attitudes to disclosure in work settings by Brohan et al. (2012) included articles published up until August 2010. The search focused on three areas: disclosure (behaviours and attitudes), mental health problems, and mental health professionals. The search term variants used are displayed in Table 1. It was beyond the scope of this conceptual paper to include all possible variants used

to describe the range of mental health problems experienced by individuals. The selection was therefore guided by the term variants used by Brohan et al. (2012). The selection of term variants for mental health professionals was additionally guided by recent research exploring issues pertaining to the mental health of mental health professionals (Grice et al., 2018; Hildebrand, 2018; Mills, 2018; Tay et al., 2018). It is acknowledged however that the restriction of search terms may have resulted in some eligible articles being overlooked. Terms were combined using the Boolean terms 'OR' and 'AND' to search for titles and/or abstracts that included both disclosure related terms and mental health problem related terms and mental health professional related terms, and, where appropriate, truncation (*) was used to ensure that the search captured variant endings for terms.

The inclusion and exclusion criteria outlined in Table 2 were applied to the 670 articles identified from the literature search. Of these, 11 were identified as potentially relevant through a review of article titles and abstracts. Where there remained ambiguity about inclusion, entire papers were read. A review of the literature cited in these publications identified another four relevant studies.

Table 1
Literature search terms and their variants

Disclosure	Mental health problems	Mental health professionals
disclos*	mental disorder*	mental health professional*
non-disclos*	mental ill*	mental health worker*
conceal*	mental health	psychiatrist*
discriminat*	psychiatric disabil*	therapist*
prejudice*	Schizophrenia	counselor*
stigma*	Bipolar	counsellor*
	Depression	psychotherapist*
	anxiety	psychologist*
		mental health nurse*
		psychiatric nurse*

The symbol * indicates the use of truncation to capture variant endings for search terms.

Table 2
Inclusion criteria for literature search

Aspect of interest	Inclusion criteria
1. Population	Mental health professional with a self-disclosed mental health problem.
2. Context	Not specified.
3. Outcome	Evidence to address any of the issues below: <ol style="list-style-type: none"> 1. Disclosure beliefs of mental health professionals regarding their own mental health problem(s) (past, present, possible future). 2. Disclosure behaviours, and intended behaviours, of mental health professionals with a mental health problem (past, present, possible future). 3. Factors related to disclosure.
4. Study type	Any type of study.
5. Publication type	Published journal papers or journal papers in press, unpublished theses.
6. Language	English
7. Time frame	31 August 2010 to 1 January 2019
8. Species	Human

4.2 Overview of studies included in the review

In total, 15 articles were included in this review – 11 from the original search and a further four identified through a review of the literature cited in these publications (see Table 3 for an overview of the studies reviewed).

Four focused broadly on mental health professionals and were not profession-specific; the remainder varied with four articles focusing on clinical psychologists (with one of the four looking at trainee psychologists only), two on mental health nurses, two on doctors, one exploring the varied experiences of a psychiatrist and peer support worker, one on art therapists and one on student nurses.

Eight of the 15 articles were original empirical studies employing cross-sectional designs using web-based surveys, and focused on any type of mental health problem. These studies varied in sample size (20 to 1,954), population, geographical location and focal topic. Four publications were personal case accounts, only one of which specified the mental health problem of the author. Three were review papers,

including one literature review, one governmental review, and one review of the prevalence of dual diagnosis of mental health problems and substance use disorders amongst doctors. The key findings of these 15 publications are summarised below by main findings.

Table 3*Overview of articles included in the review*

Study & location	Sample	Design & method	Study focus	Key findings
Boyd, J. E., Zeiss, A., Reddy, S., & Skinner, S. (2016). USA.	77 mental health professionals with lived experience working in the Veterans Health Administration.	Cross-sectional; web based survey.	Productivity; disclosure attitudes and behaviours; any type of mental health problem.	<ul style="list-style-type: none"> • Only 16% had disclosed to colleagues. • Attitudes to disclosure varied ranging from calls for openness and pride, to caution for fear of discrimination at work and possible loss of employment. • Workplace accommodations sought by 15%, predominantly flexible working hours, which were successful. • Lived experienced viewed as an asset, whether or not disclosure took place, increasing empathy towards patients and the ability to develop targeted interventions.
Braquehais, M. D., Lusilla, P., Bel, M. J., Navarro, M. C., Nasillo, V., Diaz, A., ... Casas, M. (2014). International.	Review of prevalence of dual diagnosis amongst doctors.	Overview of literature on prevalence of dual diagnosis among doctors; presentation of etiological model of dual diagnosis.	Dual diagnosis (any type of substance and mental health problem).	<ul style="list-style-type: none"> • Doctors at higher risk of committing suicide and receiving a psychiatric diagnosis. • Substance-use and non-substance related mental health problems occurred at prevalence similar to general population. • Combined alcohol and affective disorders accounted for half of all dual diagnosis. • Delayed help-seeking attributed to interacting factors: social and medical culture (perfectionism, denial of needs, location of illness in patients not professionals), public stigma related to substance use and mental health problems, and individual defence mechanisms (minimisation, denial, rationalisation).

Cohen, D., Winstanley, S.J. & Green, G. (2016). UK.	1,954 doctors.	Cross-sectional; web-based survey.	Disclosure attitudes and behaviours; obstacles to help seeking; any type of mental health problem.	<ul style="list-style-type: none"> • 60% reported lived experience. • Discrepancy between hypothesised and actually disclosure behaviour: 73% of doctors with no lived experience said they would disclose if unwell, but only 41% with lived experienced had disclosed. • Younger and trainee doctors were least likely to disclose. • Barriers to disclosure: perceived lack of care pathways, fear of labelling, confidentiality fears, uncertainty over support available and belief in the need to self-cope.
Deacon, M. (2015). UK.	Personal account by one mental health nurse.	Self-study.	Depression; cancer; disclosure; stigma.	<ul style="list-style-type: none"> • Public, structural and self-stigma were found to negatively affect disclosure and help seeking. • A culture within mental health services that locates mental ill health in patients, minimising illness amongst professionals, was found to hinder help-seeking and disclosure, increasing self-stigma.
Department of Health (2010). UK.	UK-wide review of evidence regarding the health care of NHS employees.	Government review.	Review of all aspects of health care of NHS staff; any type of mental health problem.	<ul style="list-style-type: none"> • Higher rates of depression, anxiety, workplace stress, suicidal thoughts and completed suicides amongst mental health professionals compared to other groups of workers. • Barriers to help seeking: culture of self-reliance and coping, belief about not being susceptible to illness, workload and guilt of being away from work, stigma, fear of discrimination and jeopardising future job prospects, fear of regulating authority involvement, confidentiality and privacy.

Edwards, J.L. & Crisp, D.A. (2017). Australia.	98 mental health professionals (qualified and in training).	Cross-sectional; web based survey.	Help seeking behaviours; barriers to help seeking; disclosure attitudes; any type of mental health problem.	<ul style="list-style-type: none"> • 41% of participants had experienced a past mental health problem, with 33% currently engaged in treatment for a mental health problem. • 89% said they would seek help for a future mental health problem, yet 58% with lived experience reported not having sought help when it would have been beneficial to do so. This is despite 61% of these participants reporting a belief that their mental health problem had negatively affected the quality of their work. • Barriers to disclosure: desire to self-cope, fear of exposure at work, fear of fitness to practise and licensing queries and belief there was no-one suitable to consult.
Grice, T., Alcock, K., & Scior, K. (2018). UK.	348 trainee clinical psychologists.	Cross-sectional; web based survey (including Multidimensional Perfectionism Scale (Frost, Marten, Lahart, & Rosenblate, 1990), adapted Perceived Discrimination and Devaluation Scale (Link et al., 1987) and specific questions designed for study).	Incidence of lived experience of mental health problems; factors associated with disclosure; any type of mental health problem.	<ul style="list-style-type: none"> • 67% reported past and 29% current mental health problems. • Levels of anticipated stigma higher for more severe disorders (for example schizophrenia) and for hypothetical current versus past mental health problems. • As maladaptive perfectionism and anticipated stigma related to a past mental health problem increased, the anticipated likelihood of disclosure decreased. • Recipient type was significant associated with the likelihood of disclosure of a hypothetical mental health problem with disclosure most likely to family, friends or health professionals and least likely to a placement supervisor. • Maladaptive perfectionism negatively predicted disclosure to all recipient types except for specific phobia to friends. • For all types of problem, the anticipated likelihood of disclosure was highest if the problem was current.

Harris, J. I., Leskela, J., & Hoffman-Konn, L. (2016). USA.	101 clinical mental health service providers in a Veterans Affairs Medical Centre.	Cross-sectional; web-based survey (Utrecht Work Engagement Scale (Seppälä et al., 2009); Recovery Knowledge Inventory (Bedregal, O'Connell, & Davidson, 2006); Semantic Differential Scale (Servais & Saunders, 2007) and specific questions designed for the study).	Recovery knowledge; work engagement; lived experience of mental health problems (any type); disclosure behaviours; stigma.	<ul style="list-style-type: none"> • 75% reported past mental health problems. • 38% had disclosure to a supervisor. • Those with and without past lived experience did not differ in work engagement. • Disidentification with clients lowest amongst professionals with lived experience and those with high levels of work engagement and recovery knowledge. • High levels of recovery knowledge associated with lower levels of disidentification with colleagues with lived experience.
Huet, V. & Holttum, S. (2016) UK.	20 art therapists with lived experience of mental health problems.	Cross-sectional; web-based survey (open-ended questions).	Disclosure attitudes and behaviours at application, training and post-qualification; impact on art-therapy practices; any type of mental health problem.	<ul style="list-style-type: none"> • 25% reported partial disclosure at interview for training, 25% full disclosure and 50% no disclosure. • Disclosure increased during training. • Barriers to disclosure: fear of negative judgement, questioning of competency, fear of not being accepted onto training, perception of non-disclosure as the norm, and not feeling safe to disclose. • Disclosure to peers experienced as supportive with some reciprocity, and less supportive from tutors and supervisors, which was found to worsen anxiety and limit learning.

Mitchell, A. E. P. (2018). UK.	121 student nurses.	Cross-sectional; web-based survey (Symptom Check List-90 (Derogatis, 1994); specific questions designed for the study on support seeking).	Psychological distress amongst student nurses; disclosure and help seeking; any type of mental health problem.	<ul style="list-style-type: none"> • Psychological distress was higher than the general population (47% and 43% above threshold for anxiety depression respectively). • Help seeking: 53% and 46% of those who had experienced psychological distress sought help for anxiety and depression respectively – higher than previously evidenced. • Barriers to disclosure and help seeking: fear of being judged not suitable for nursing, fear of being talked about, fear of being watched more closely and stereotypes of people with mental illness, including unpredictability, unreliability and risk.
Peterson, A.L. (2017). UK.	1 mental health nurse.	Single case study, auto-ethnographic account.	Stigma; disclosure; help-seeking; mental health problem not specified.	<ul style="list-style-type: none"> • Experience of ambiguous institutional cultures which formally promote recovery models while fostering beliefs that nurses don't suffer with mental health problems. • Openness about mental health problems and building a "recovery together" approach could help reduce structural and self-stigma.
Sawyer, A. (2011). USA.	1 psychologist-psychotherapist.	Single case study.	Stigma; disclosure; help seeking; mental health problem not specified.	<ul style="list-style-type: none"> • Fear of stigmatisation and loss of professional standing influenced disclosure. • Institutional culture encourages achievement, fitness to practise and non-disclosure which can heighten stigma and deepen mental health problems.

Tay, S., Alcock, K. & Scior, K. (2018). UK.	678 clinical psychologists.	Cross-sectional; web-based survey (Social Distance Scale (Link et al., 1987), Stig-9 (Gierk, Löwe, Murray, & Kohlmann, 2018), Military Stigma Scale (Skopp et al., 2012), Secrecy Scale (Link et al., 2002), Attitude Towards Seeking Professional Psychological Help Scale-Short-Form (Fischer & Farina, 1995), and study-specific questions).	Prevalence of mental health problems (any type); stigma; disclosure; help seeking.	<ul style="list-style-type: none"> • 63% reported lived experience. • Perceived mental health stigma higher than external or self-stigma. • Participants more likely to disclosure to social versus work circles. Fear of being judged negatively, effect on career, self-image and shame prevented disclosure and help-seeking.
von Peter, S., & Schulz, G. (2018). UK.	2, peer support worker and psychiatrist.	Case study; auto-ethnographic account.	Factors affecting disclosure.	<ul style="list-style-type: none"> • Institutional culture and inflexible institutional boundaries perpetuate the notion of vulnerable users and invulnerable professionals, which increases stigma and fear of disclosure, negatively affecting help-seeking.

Zerubavel, N., & Wright, M. O. (2012).	Psychologists.	Literature review.	Review of literature; attitudes and responses to the wounded healer; stigma; disclosure.	<ul style="list-style-type: none">• False dichotomy between sick-patients and well-professionals discourages help-seeking and accessing timely interventions by professionals.• Psychologists seen as gatekeepers who monitor colleagues' mental health and wellbeing which can create a barrier to disclosure and help seeking.• Disclosure and help-seeking prevented due to interacting factors which heighten secrecy, self-stigma and shame: fear of impairment and stigma, fear of colleague judgement, perceptions of dangerousness, overt versus covert symptoms, negative prognosis of recovery and views regarding personal blame for problems.• Psychologists in training fearful of disclosure due to their trainee position.
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4.3 Main findings

The main findings of the 15 publications reviewed were summarised into five categories, expounded on below.

4.3.1 Prevalence of mental health problems amongst mental health professionals

Nine of the 15 articles explored the prevalence of mental health problems amongst mental health professionals. As noted previously, the variance between articles is significant and therefore drawing conclusions about overall prevalence trends is not feasible. While some reported higher prevalence of mental health problems amongst mental health professionals compared to the general population, this was not the case across all of the articles, and there was a shared concern at the lack of data available.

The UK-wide Department of Health review of health care amongst health care professionals employed in the UK NHS, aptly titled *Invisible Patients* (2010), found that little is known about the health needs of these professionals, including their mental health. Evidence gathered for the review suggested higher rates of depression and anxiety amongst healthcare professionals than in any other group of workers, as well as higher rates of workplace stress, suicidal thoughts and completed suicides, specifically amongst doctors, dentists, nurses and pharmacists. However, the authors caution that the evidence suggesting elevated prevalence comes from predominantly small cross-sectional studies examining specific groups of health care professionals, whereas the few larger studies reviewed tended to show that prevalence levels were similar for healthcare professionals and other occupational groups. This suggests that elevated prevalence might be profession specific rather than similar or the same across all healthcare professionals. Furthermore, in relation

to mental health professionals, the review did not include some categories of healthcare professionals. Psychologists and psychotherapists, for example, were not included in the list of professions reviewed, while art therapists were, and the regulatory body for psychologists, the BPS, was not included amongst organisations consulted in the call for evidence, limiting the review's reach, applicability and generalisability.

Two articles exploring mental health prevalence across mental health professionals found varied prevalence rates. An online survey of qualified and in-training mental health professionals in Australia reported a prevalence of 41% (Edwards & Crisp, 2017), while one focused on the experience of 77 mental health professionals in a single setting in the USA found 75% reporting lived experience (Boyd, Zeiss, Reddy, & Skinner, 2016). The remaining publications address prevalence within specific professions. Three publications addressed the prevalence of lived experience amongst clinical psychologists with evidence indicating higher prevalence compared to the general population. Zerubavel et al. (2012) in their review cited evidence to suggest that psychologists and psychotherapists choose their profession due to their personal history of mental health and/or childhood problems. They reference studies evidencing the high percentage of therapists reporting engagement in therapy as further evidence, for example, citing the 87% of the 3,995 mental health professionals reported as engaging in psychological therapy in a study across six English-speaking countries (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). However as the authors acknowledge, these figures may be skewed by the requirement to attend therapy of some training courses. They further cited studies which evidence therapists seeking support for specific psychological, interpersonal or substance use problems.

Two UK-based studies of qualified and trainee clinical psychologists reported a prevalence of lived experience at 67% (Tay et al., 2018) and 63% (Grice et al., 2018), the latter reporting a higher prevalence of anxiety (43%) compared to depression (39%). Similarly, in Cohen, Winstanley and Greene's (2016) study of UK doctors 60% reported lived experience. Mitchell's (2018) paper on UK-based student nurses found higher levels of psychological distress compared to the general population, reporting above threshold levels of anxiety and depression (47% and 42% respectively).

Finally, a review of international literature on dual-diagnosis amongst doctors by Braquehais et al. (2014), found the incidence of substance use and mental health problems to be similar to that found in the general population, although the incidence of schizophrenia was lower. However, they found evidence to suggest that doctors were at a higher risk of committing suicide and receiving a psychiatric diagnosis, with comorbid alcohol and affective disorders found to be the most frequently occurring dual-diagnosis.

4.3.2 Past and future disclosure behaviours and intentions

Six articles reported disclosure prevalence, with five reporting historic disclosure only, with mixed results. Two studies of mental health professionals based in services for military veterans in the USA reported historic disclosure at 16% to colleagues ($n = 77$; Boyd et al., 2016), and 67% to colleagues and 38% to supervisors ($n = 101$; Harris, Leskela, & Hoffman-Konn, 2016). Two small UK-based cross-sectional studies reported mixed results regarding disclosure. One reported disclosure of mental health problems by art therapists at interview for art therapy training and during training ($n = 20$). Eighty percent of respondents had experienced a mental health problem prior to training, and of these, 50% reported not

disclosing at interview to the course, with 25% reporting partial disclosure and 25% full disclosure (Huet & Holttum, 2016). Of those who had not disclosed at interview, 75% went on to fully disclose and 25% to partially disclose to a tutor, peers or in a group setting during the course. Of the remaining respondents who had partially disclosed at interview, 75% went on to partially disclose to a tutor, peers or in a group setting during the course, and 25% reported not disclosing at all during the course. Of those who did not disclose at interview, all went on to disclose during training, with 25% reporting full disclosure to a tutor and peers during training and the remaining 75% reporting partial disclosure to peers, a tutor or in a group setting during the course.

Mitchell's (2018) study of 121 student nurses found disclosure rates of 53% and 46% for those respondents recording above threshold anxiety and depression respectively. Disclosure was highest to GPs (35%), followed by university counselling services (26%) and student support and guidance services (25%). Those respondents scoring above threshold levels of anxiety and depression were most fearful of disclosure (47% and 43% respectively). Tay et al.'s (2018; $n = 678$) survey of UK-based clinical psychologists reported that 89% had disclosed their lived experience across family, social and work settings. Respondents were more likely to disclose to social circles than in work settings, with past disclosure reported as highest to family (68%) and/or friends (65%) compared with work settings (45%). In work settings disclosure was highest to colleagues and peers (38%) compared to employers (26%). Disclosure to friends was rated most positively, followed by family, colleagues and peers compared to employers which was rated as most negative. There was no significant difference found between disclosure rates for heavily and less stigmatised mental health problems.

Cohen et al.'s (2016) study explored workplace disclosure amongst UK doctors addressing historic disclosure and future disclosure intentions. Discrepancies were found between disclosure intentions and behaviour. While 73% of those who had not experienced a mental health problem said they would disclose, in reality only 41% of those who had a past mental health problem had actually done so. There was additionally a discrepancy between the intended timing of disclosure with those who had previously disclosed reporting later disclosure than those considering hypothetical future disclosure. As with Tay et al.'s (2018) study, they found reported disclosure to be higher outside of the workplace, with 97% reporting disclosure to social circles, 30% to colleagues, and 14% to a line manager. Those who disclosed at work reported that they had done so because this had been a requirement by occupational health or service management, rather than a choice.

One study explored factors predicting disclosure intentions amongst UK-based trainee clinical psychologists ($n = 348$; Grice et al., 2018). The likelihood of disclosure was predicted by recipient type, with higher likelihood of disclosure to friends and family compared to course staff or supervisors, and whether the problem was past or current, with a preference for disclosure of current problems.

4.3.3 Disclosure beliefs

Fear of perceived negative consequences dominated attitudes to disclosure in eight articles, centring on six themes: negative judgements, effect on career, concerns regarding disclosure and confidentiality, availability of support and care pathways, and institutional culture and stigma.

The majority of these papers touched on a broad fear that disclosure might lead to negative judgements by colleagues (Cohen et al., 2016; Huet et al., 2016; Sawyer, 2011; Tay et al., 2018; Zerubavel et al., 2012), with others reporting specific

fears about being labelled unfit to practice (Edwards et al., 2017; Huet et al., 2016; Sawyer, 2011), a fear amongst trainees of being judged not suitable to work in the profession of their choice (Huet et al., 2016; Mitchell, 2018), and fear that disclosure in a workplace context might lead to referrals to licensing boards or professional bodies which could result in withdrawal or suspension of license to practise (Boyd et al., 2016; Cohen et al., 2016; Edwards et al., 2017). There was also a broad fear, particularly amongst professionals in training or in locum positions, that disclosure might negatively affect career progression (Huet et al. 2016; Mitchell, 2018; Tay et al., 2018; Zerubavel et al., 2012).

In some articles participants reported fear that disclosure would lead to confidentiality being breached (Cohen et al., 2016; Edwards et al., 2017), and this sat alongside fears of being increasingly talked about and monitoring by colleagues and managers (Edwards et al., 2017). The wounded healer literature (Zerubavel et al., 2012) furthermore found that beliefs about the role of psychologists as gatekeepers within workplaces, responsible for monitoring colleagues' mental health and wellbeing, discouraged disclosure and help seeking. Concerns about the lack of clear care pathways for professionals disclosing lived experience, lack of clarity about the support available, and beliefs that no suitable professionals were available to consult regarding mental health problems, were also cited as concerns (Cohen et al. 2016; Edwards et al. 2017).

Only two articles reported some positive beliefs about disclosure. Boyd et al. (2016) found that participants viewed lived experience as an asset, increasing empathy towards patients as well as enabling them to develop targeted interventions, whether or not disclosure took place. Of those who had disclosed (16%), disclosure was found to be a positive experience and was viewed as an important part of the

recovery process for both professionals with lived experience, fellow professionals without lived experience and patients. As such, these participants advocated openness and pride regarding their experience of mental health problems. However, amongst those who had not disclosed caution was advised, with participants expressing concerns about discrimination at work and possible loss of employment.

Grice et al.'s (2018) study of trainee clinical psychologists found pragmatism influencing attitudes to future disclosure. Participants reported that they would disclose in a work setting if they considered their problems to be serious (for example, a diagnosis of schizophrenia) despite severity being associated with higher levels of perceived stigma, and if the problems were harder to conceal. Participants were more open to disclosure of past mental health problems to social circles. The authors hypothesise that disclosure to social circles may be associated with emotional support seeking, whereas workplace disclosure was hypothesised as relating to the need for support, accommodations and a sense of professional responsibility related to an awareness of the effect mental health problems may have on work performance.

Nine papers found that participant perceptions of institutional culture, public and structural stigma influenced their attitudes to disclosure. Two papers on nurses and art therapists found the belief that non-disclosure was standard amongst these professions, which led participants themselves to avoid disclosure (Harris et al., 2016; Huet et al., 2016). Four touched on broader public and institutional beliefs about healthcare professionals as high achievers and perfectionists who prefer and are seen to self-cope in relation to their own problems, leading to a denial of needs and concealment (Braquehais et al., 2014; Cohen et al., 2016; Edwards et al., 2017; Sawyer, 2011).

Three spoke to the broader question of an institutional culture which locates illness within patients, creating a healer-patient dichotomy which sanctifies professionals as well healers, and therefore makes disclosure a taboo (Peterson, 2017; von Peter & Schulz, 2018; Zerubavel et al., 2012). One spoke to a professional's personal experience of colleagues minimising her depression as one of the "coughs and colds of psychiatry" (Deacon, 2015, p. 457), heightening her perception that her own mental health problems would not be taken seriously if she chose to disclose them.

Finally, articles explored the relationship between stigma (public, structural and self-stigma) and disclosure beliefs, finding perceived stigma to be negatively associated with disclosure. Braquehais et al.'s (2014) found that the public stigma associated with substance use disorders and mental health problems was a factor negatively predicting disclosure amongst doctors. Similarly, Zerubavel et al. (2012) found that perceptions of dangerousness and views regarding personal blame for mental health problems negatively influenced attitudes relating to disclosure, encouraging self-coping and concealment of difficulties and heightening perceived public stigma.

Harris et al. (2016) found that the aforementioned professional culture of non-disclosure was associated with increased levels of stigma towards colleagues and patients with mental health problems and disidentification, and that this was heightened in relation to particular mental health problems (personality disorders producing higher disidentification compared to schizophrenia).

Interestingly, Tay et al.'s (2018) study of clinical psychologists found perceived stigma was higher than external or self-stigma. They hypothesise that professional role, knowledge of mental health problems and recovery might reduce

vulnerability to self-stigma, although fear of the negative consequences of disclosure remained prominent. Grice et al.'s (2018) study of trainee psychologists found high levels of anticipated stigma and maladaptive perfectionism to be negatively associated with the likelihood of future disclosure. However, contrary to existing research, participants said they would be more likely to disclose a more stigmatised mental health problem, such as schizophrenia, compared to anxiety and depression. The authors posit that this was influenced by the perceived severity of the condition, beliefs regarding professional responsibility and fitness to practise, and whether the problem is perceived as easily concealable (hypothesising that the more concealable a problem, the less likely disclosure will occur).

Finally, six articles address the complex relationship between perceived stigma (public and structural), institutional culture of non-disclosure and self-stigma. They conclude that anticipated public and structural stigma can reinforce beliefs in the need for secrecy and feelings of shame, which in turn increases level of self-stigma, leading to a further deterioration in mental health (Deacon, 2015; Huet et al., 2016; Peterson, 2017; Sawyer, 2011; von Peter et al., 2018; Zerubavel et al., 2012).

4.3.4 Disclosure outcomes

Only three articles explored outcomes of past disclosure, finding that the disclosure target and context influenced the perceived helpfulness of disclosure. Huet et al.'s (2016) study of art therapists found mixed disclosure experiences depending on the disclosure target and context. Disclosure to peers was reported as predominantly supportive with some reciprocity, compared to tutors and supervisors who were found to be less supportive, leading to heightened anxiety which was perceived to limit learning.

Boyd et al., (2016) found that, of those who had disclosed their lived experience at work (16% of those surveyed), 15% had done so to successfully request workplace accommodations, predominantly flexible working hours. Finally, Tay et al.'s (2018) study asked participants to rate disclosure experiences to different targets, finding family and friends to be rated most positively (6.74/10 and 7.49/10 respectively) followed by colleagues (6.65/10) and lastly employers (4.95/10).

4.3.5 Disclosure, stigma and help seeking

Ten articles explored how the interaction of disclosure beliefs and stigma (self, structural and public) negatively affected help-seeking. The interaction of institutional culture and public stigma was found to lead to a delay or avoidance of help-seeking while heightening self-stigma and worsening mental health (Braquehais et al., 2014; Cohen et al., 2016; Deacon, 2015; Peterson, 2017; von Peter et al., 2018; Zerubavel et al., 2012). Fears about confidentiality and the perceived unavailability of care pathways for professionals was furthermore found to prevent help-seeking (Cohen et al., 2016; Edwards et al., 2017; Sawyer, 2011) as were fears of colleague judgement, negative effect on career progression, worsening self-image and feelings of shame (Tay et al., 2018; Zerubavel et al., 2012). Large workloads and feelings of guilt at being away from work and leaving colleagues to manage furthermore discouraged help seeking (Department of Health, 2010; Zerubavel et al., 2012).

4.4 Limitations of the studies reviewed

A full literature review was beyond the scope of this conceptual introduction. While the articles reviewed all provided further insight into the complex challenges and facets of disclosure of mental health problems amongst mental health professionals, they nonetheless shared significant methodological weaknesses. The primary weaknesses concern sampling methods, sample size and sample biases.

These predominantly cross-sectional studies used convenience sampling and had predominantly small sample sizes, and as such may not have been representative of their target population. They may also suffer from self-selection bias, as professionals who have experienced mental health problems are more likely to participate in research which they feel is particularly relevant to them and which they may perhaps feel invested in. Additionally, the use of self-report methods such as surveys, questionnaires and interviews could have given rise to social desirability biases which may skew results, for example studies which found discrepancies between disclosure intentions and actual disclosure behaviour. Acquiescence biases – a response bias characterised by a tendency to agree or respond positively to questions – may also be present in studies where trainees or more inexperienced staff members were surveyed.

The three review articles were not systematic reviews and details were not provided of search strategies, making it difficult to generalise from these findings. Finally, four of the studies were self-accounts of lived experience, including one which took an auto-ethnographic approach – a form of qualitative research in which self-reflection by the author is used to explore personal experiences within wider cultural, political and social contexts (von Peter et al., 2018). While such studies provide rich experiential accounts and invaluable insights into lived experiences, it is also the case that they speak to a single experience and as such the ability to draw conclusions or to compare findings with other studies is limited.

5. Understanding disclosure: The Disclosure Process Model

The DPM (Chaudoir et al., 2010; Chaudoir, Fisher, & Simoni, 2011) is a unified model of disclosure advanced to study when and why the verbal disclosure of a concealable stigmatised identity to a confidant may be beneficial, and how it

affects wellbeing. Disclosure is theorised as a dynamic and ongoing process involving a single disclosure event nested within a lifelong series of disclosure events. Each disclosure episode consists of decision-making and outcome processes. The model has five parts, as contained in Figure 2: antecedent goals (Box A), disclosure event (Box B), mediating processes (Box C), outcomes (Box D) and a feedback loop (Box E).

The model advances that disclosure begins with disclosure decision making, shaped by antecedent goals representing approach and avoidance motivational systems. The authors draw on literature examining motivations, self-regulation and goal pursuit, advancing that existing theories (see for example Derlega & Grzelak, 1979; Omarzu, 2000) do not consider the effect that these goals may have on how the disclosure event unfolds and in turn how such disclosure affects outcomes. In the model, approach goals represent the desire for positive outcomes or a desired end state, for example increased support or alleviation of disclosure distress, while avoidance goals are driven by a desire to avoid the perceived negative consequences of disclosure, or an undesired end state, for example professional rejection or negative effect on career progression. The author posits therefore that understanding the goals which drive an individual to disclose will elucidate firstly whether a disclosure event is likely, the content and style of the disclosure event, the recipient's response, and whether disclosure will ultimately be beneficial.

The disclosure event itself may occur as a one-off event in which a concealable identity is disclosed, or over a longer period of time in which the discloser attempts to determine whether disclosure is likely to elicit a positive or negative response, for example by introducing the topic (such as depression) in relation to others first. A disclosure episode is deemed complete when the discloser

believes the confidant to be fully aware of their previously concealed identity, and when the recipient understands that the discloser is in possession of this identity and has reacted in a supportive or unsupportive way. The DPM is concerned with the communication style of the discloser, including the depth, breadth, duration and emotional content of what is disclosed, as well as the reaction of the confidant. An individual with approach goals is thought to be more likely to use effective communication strategies likely to elicit positive confidant responses.

Approach and avoidance goals are thought to moderate the magnitude of the effect of disclosure on outcomes, and consequently discloser wellbeing. This moderating effect is further mediated by three processes thought to operate simultaneously, regardless of the type of antecedent goal: alleviation of inhibition, which acts to remove the negative psychological and physiological consequences of concealment; increased social support, which opens the individual to social evaluation which can either be supportive or stigmatising; and changes in social information as previously concealed information is placed in a broader social context, which can in turn affect the nature of social interactions amongst the discloser, recipient and their social context.

Finally the outcomes of disclosure are posited to include individual (psychological, behavioural and health), dyadic (linking, intimacy and trust), and social conceptual (cultural stigma and norms for disclosure) outcomes with each disclosure experience hypothesised to influence subsequent disclosure strategies and trajectories via a feedback loop.

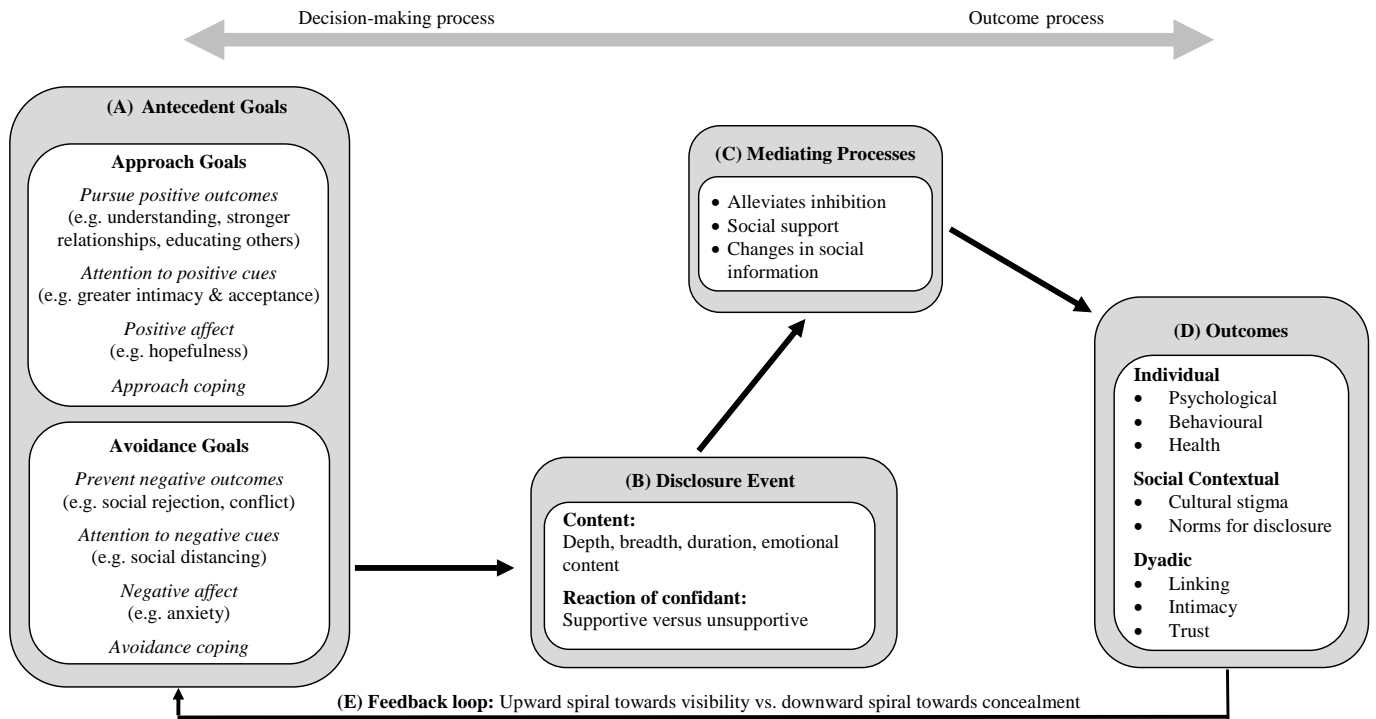


Figure 2: The original Disclosure Process Model (Chaudoir et al., 2010).

6. Aims and research questions for empirical study

The aim of the current study was to apply the DPM to further understand the disclosure experiences of mental health professionals with lived experience of mental health problems. As such, the DPM was applied to the data collected at baseline as part of the HOP-MHP pilot RCT – a programme which seeks to support decision making about disclosure of mental health problems among mental health professionals. The primary objective of the HOP-MHP programme is to reduce stigma and distress associated with mental health problems by supporting mental health professionals to reach decisions about disclosing mental health problems, and acting accordingly.

The original *Honest, Open, Proud* programme (HOP; Corrigan et al., 2013) – a manualised peer-led group intervention – was developed with a view to normalising mental health experiences, thereby reducing distress and societal and self-stigma. The adaptations made for HOP-MHP followed extensive stakeholder consultation leading to the development of a guided self-help intervention suitable for mental health professionals (Hildebrand, 2018; Mills, 2018).

For the purpose of this study, the fit of three elements contained in the DPM will be evaluated: antecedent goals (Box A), the disclosure event (Box B), and outcomes (Box D) (detailed in Figure 3). Using logistic and multiple regression analysis, the following four hypotheses will be tested:

1. Do antecedent goals predict a disclosure event?

In line with the DPM, it was predicted that participants' antecedent goals would predict the likelihood of a disclosure event occurring, with higher approach goal scores more likely to predict a disclosure event.

2. Do antecedent goals predict the nature of the disclosure event?

It was hypothesised that participants' antecedent goals would predict the nature of a disclosure event, specifically higher approach goal scores would predict that both the disclosure process and confidant reaction would be rated as helpful, whereas higher avoidance goal scores would predict lower perceived helpfulness.

3. Do antecedent goals predict disclosure outcomes?

It was predicted that higher approach goal scores would predict positive disclosure outcomes, specifically a lower level of disclosure distress, stigma stress and stress associated with secrecy, compared to higher avoidance goal scores which would predict a higher level of distress.

4. Do disclosure experiences predict disclosure outcomes?

It was predicted that a positive disclosure experience would predict positive disclosure outcomes, as would a positive confidant reaction, specifically lower levels of disclosure distress, stigma stress and stress associated with secrecy, compared to a negative disclosure experience and confidant reaction.

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Part Two: Empirical Paper

Understanding disclosure of mental health problems by mental health professionals: An application of the Disclosure Process Model.

1. Abstract

Background: Disclosure and concealment of mental health problems can affect mental wellbeing, access to informal and formal support, and recovery, including for mental health professionals. To date, no comprehensive theoretical framework has been applied to further understanding of when and why disclosure might be beneficial for this population. The Disclosure Process Model (DPM) provides a theoretical framework for understanding disclosure, theorising that the disclosure process comprises antecedent goals, a disclosure event, mediating processes, outcomes and a feedback loop.

Aims: In this study, the DPM was applied to examine the disclosure of mental health problems amongst UK mental health professionals taking part in the *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) pilot randomised controlled trial (RCT).

Method: Responses from 60 UK-based mental health professionals collected at the start of the HOP-MHP study were used to explore the relationship between antecedent goals, disclosure experiences and outcomes (stress associated with secrecy, stigma related stress and disclosure related distress).

Results: Antecedent goals were not predictive of disclosure or the perceived helpfulness of a disclosure event, and the perceived helpfulness of a disclosure event did not predict disclosure outcomes. However, antecedent goals did predict stress associated with secrecy but did not predict other disclosure outcomes.

Conclusions: An initial application of the DPM to data gathered from UK mental health professionals taking part in the HOP-MHP pilot RCT did not elucidate when and why disclosure of mental health problems by mental health professionals might be beneficial. Recommendations are made in light of study limitations.

2. Introduction

Concealable stigmatised identities (such as mental health problems, HIV-status, sexual orientation or sexual abuse history) are identities with socially devalued personal attributes that are not easily discernible, and as such can be kept hidden (Quinn & Chaudoir, 2009). Research indicates that individuals with concealable stigmatised identities, far from escaping the stigma and discrimination experienced by those with visible devalued traits (Goffman, 1963), face considerable psychological stressors (Pachankis, 2007).

Self-disclosure, the intentional verbal sharing of information about oneself with another (Brohan et al., 2012; Chaudoir & Fisher, 2010), has been linked to numerous positive outcomes. An important part of social interaction, self-disclosure is thought to improve intimacy and personal relationships and build a stronger sense of self (Derlega & Grzelak, 1979; Greene, Derlega, & Mathews, 2006), reduce depression, self-stigma and stigma stress and improve self-esteem (Corrigan et al., 2010; Mulfinger et al., 2018; Rüsçh, Brohan, Gabbidon, Thornicroft, & Clement, 2014a). However, the common-sense belief that ‘confession is good for the soul’ is misguided (Kelly & McKillop, 2005), as it ignores potential negative consequences. Disclosure of a stigmatised identity can result in discrimination, for example some people who disclose their sexual minority identity report ongoing hate crime and harassment (Herek, 2009) and those with mental health problems continue to report experiences of stigma and discrimination when it comes to finding work despite legislative changes prohibiting unfavourable treatment due to mental ill health (Brohan et al., 2012). As such, disclosure decision-making is complex for individuals with concealable stigmatised identities, often resulting in a disclosure-concealment dilemma (Grice, Alcock, & Scior, 2018), with many individuals feeling

under significant pressure to conceal their stigmatised identity for fear of negative evaluation and outcomes (Masuda, Boone, & Timko, 2011).

When it comes to the disclosure of mental health problems, research indicates that disclosure can help normalise mental health, thus reducing broader public stigma and discrimination (Corrigan & Matthews, 2003). Yet evidence suggests that people disclose selectively with less than 40% seeking help, despite the efficacy of psychological treatments for mental health problems (Bos, Kanner, Muris, Janssen, & Mayer, 2009). Existing literature suggests that disclosure decisions are influenced by numerous factors including previous experiences of discrimination (Ragins, Singh, & Cornwell, 2007), anticipated stigma and fear of social rejection, as well as the disclosure target (Clement et al., 2015; Grice et al., 2018). Workplace disclosure has been found to be particularly complex as individuals weigh up the anticipated costs of disclosure, including fear of discrimination, against the potential benefits of disclosure, including gaining adjustments and being a role model (Brohan et al., 2012).

Concealment of mental health problems has been associated with aversion to help-seeking (Vogel, Wade, & Haake, 2006) and the use of harmful coping strategies to manage psychological distress (Thomas, Caputi, & Wilson, 2014). Concealment has also been linked to numerous psychological stressors including heightened vigilance and suspiciousness, anxiety, depression, increased social avoidance and isolation, difficulties in close relationships, reduced self-efficacy and identity ambivalence (Pachankis, 2007), lowered self-esteem (Hinshaw, 2007), reduced psychological flexibility (Masuda et al., 2011), shame and self-stigma (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2011) and overall heightened psychological distress (Quinn et al., 2009).

Research weighing up the pros and cons of mental health disclosure increasingly points to the value of selective disclosure to confidants who are anticipated to be supportive and understanding, rather than indiscriminate disclosure (Bos et al., 2009; Corrigan & Rao, 2012). Such selective disclosure is thought to minimise some of the potential negative consequences of disclosure, helping to reduce self-stigma by creating a greater congruence between private and public selves (Corrigan, Kosyluk, & Rüsçh, 2013; Corrigan et al., 2010), increasing emotional and social support (Weisz, Quinn, & Williams, 2016) and therefore improving quality of life (Rüsçh et al., 2014a).

2.1 Disclosure amongst mental health professionals with mental health problems

Mental health professionals are as vulnerable to mental health problems and subsequent stigma and discrimination as the general population (Horsfall, Cleary, & Hunt, 2010; Tay, Alcock, & Scior, 2018) and therefore face the same disclosure-concealment dilemma. The British Psychological Society and New Savoy Partnership staff wellbeing survey found psychological professionals reporting feelings of depression (46% of the 1,106 respondents), feelings of being a failure (49%), and increased pressure to reach what were seen as unachievable targets with high levels of work related stress (Rao, Bhutani, Clarke, Dosanjh, Parhar, 2015).

This reflects broader research into the wellbeing of healthcare professionals across the UK National Health Service (NHS) which employs some 1.4 million people. Research indicates that NHS staff and learners are facing increased levels of psychological distress and symptoms of a mental health problem (Deloitte UK, 2017), increased burnout, self-harm and suicidality (Stevenson & Farmer, 2017), and illness due to work-related stress (NHS Survey Coordinating Centre, 2017). Poor

mental health of NHS staff is estimated to cost the organisation £1,794 - £2,174 per NHS employee per year, yet the return on investment in workplace mental health interventions was reported at £4.20 for every £1 spent (Deloitte UK, 2017).

What is concerning about these reports is the acknowledgement that despite significant advances in reducing public mental health stigma and discrimination (Gronholm, Henderson, Deb, & Thornicroft, 2017; Henderson & Thornicroft, 2013), healthcare professionals continue to struggle with anticipated and experienced stigma and discrimination within the workplace, and self-stigma, and that these act as significant barriers to help-seeking (Health Education England, 2019).

Experiences of stigma and discrimination are thought to be exacerbated by an institutional culture which encourages a sick-patient well-professional dichotomy which discourages disclosure by staff and limits help-seeking (Zerubavel & Wright, 2012). Disclosure is further thought to be discouraged by some of the pessimistic beliefs held by mental health professionals regarding the likelihood of recovery from mental health problems (Hugo, 2001).

It is therefore perhaps not surprising that mental health professionals face a disclosure-concealment dilemma. This was evident in the findings of two UK wide surveys which investigated personal experiences of mental health problems and views on disclosure and help-seeking among UK-based qualified and trainee clinical psychologists (Grice et al., 2018; Tay et al., 2018). Of the 348 trainee clinical psychologists surveyed, 67% said that they had personal experience of significant mental health problems, with 29% reporting current problems (Grice et al., 2018). When it came to qualified psychologists, of the 678 surveyed, 63% had lived experience, and of these 11% had not disclosed, with many expressing concerns

about the possible negative consequences of professional disclosure for fear of unsympathetic and discriminatory responses (Tay et al., 2018).

The limited research conducted thus far into the disclosure of mental health problems by UK-based mental health professionals indicates that concealment remains the predominant choice in a professional context. This seems to be driven by expectations and experiences of stigma and discrimination, fear of unfavourable treatment, devaluation at work and fear of being rejected or excluded by colleagues (Brohan et al., 2012; Cohen, Winstanley, & Greene, 2016; Deacon, 2015; Grice et al., 2018; Huet & Holttum, 2016; Mitchell, 2018; Peterson, 2017; Tay et al., 2018). Such fears act to limit help-seeking and potential adjustments at work which could facilitate recovery and wellbeing.

It is also potentially the case that, in not acknowledging their own mental health difficulties, professionals are contributing to the polarisation of service users and professionals, encouraging disidentification – the distancing of oneself from a shared stigmatised identity (Major & O'Brien, 2005). Concealment is also thought to reinforce public, structural and self-stigma (Garthwaite, 2016; von Peter & Schulz, 2018; Zerubavel et al., 2012). Indeed, so great were the concerns regarding stigma and reluctance to disclose that a UK-wide review on the health of healthcare professionals was aptly titled *Invisible Patients* (Department of Health, 2010).

The growing body of research on the mental health of mental health professionals and the disclosure-concealment dilemma they face suggests that further research and interventions are required to better understand and support these professionals with disclosure decision-making.

2.2 The Disclosure Process Model

The Disclosure Process Model (DPM) was advanced by Chaudoir et al. (2010) as a theoretical framework for understanding when and why the disclosure of a concealable stigmatised identity may be beneficial. The authors posit that disclosure is a dynamic, circular process comprising antecedent goals representing approach and avoidance motivational systems, a disclosure event, mediating processes and disclosure outcomes. In the model, which has thus far been applied to disclosure of HIV-status (Chaudoir, Fisher, & Simoni, 2011), a single disclosure event is nested within a lifelong series of disclosure events, with each disclosure event affecting subsequent disclosure events via a feedback loop. Figure 1 presents a diagram of the original model which consists of five interrelated components: antecedent goals (Box A), a disclosure event (Box B), mediating processes (Box C), outcomes (Box D) and a feedback loop (Box E).

2.2.1 Antecedent goals.

Each new disclosure episode begins with disclosure decision-making, which is hypothesised to be influenced by preceding disclosure experiences via a feedback loop. Antecedent goals encapsulate the disclosure-concealment dilemma, with approach goals representing a focus on positive outcomes, for example, increased support or an alleviation of disclosure distress, and avoidance goals on a wish to avoid feared negative consequences, for example, the negative effect of disclosure on career progression. The nature of an individual's antecedent goals are hypothesised to influence whether a disclosure event is likely and the content and style of the disclosure event. Antecedent goals are also thought to influence when disclosure will be beneficial. Specifically, approach goals are associated with positive affect, a focus on approach-focused coping strategies and attention to

positive stimuli which are hypothesised to positively influence disclosure outcomes, as opposed to avoidance goals which are hypothesised to negatively influence the disclosure process and subsequently disclosure outcomes (Chaudoir et al., 2011).

2.2.2 Disclosure event.

Having decided to disclose, an individual will then proceed to share their concealed information with a chosen confidant through verbal communication. The authors note that full disclosure may happen over time, for example, an individual may initially ascertain the likely response of a confidant before making a disclosure, perhaps by asking their views on depression in general. The content and style of the disclosure event includes the depth, duration, emotional content and what is disclosed. The model theorises that antecedent goals will predict the content of disclosure and therefore the confidant response. An individual who enters a disclosure process with a greater emphasis on approach goals is thought to employ more effective communication strategies, which are in turn likely to elicit positive confidant responses (Chaudoir et al., 2010).

2.2.3 Disclosure outcomes.

The moderating effect of antecedent goals on disclosure and disclosure outcomes is thought to be mediated by three additional processes operating simultaneously: the extent to which disclosure results in an alleviation of inhibition, removing the negative psychological and physiological consequences of concealment, and whether disclosure results in increased social support and changes in social information. The latter process in turn can affect the nature of social interactions amongst the discloser, recipient and their social context. Disclosure outcomes are thought to comprise individual (behavioural, psychological and health), dyadic (intimacy, trust and linking), and social conceptual outcomes

(cultural stigma and norms for disclosure). Finally, each episode of disclosure is hypothesised to influence future disclosure decision-making and outcomes via a feedback loop, with positive experiences thought to create a trajectory towards greater disclosure compared to negative experiences which encourage concealment (Chaudoir et al., 2010).

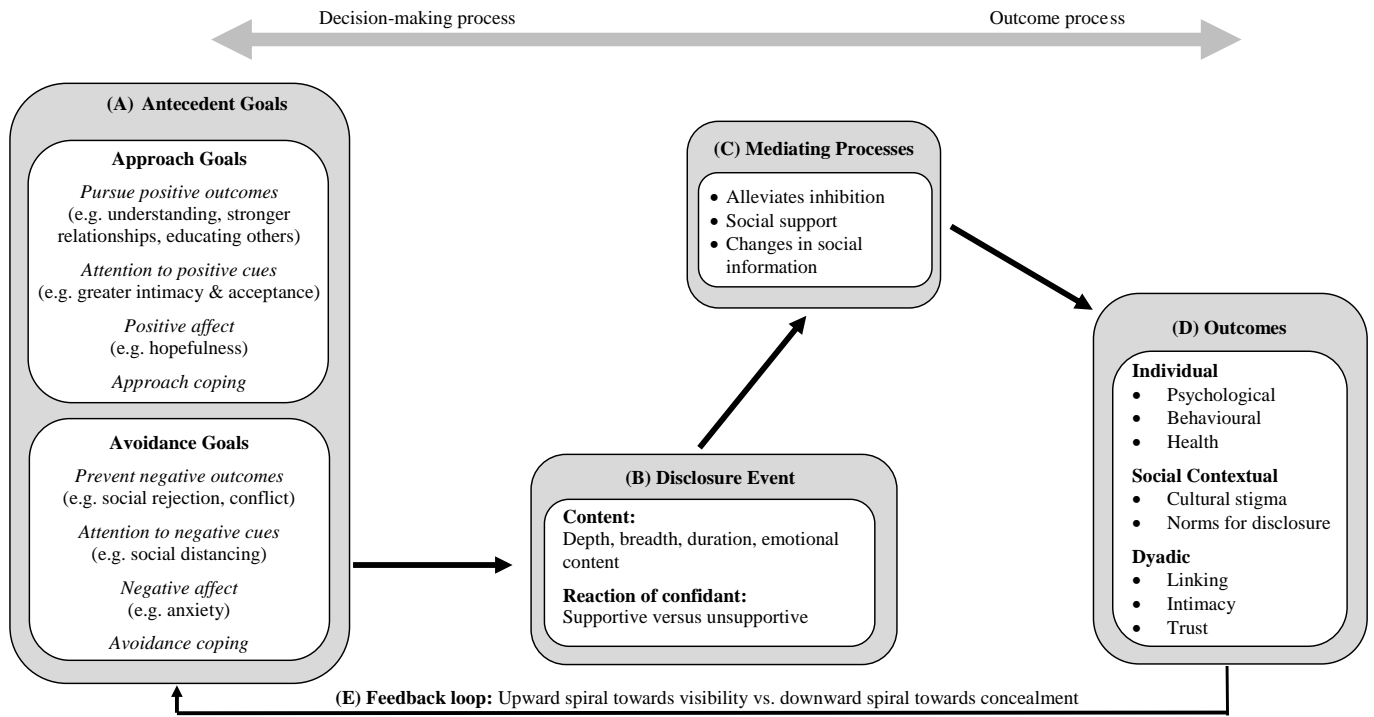


Figure 1: The original Disclosure Process Model (Chaudoir et al., 2010).

2.3 Honest, Open, Proud for Mental Health Professionals

Honest, Open, Proud for Mental Health Professionals (HOP-MHP) is an adaptation of the original manualised *Honest, Open, Proud* (HOP) peer-led group intervention designed to aid disclosure decision-making. HOP seeks to normalise mental health problems and experiences through peer engagement and to reduce the negative impact of stigma and concealment amongst people with mental health problems (Corrigan et al., 2003, 2010, 2013; Corrigan, Larson & Rüsch, 2009; Corrigan & Watson, 2002; Rüsch et al., 2014a). Research evaluating the efficacy of the original HOP programme found the programme to have a positive effect on self-stigma, disclosure related distress, secrecy, the perceived benefits of disclosure, stigma stress, and help-seeking intentions (Corrigan et al., 2015; Mulfinger et al., 2018; Rüsch et al., 2014b). Mulfinger et al. (2018) suggested that the HOP programme may improve participants' subjective quality of life through the mediating effect of reducing stigma stress.

HOP was initially modelled on the 'coming out' movement amongst lesbian, gay and bisexual communities where disclosure was advocated as a way to reduce self and public stigma and its associated harms. The HOP programme was therefore devised to increase disclosure as a way of normalising mental health and reducing public stigma. While it may be too soon to evaluate whether the HOP programme has contributed to a reduction in public stigma, these initial studies indicate that, at an individual level, being given the opportunity to carefully consider disclosure may yield multiple positive effects, whether or not the individual decides to disclose their concealable stigmatised identity.

The decision to adapt the original HOP programme to the format of a guided self-help intervention for mental health professionals reflects aforementioned

findings which suggest that fear of stigma can act as a deterrent to disclosure, and that this is particularly the case for mental health professionals. As such, HOP was adapted to be suitable for use with mental health professionals, and to support them with disclosure decision-making. The primary objective of HOP-MHP is to supporting mental health professionals to reach decisions about disclosing mental health problems, and acting accordingly (Hildebrand, 2018; Mills, 2018).

2.4 Rationale for the present study

This study was part of a pilot RCT to develop and assess the feasibility and outcomes of the HOP-MHP self-help disclosure decision-making intervention for mental health professionals with mental health problems. To date, no comprehensive theoretical framework has been applied to further understanding of when and why disclosure might be beneficial for mental health professionals with mental health problems. As such, this study applies the DPM to further understand disclosure related decisions and actions of mental health problems amongst UK mental health professionals taking part in the HOP-MHP pilot RCT.

2.5 Aims and hypotheses for present study

The initial aim of this study was to compare data collected across all three time points of the HOP-MHP pilot RCT, mapping data to the DPM and creating a statistical model to explore whether the DPM could account for participant disclosure experiences and beliefs and whether these changed following completion of the intervention. However, due to high attrition in the study, it was not possible to generate sufficient power for a statistical model of this type. As such, data collected at baseline from the 60 HOP-MHP pilot participants was used, detailing disclosure experiences and beliefs prior to starting the HOP-MHP intervention. As it was not possible to include the data gathered across the trial in this analysis, three core

aspects of the DPM were focused on in this study – antecedent goals, the disclosure experience and disclosure outcomes (see Figure 2). The outcome measures used for the study and how these are mapped to the DPM are detailed in section 3.6. There are four hypotheses for this study:

1. Do antecedent goals predict a disclosure event?

It was hypothesised that participants' antecedent goals would predict the likelihood of a disclosure event occurring, specifically that participants' with a higher approach goal score would be more likely to disclose whereas those with higher avoidance goal scores would be less likely to disclose.

2. Do antecedent goals predict the nature of the disclosure event?

It was hypothesised that participants' antecedent goals would predict the nature of a disclosure event, specifically participants' with higher approach goal scores would rate the disclosure process and confidant reaction as more helpful than those with higher avoidance goal scores, which would rate these as lower.

3. Do antecedent goals predict disclosure outcomes?

It was hypothesised that approach goals would predict positive disclosure outcomes, specifically lower levels of disclosure related distress, stigma stress and stress associated with secrecy, while avoidance goals would predict higher levels of distress across these outcomes.

4. Do disclosure experiences predict disclosure outcomes?

It was hypothesised that a positive disclosure experience would be more likely to predict positive disclosure outcomes, as would a positive confidant reaction, specifically lower levels of disclosure related distress, stigma stress

and stress associated with secrecy, compared to a negative disclosure experience and confidant reaction.

3. Method

The focus of this thesis is on exploring whether the DPM can account for participants' experiences of disclosure using data collected at baseline of the HOP-MHP pilot study only. Initially data from all three time-points was planned for use in the analysis, however due to high attrition this was not possible. My colleague (JE) explored outcome data across all three time-points and conducted a qualitative analysis of the impact of HOP-MHP on disclosure beliefs, decision-making and participant experience (Evans, 2019). (Appendix 1 details the work completed by the researcher as part of this joint project) What follows is a brief description of the development of the study with an emphasis on phase two and the work of the author.

3.1 Development of HOP-MHP and pilot

Phase one involved extensive stakeholder consultation of both qualified and trainee mental health professionals with lived experience of mental health problems. This allowed for the development of the research protocol, including the adaptation of the original HOP group intervention in order to render it suitable for UK based mental health professionals with lived experience of mental health problems (see Appendix 2 for the HOP-MHP self-help guide). Stakeholders were also consulted on the acceptability of the outcome measures being used, taking into consideration completion time as well as language. The author participated in the stakeholder consultation process as a stakeholder, including reviewing a draft of the HOP-MHP guide prior to launch.

An initial pair of researchers (AH and HM) ran the project through phase one, conducting a preliminary analysis including feasibility, acceptability and preliminary outcomes (Hildebrand, 2018; Mills, 2018). The author and a second researcher (JE) took over the running of the study for phase two, which included

managing a second recruitment drive, the completion of the pilot RCT and evaluation of preliminary outcomes at follow-up.

3.2 Recruitment and eligibility criteria

As this was a pilot RCT, eligibility requirements were kept to a minimum. Participation was open to UK-based mental health professionals over the age of 18, whether qualified or in training, with self-defined experience of mental health problems (either past or current) which they experienced as having diminished their capacity for coping with the demands of everyday life. As the study focus was aiding disclosure decision-making, participants were required to not have extensively disclosed their mental health problems at the outset, or to have disclosed very selectively in a limited context, for example, to friends but not professionally. Potential participants were asked to complete a brief screening questionnaire and consent form, adapted part-way through the trial to comply with the new General Data Protection Regulation (GDPR), to assess eligibility for the study (see Appendix 3). They were also required to agree to completing the battery of outcome measures at each time-point. They were excluded if they did not have personal experience of a mental health problem or were no longer working as a mental health professional.

Participants' current mental health status was assessed using the Generalised Anxiety Disorder 7 questionnaire (a measure of anxiety; GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) and the Patient Health Questionnaire (a measure of depression; PHQ-9; Kroenke & Spitzer, 2002). Where it was found that participants were experiencing significant psychological distress, by selecting the highest score in self-harm or suicidal ideation on the PHQ-9, they were advised that they were not suitable for the intervention at this time, and were signposted to information about accessing support and crisis services.

Participants were recruited across both phases of the project via numerous routes, all of which included information about the study and a web link to the study webpage (<https://www.ucl.ac.uk/pals/hop-mhp-project-0>), which housed the study information sheet (see Appendix 4), consent form and the brief eligibility screening measure. The study website additionally provided information regarding sources of support and self-care, fitness to practise information and signposting to legal and employment services. Potential participants were requested to make contact via the study email address if they had any questions about the study or to return their consent paperwork. A second recruitment drive was launched in the second phase which included updated publicity material (for an example advertising poster see Appendix 5).

This phase of recruitment included sending information to the following organisations and individuals requesting dissemination of the study to their respective networks (see Appendix 6 for an example recruitment email sent out during phase two): Psychological Practitioner networks (excluding the North West), Improving Access to Psychological Therapies (IAPT) course directors and the IAPT National Therapist Workforce email list, course leads for UK based clinical psychology training courses with a request to disseminate the information to first years only as a similar request had been sent out during phase one, UK based counselling psychology doctoral course leads, Counsellors in the NHS Network and the Paediatric Psychologists Network. The study was also disseminated via text message and email amongst peers across UK based clinical psychology training courses and across various social media platforms including Twitter and Facebook and the UCL Unit for Stigma Research. A follow-up short article was included in the North-West England Psychological Practitioner Network newsletter.

Unfortunately due to internal procedural difficulties, despite efforts across both phase one and two, the study was not disseminated via the British Psychological Society Division of Clinical Psychology (BPS DCP) mailing list as originally planned. As the study had institutional but not NHS ethical approval, it was not possible to disseminate the study via NHS networks.

The pilot RCT was registered with a clinical trials register and has the International Standard Randomised Control Trial Number (ISRCTN) reference number 18418155.

3.3 Ethical considerations

The UCL Research Ethics Committee approved the study and subsequent amendments to extend the study period through phase one and two (Project ID No. 9297/002; Appendix 7). Participation in the study was voluntary. Participants were asked to give informed signed consent to take part in the study and as outlined above, participants were provided with an information sheet, consent form and details for further support and guidance on signing up for the trial and throughout, including on the study website. Participant confidentiality was ensured through the use of unique identifiers for the completion of all measures, and personal identifiable data were securely stored in the UCL Data Safe Haven with all data stored in accordance with GDPR. No personally identifiable information was stored on Qualtrics. Participants were further invited and advised, at the recruitment and consent stage and following allocation to the intervention arm, to set up an alias email address for the study to help protect confidentiality. Given potential concerns regarding disclosure, the collection of socio-demographic data was kept to a minimum. Participants were informed that they were able to withdraw their data or participation from the study at any point up until the follow-up stage.

3.4 Managing potential risk

The aim of HOP-MHP was to provide participants with the opportunity to consider in-depth various aspects relating to the disclosure of their mental health problems. It was hoped that this would prove beneficial for participants, whether they chose to disclose as part of the process or not. However, it was also recognised that such an in-depth reflection on their mental health problems, including their past disclosure experiences, might potentially lead to heightened distress for some participants. As such, the study took a number of steps to provide support to participants including access to the web based peer forum for those in the intervention arm to discuss their experiences, and for all participants access to information about sources of support and guidance via the HOP-MHP webpage. Participants were furthermore advised to contact the study leads (KS and HC) for a confidential conversation should they experience any increase in distress during the study. There were no such communications made during the pilot study nor were any ethical concerns raised.

3.5 Measures

The measures used for the study were based on or adapted from those used by Rüsçh et al. (2014b) in their evaluation of the original HOP intervention. The measures were adapted in part as detailed below in response to stakeholder feedback, to make the questions more suitable to mental health professionals with a higher level of knowledge and understanding of mental health, and in order to ensure that specific aspects of the DPM were captured. All outcome measures used for the HOP-MHP study are detailed in Appendix 9, with adaptations highlighted. The mapping of measures to the variables contained in the DPM being assessed for this study are contained in Table 1 below.

Participants completed the same battery of measures at three time points – at baseline prior to starting the intervention (T0), approximately four to six weeks later (the estimated time of completion of the core sessions for those in the intervention group; T1), and 10-12 weeks following T0 (the estimated time of completion of the follow-up session for those in the intervention group; T2). The measures were estimated to take up to 20 minutes to complete, and assessed current mental distress, past disclosure, disclosure related distress, stress associated with secrecy, reasons for disclosure and concealment (past, current and future intentions) and stigma related stress. The baseline survey also included sociodemographic questions (Table 2) and questions relating to current and past mental health problems and access to formal support (Table 3).

3.5.1 Perceived benefits of disclosure and concealment.

The Coming Out with Mental Illness Scale (COMIS) is a measure adapted from Corrigan et al. (2010). It has an acceptable level of internal consistency as measured across three time points by Rüschi et al. (2014b; $\alpha = 0.76, 0.78$ and 0.77). The scale initially asks whether participants have already disclosed their mental health difficulties to most of their social network ('Yes' or 'No'). If they respond 'yes', participants are guided to a subset of items exploring their beliefs about the benefits of disclosure (11 items, four of which were added to the original scale) and then to a second subset of questions exploring reasons for past concealment (16 items, two of which were added to the original scale). If they respond 'no', participants are directed to a subscale asking their beliefs on the possible benefits of future disclosure (11 items, as aforementioned) and then to a second subset of questions exploring current reasons for concealment of their mental health difficulties (16 items, as aforementioned). The items in these two subscales (reasons

for disclosure and reasons for concealment) are scored on a 7-point Likert scale (1 = ‘strongly disagree’ to 7 = ‘strongly agree’), with higher mean scores indicating stronger agreement with the benefits of disclosure or reasons for concealment.

Adaptations to the scale following the stakeholder consultation included minor language changes, for example changing ‘came out of the closet’ to ‘disclosed’, and the inclusion of reasons for disclosure or concealment which map on to the DPM, for example ‘I disclose...to educate others’ and ‘I conceal...to avoid a negative impact on my future career’.

3.5.2 Disclosure experiences.

The Disclosure Related Experiences Scale (DRE), devised for the purpose of this study, comprises two subscales with 11 items each measuring the perceived helpfulness of the disclosure process and of the confidant reaction (Hildebrand, 2018; Mills, 2018). Items are scored on an 8-point Likert scale (1 = very unhelpful to 7 = very helpful), and include a ‘not applicable’ option (item 8). There are no psychometric properties available for this scale at present as participants are expected to record different responses for each target recipient.

3.5.3 Beliefs about the need for secrecy.

The Secrecy Scale (SS) is a nine item scale with good internal consistency ($\alpha = .84$; Link et al., 2011). The scale measures an individual’s belief in the importance of keeping their mental health difficulties secret as a way to avoid discrimination. Items are scored on a 4-point Likert scale (1 = strong disagree to 4 = strongly agree) with higher mean scores indicating a stronger tendency towards secrecy.

3.5.4 Stigma stress.

Stress associated with mental health stigma was measured using the Stigma Stress Scale (SSS), an eight item scale adapted from (Rüsch et al., 2009a; Rüsch et

al., 2009b) with two subscales – a harmfulness subscale measuring the extent to which individuals appraise mental health stigma as harmful to themselves (four items with good internal consistency; $\alpha = .88$), and a resourcefulness subscale measuring participants' appraisal of their own resources to cope with stigma (four additional items with good internal consistency; $\alpha = .78$). Items are scored on a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree). An overall stigma stress score is derived by subtracting mean perceived resourcefulness from mean perceived harmfulness, with higher scores indicating higher levels of stigma stress (Rüsch et al., 2009a).

This measure was adapted for the purpose of the study, firstly by making some minor language changes in line with stakeholder feedback, for example, the use of “mental health problem” rather than “mental illness”, and secondly, two items were added to each subscale to reflect the target population for the study.

3.5.5 Disclosure related distress.

The Disclosure Related Distress measure (DRD), originally a single item measure by Rüsch et al. (2014b) asks, ‘In general, how distressed or worried are you with respect to secrecy or disclosure of your mental illness to others?’. Responses are on a seven-point Likert scale with higher scores indicating higher levels of distress or worry.

This item was adapted into two subscales designed to measure the level of distress or worry associated with keeping mental health problems secret, and the level of distress or worry associated with mental health problems being found out – both rated on a 7-item Likert scale (1 = ‘not at all’ to 7 = ‘very much’) in relation to 11 types of people (comprising social networks, professional networks and service users). Response options of, ‘I’ve already disclosed to them’ and ‘Not applicable’

were also added. Minor language changes in line with stakeholder feedback were made, for example, the use of “mental health problem” rather than “mental illness”. There are no psychometric properties available for this scale at present as participants are expected to record different responses for each target recipient.

3.5.6 Psychometric properties of the measures with this sample.

Reliability analyses were conducted to assess the psychometric properties of all scales when administered to the present sample at baseline. All of the COMIS subscales had good internal consistency (COMIS past disclosure reasons, $\alpha = .829$, COMIS past concealment reasons, $\alpha = .894$, COMIS future disclosure reasons, $\alpha = .866$, and COMIS current concealment reasons, $\alpha = .875$). Similarly the SS had a good internal consistency ($\alpha = .801$), as did both subscales of the SSS (perceived harmfulness $\alpha = .915$, perceived resourcefulness $\alpha = .814$). As mentioned previously, psychometric properties were not available for the DRD or DRE scales due to the expectation that participant responses would vary for these measures.

Table 1*Variables contained in the adapted DPM and how these were measured*

DPM	Variable	Measure	Survey Question
<i>Approach Goals (Box A)</i>	Educate others Challenge stigma Increase understanding Increase support Increase help-seeking options Decrease shame	Coming Out with Mental Illness Scale: Reasons for past disclosure Reasons for future disclosure	2.2 2.2
<i>Avoidance Goals (Box A)</i>	Fear of stigma Fear of professional rejection Fear of damage to reputation Fear of negative career impact Fear of social rejection	Coming Out with Mental Illness Scale: Reasons for current concealment Reasons for future concealment	2.3 2.3
<i>Disclosure Event (Box B)</i>	Has disclosure occurred? Helpfulness of disclosure process Helpfulness of confidant reaction	Disclosure event (Y/N) Disclosure Related Experiences Scale - Process Disclosure Related Experiences Scale - Confidant reaction	2.1 2.4 2.5
<i>Outcomes (Box D)</i>	Reduction in disclosure related distress Reduction in stress associated with secrecy Reduction in stigma stress	Disclosure Related Distress Scale (Finding Out and Keeping secret) Secrecy Scale Stigma Stress Scale (perceived harmfulness and resourcefulness)	2.8, 2.9 2.10 3.1, 3.2

3.6 Researcher stance

The author initially took part in the stakeholder consultation as a mental health professional with lived experience of mental health problems, and was subsequently recruited as a researcher during the second phase of the HOP-MHP pilot RCT. Prior to involvement, the researcher adopted a stance broadly in favour of disclosure in social and professional contexts, and believed that disclosure could help at an individual and societal level to reduce stigma and discrimination against people with mental health problems. The researcher had had both positive and negative previous disclosure experiences at that point. However, the researcher's stance changed through the process of taking part in the stakeholder consultation, the experience of clinical training and attending personal therapy. This was particularly in relation to disclosure in a professional context which the researcher came to view as something which should occur with careful consideration of the aims of disclosure and hoped for outcomes for each disclosure event. Through the stakeholder consultation and in the final drafting of the HOP-MHP guide attention was paid to making the intervention one in which disclosure is weighed up, with due attention to both the potential positive *and* negative consequences of disclosure, rather than simply adopting an approach which assumes that disclosure is always positive. As such, it is possible that shifting position on disclosure over the course of the project helped to reduce any potential bias in the researcher's approach to the study, analysis of the data and the writing up of findings.

3.7 Statistical analysis

Analyses were performed using IBM SPSS Version 25 (IBM Corp., 2017). The hypotheses were tested using both logistic and multiple regression. A logistic regression analysis was used to assess hypothesis one – whether the nature of

antecedent goals (approach and avoidance; two continuous predictor variables), predicts a disclosure event (binomial categorical variable). Multiple regression analyses were run to assess the remaining three hypotheses: whether the nature of antecedent goals (approach and avoidance; two continuous predictor variables) predict the nature of a disclosure event (helpfulness of the disclosure process and confidant reaction; two continuous outcome variables); whether the nature of antecedent goals (approach and avoidance; two continuous predictor variables) predict disclosure outcomes (levels of stigma stress, stress associated with secrecy and disclosure related distress – keeping secret and finding out; four continuous outcome variables); and finally whether the nature of the disclosure event (helpfulness of the disclosure process and confidant reaction; two continuous predictor variables) predicts disclosure outcomes (levels of stigma stress, stress associated with secrecy and disclosure related distress – keeping secret and finding out; four continuous outcome variables). Each test met the assumptions required for statistical analysis, as detailed in the result below.

3.8 Power analysis

A power analysis was conducted using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007) for a multiple regression with two predictor variables. The analysis was based on Rüscher et al.'s, (2014b) findings on the measure of stigma stress which yielded an effect size of partial $\eta^2 = 0.10$ between T1 (baseline) and post-intervention. The following input parameters were entered into G*Power 3.1: $f = 0.33$ (equivalent to partial $\eta^2 = 0.10$), $\alpha = .05$, power = 80%. The calculation yielded an estimated overall sample size of 33 participants.

There was no previous literature to guide a power calculation to determine the sample size required to run the logistic regression. As such, the data from the

logistic regression conducted for this study was used to calculate the estimated sample size needed in order for the effect found to be statistically significant. The following parameters were entered into G*Power 3.1 for approach goals: $H1 = 0.27$, $H0 = 0.38$, $R^2 \text{ other } X = .006$; and for avoidance goals: $H1 = 0.50$, $H0 = 0.38$, $R^2 \text{ other } X = .038$. This returned a required sample size of 115 for approach goals and 126 for avoidance goals.

3.9 Normality testing and assumptions for statistical tests

All data was tested for normality of distribution. Skewness and kurtosis z-scores were used to assess the normality of the distribution of mean scores, recommended for small samples ($n < 50$), with z-scores >1.96 indicating a significant departure from normality at a level of $p = .05$ (Field, 2009). Outliers were identified using standardised z-scores and boxplots. Potential outliers were identified by z-scores >1.96 (with the expectation of 5% or less present in a normal distribution), probable outliers by scores >2.58 (expected in approximately 1% of normal distributions), and extreme outliers by scores >3.29 which should not be present in data that is normally distributed (Field, 2009). As such, outliers in the data set which were above the aforementioned percentages for a normal distribution were corrected using the 'Winsorizing' method, where the outlier is substituted with the nearest non-outlier value in the dataset (Field, 2009). A total of nine outliers were winsorized across six of the measures in the baseline survey (one in item 2.1 and 2.2, two 1.7 and 2.3 and three in 1.8). Following this procedure, normality testing was repeated and all skew and kurtosis values fell within the normal range.

Both binomial logistic and multiple regression analyses were conducted, and the relevant assumptions required for these statistical tests met. For the binomial logistic regression, linearity of the continuous independent variables with respect to

the logit of the dependent variable was assessed via the Box-Tidwell procedure. A Bonferroni correction was applied, resulting in statistical significance being accepted in the case of $p < .025$ (Tabachnick & Fidell, 2014). Based on this assessment, the independent variables were found to be linearly related to the logit of the dependent variable. There were no cases with standardised residual values greater than 2 standard deviations.

For all of the multiple regression analyses there was linearity as assessed by partial regression plots and a plot of standardised residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.05. There was homoscedasticity, as assessed by tolerance values greater than 0.1. There were no standardised deleted residuals greater than ± 3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by a Q-Q Plot.

3.10 Missing data

The extent of user missing data was analysed in SPSS (IBM Corp., 2017). There was at least one missing value for 28 of the 74 variables included in the analysis (38%), with 8 cases (13%) found to have at least one missing value on a variable and a total of 2% of the values were missing. Multiple imputation is recommended if the percentage of missing values are below 20% (Royston & White, 2011). The assumptions for conducting a multiple imputation were met (see IBM Corp, 2012; Jakobsen, Gluud, Wetterslev, & Winkel, 2017; Royston et al., 2011): the missing value pattern was not monotonic and the pattern frequencies graph indicated an equal pattern of missing data, suggesting that the data was missing completely at random (MCAR) with Little's MCAR test returning a non-significant result: $\chi^2(287)$

= 254.084, $p = .920$. Multiple imputations were conducted with imputations set at 100 as recommended by Royston et al. (2011).

Finally, in preparation for the analysis, ratio total scores were calculated in order to account for variability across participants in the number of type of groups people disclosed to for the DRE and the DRD scales.

4. Results

Participant socio-demographic characteristics and the results of the study are described in detail below. In summary, the four main hypotheses were not met. Contrary to predictions, antecedent goals were not found to predict a disclosure event, nor were they found to predict the helpfulness of the disclosure event (confidant reaction and disclosure process). When it came to disclosure outcomes, antecedent goals were not found to predict two outcomes – disclosure related distress or stigma stress. However, antecedent goals were found to predict stress associated with secrecy, and there was a medium to large positive correlation between avoidance goals and stress associated with secrecy. Finally, the hypothesis that the disclosure event (helpfulness of confidant reaction and process) would predict disclosure outcomes (stigma stress, secrecy stress and disclosure related distress) was not supported.

4.1 Participants

Table 2 contains participant socio-demographic characteristics. A total of 74 eligible participants consented to take part in the pilot RCT, and of these 60 completed the baseline survey, which is the focus of this paper (Appendix 8 contains a consort flow diagram of the HOP-MHP pilot RCT).

The majority of participants were female (85%, $n = 51$), under 35 years of age ($n = 41$, 68%), heterosexual (72%, $n = 43$) and classified their ethnicity as white British/white other ($n = 57$, 95%). The majority of participants were clinical psychologists ($n = 41$, 68%), with the remaining participants spread across a range of mental health professions. Just over half of the participants were in training ($n = 32$, 53%), predominantly as clinical psychologists ($n = 25$, 78%). Of those who were qualified ($n = 28$, 47%), length of qualification varied from less than two years ($n = 7$, 12%) to over 20 years ($n = 5$, 18%).

Table 3 details participants' mental health history, and access to formal support. The majority of participants at baseline reported ongoing difficulties with their mental health. While only 28% of participants reported that they were experiencing a mental health problem at the time of completing the baseline survey ($n = 17$), the majority of participants reported having experienced a mental health problem in the past ($n = 58$, 97%). Of those experiencing a current mental health problem, 12% reported that they were on the cusp of a potential mental health crisis ($n = 7$). The majority of those who reported experiencing a mental health problem in the past believed that they were either at risk of a new episode of mental ill health or were continuing to struggle with their mental health ($n = 16$, 27%, and $n = 20$, 33% respectively). Only 17% ($n = 10$) of the participants experiencing a current mental health problem reported that they were in recovery, as did 37% ($n = 22$) of those who had experienced a past mental health problem.

Sixty percent of participants reported having received a mental health diagnosis ($n = 36$), of whom the majority reported multiple diagnoses ($n = 23$, 63%). Participants were asked to specify their diagnoses and the majority reported struggling with depression and/or anxiety ($n = 26$, 72% and $n = 16$, 44%

respectively). At baseline, the average depression score for participants, recorded using the PHQ-9 (Kroenke et al., 2002), was 6.43 ($SD = 4.85$) and the average anxiety score, recorded using the GAD-7 (Spitzer et al., 2006) was 6.23 ($SD = 4.06$). The majority of participants therefore fell below the recommended clinical threshold or in the mild category for depression ($n = 25, 42\%$ and $n = 22, 37\%$ respectively) and anxiety ($n = 29, 48\%$ and $n = 22, 37\%$ respectively). The remaining participants scored in the moderate and moderately severe range for depression ($n = 7, 12\%$ and $n = 6, 10\%$ respectively) and in the moderate range for anxiety ($n = 9, 15\%$), with no participants scoring in the severe range for either depression or anxiety.

With regards help-seeking behaviour, a total of 57 participants (95%) had sought professional help for their mental health problems. The majority of participants listed seeking help from a private therapist or counsellor ($n = 27, 47\%$), followed closely by a GP ($n = 26, 46\%$). The range of all professionals consulted are contained in Table 3.

Finally, with regards disclosure of their mental health problems, 62% of participants ($n = 37$) selected “No, I have not disclosed, or only to a very select number of people”, with the remaining 38% ($n = 23$) selecting, “Yes, I have disclosed to most of my family and friends”.

Table 2
*Socio-demographic characteristics of the sample at baseline**

	<i>N</i>	<i>%</i>
<i>Gender</i>	60	
Male	9	15
Female	51	85
<i>Sexual Orientation</i>	60	
Heterosexual	43	72
Homosexual	4	6
Bisexual	12	20
Other	1	2
<i>Age</i>	60	
18-24	5	8
25-34	36	60
35-44	12	20
45-54	4	7
55-64	2	3
65+	1	2
<i>Ethnicity</i>	60	
Asian/British Asian	1	2
White British/white other	57	95
Other	2	3
<i>Profession</i>	60	
Clinical psychologist	41	68
IAPT high intensity therapist	2	3
IAPT low intensity therapist	5	8
Mental health nurse	5	8
Psychiatrist	1	2
Psychotherapist	1	2
Other**	5	8
<i>Qualification status</i>	60	
Qualified	28	47
Trainee	32	53
<i>Length of time qualified</i>	28	
<2 years	7	26
2-5 years	3	11
5-10 years	7	26
10-20 years	5	18
>20 years	5	18

Note:

* Only categories with ≥ 1 response are listed.

** 'Other' consisted of three social workers, a recovery worker and a chaplain.

Table 3
*Participant mental health history and access to formal support**

	<i>N</i>	<i>%</i>
<i>Diagnoses**</i>		
Depression	26	72
Anxiety	16	44
Eating disorder	10	28
Personality disorder	9	25
Post-traumatic stress disorder	3	8
Obsessive compulsive disorder	3	8
Specific phobia	2	6
Dissociative disorder not otherwise specified	2	6
Attention deficit hyperactivity disorder	1	3
Schizoaffective disorder	1	3
Trichotillomania	1	3
Complex trauma	1	3
<i>Sought professional help</i>		
Yes	57	95
No	3	5
<i>Professionals consulted***</i>		
Private therapist	27	47
GP	26	46
NHS Psychiatrist	10	18
NHS clinical psychologist	9	16
NHS therapist or counsellor	7	12
Private clinical psychologist	7	12
Private psychiatrist	3	5
NHS inpatient unit	2	4
NHS community psychiatric nurse	2	4
Art therapist	1	2
NHS online CBT course	1	2
Third sector organisation	1	2
University CBT therapist	1	2
NHS IAPT service	1	2

Note:

* Only categories with ≥ 1 response are listed.

** Where appropriate, participant responses were clustered, for example social anxiety and general anxiety were clustered into the category 'anxiety'. This was done for anxiety, depression and personality disorders only.

*** The majority of participants reported consulting multiple professionals and therefore figures will not total 100%.

4.2 Do antecedent goals predict a disclosure event?

The majority of participants reported that they had not disclosed in the past or only very selectively ($n = 37$, 62%). The overall mean avoidance goal score for all 60 participants ($M = 84.95$, $SD = 13.56$) was larger than the mean approach goal score ($M = 49.88$, $SD = 10.13$), suggesting that participants rated reasons for concealment of mental health problems (both current and past concealment) more highly than reasons for disclosure.

A further exploration of reasons for past concealment amongst those who had disclosed selectively ($n = 23$), found that the majority of participants agreed with the statement, *To avoid a negative impact on my future career* ($n = 21$, 92%), and disagreed most with the statement, *To maintain my personal safety* ($n = 11$, 48%). When it came to reasons for current concealment ($n = 37$), the majority agreed with the statement, *To avoid becoming vulnerable* ($n = 33$, 89%), and disagreed with the statement, *To maintain my personal safety* ($n = 17$, 46%). With regards to reasons for past disclosure ($n = 23$), the majority of the participants were most in agreement with the statement, *To educate others* ($n = 20$, 87%), and disagreed most with the statement, *To broaden my network of family, friends and others* ($n = 20$, 87%). Similarly, amongst those who had not disclosed ($n = 37$), the statement, *To educate others*, was cited as a reason for future disclosure by the majority of participants ($n = 32$, 87%) while the statement these participants most disagreed with was, *To gain acceptance* ($n = 28$, 76%).

A binomial logistic regression was conducted to investigate the effect of approach and avoidance goals on the likelihood of a disclosure event (Table 4). The logistic regression model was not statistically significant, $\chi^2(2) = 2.37$, $p = .30$. The model explained 5% of the variance in disclosure (Nagelkerke $R^2 = .05$) and

correctly classified 62% of the cases. Sensitivity was 9%, specificity 95%, positive predictive value 50% and negative predictive value 63%. Neither of the predictor variables were statistically significant. As such, the hypothesis that antecedent goals would predict disclosure outcomes was not supported.

Table 4

Logistic regression predicting the likelihood of a disclosure event based on antecedent goals

	B	SE	Wald	df	p	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Constant	-0.08	1.99	0.00	1	.96			
Approach	0.04	0.03	2.02	1	.15	1.04	0.98	1.10
Avoidance	-0.08	0.02		1		0.98	0.94	1.02

4.3. Do antecedent goals predict the nature of a disclosure event?

The overall mean scores for helpfulness of the disclosure process and confidant reaction amongst the 23 participants (38%) who reported previous disclosure were the same, with only a slight variance in the standard deviation for each mean ($M = .71, SD = .12$ and $M = .71, SD = .13$ respectively). A further exploration of the helpfulness of the disclosure process found that participants ranked disclosure to a *Close friend* as most helpful ($n = 21, 92\%$), and disclosure to a *Clinical supervisor* as least helpful ($n = 6, 27\%$). When it came to the reaction of the confidant, participants similarly reported the reaction of a *Close friend* as most helpful ($n = 17, 87\%$), and *Line manager* as least helpful ($n = 6, 27\%$). Multiple regression analyses were employed to investigate the effect of both approach and avoidance goals on the perceived helpfulness of the disclosure process and on the perceived helpfulness of the reaction of the disclosure confidant (see Table 5).

4.3.1 Helpfulness of the process.

A multiple regression was run to predict perceived helpfulness of the disclosure process from approach and avoidance goals. The multiple regression model was not a significant predictor of perceived helpfulness of the disclosure process, $F(2, 20) = 0.38, p = .68$. There was a very weak, non-significant negative correlation between approach goals and the perceived helpfulness of the process ($r = -.19, p = .17$) and between avoidance goals and the perceived helpfulness of the process ($r = -.03, p = .43$). Together, approach and avoidance goals explained 4% of the variance in perceived helpfulness ($R^2 = .04$). Both approach goals ($\beta = -.19, t = 0.86, p = .39$) and avoidance goals ($\beta = .02, t = 0.12, p = .90$) were non-significant predictors.

4.3.2 Helpfulness of confidant reaction.

A multiple regression was run to predict perceived helpfulness of confidant reaction from approach and avoidance goals.

The multiple regression model was not a significant predictor of perceived helpfulness of the confidant reaction, $F(2, 20) = 1.02, p = .37$. There was a weak, non-significant negative correlation between approach goals and the perceived helpfulness of the confidant reaction ($r = -.28, p = .09$) and a weak non-significant positive correlation between avoidance goals and the perceived helpfulness of confidant reaction ($r = .02, p = .45$). Together, approach and avoidance goals explained 9% of the variance in perceived helpfulness ($R^2 = .09$). Neither approach goals ($\beta = -.32, t = 1.42, p = .16$) nor avoidance goals ($\beta = .12, t = 0.575, p = .57$) contributed significantly to the model.

Accordingly, the hypothesis that antecedent goals would predict the perceived helpfulness of a disclosure event and the perceived helpfulness of confidant reaction was not supported.

Table 5

Multiple regression analysis exploring the effect of participant antecedent goals on the perceived helpfulness of disclosure experience

	B	SE B	β	95% CI for SE B	
				Lower	Upper
Helpfulness of process					
Constant	0.80	0.17			
Approach goal	-0.002	0.003	-.19	-0.008	-0.003
Avoidance goal	0.000	0.002	.02	-0.004	0.004*
Helpfulness of confidant reaction					
Constant	0.81	0.17			
Approach goal	-0.004	0.003	-.32	-0.01	0.002*
Avoidance goal	0.001	0.002	.12	-0.003	0.005*

Note:

* Confidence limits cross zero

4.4 Do antecedent goals predict disclosure outcomes?

For the purpose of this study, disclosure outcomes were assessed using measures of stigma stress, disclosure related distress (finding out and keeping secret), and stress associated with secrecy. Multiple regression analysis was employed to investigate the effect of both approach and avoidance goals on stigma stress, disclosure related distress (finding out and keeping secret) and stress associated with secrecy (Table 6 contains the key statistics from these analyses).

4.4.1 Stress associated with secrecy.

The average score for stress associated with secrecy is low suggesting that participants believe that openness regarding mental health problems is preferable to secrecy ($n = 60$, $M = 2.17$, $SD = .44$). However, investigation of participant

responses indicates that secrecy was rated more highly in relation to participants' own mental health problems and treatment (two out of nine questions) compared to beliefs about the need for secrecy in relation to others with the majority of participants agreeing with the statement *If you were in treatment for a mental health problem you would worry about certain people finding out about your treatment* ($n = 55, 92\%$) and disagreeing with the statement *If you had a close relative who had been treated for a mental health problem, you would advise him or her not to tell anyone about it* ($n = 57, 95\%$).

A multiple regression analysis was run to predict stress associated with secrecy from both approach and avoidance goals.

The multiple regression model was a significant predictor of stress associated with secrecy, $F(2, 57) = 10.51, p < .001$. There was a very weak, non-significant negative correlation between approach goals and stress associated with secrecy ($r = -.14, p = .13$), however there was a medium to large positive correlation between avoidance goals and stress associated with secrecy ($r = .45, p < .001$). Together, approach and avoidance goals explained 27% of the variance in stress associated with secrecy ($R^2 = .27$). Both approach goals ($\beta = -.24, t = 2.13, p = .03$) and avoidance goals ($\beta = .51, t = 4.40, p < .001$) contributed significantly to the model, with avoidance goals making a greater contribution than approach goals. Since the confidence limits (see Table 6) did not cross zero, it can be concluded that the population regression coefficient for approach and avoidance goals was a significant predictor. As such, a standard deviation change in approach goals ($SD = 10.13$) saw a decrease in stress associated with secrecy by -0.24 standard deviations, and a standard deviation change in avoidance goals ($SD = 13.56$) saw an increase in stress associated with secrecy by 0.51 standard deviations.

4.4.2 Stigma stress.

The average stigma stress score (calculated by subtracting mean perceived resourcefulness from mean perceived harmfulness) was 5.03 ($n = 60$, $SD = 9.89$). Participants rated their perceived resourcefulness ($M = 33.20$, $SD = 5.12$) slightly higher than the perceived harmfulness of mental health stigma ($M = 28.16$, $SD = 7.85$). Responses regarding harmfulness indicated that participants were most concerned that stigma might have a negative impact in a professional context, specifically on their career and professional reputation ($n = 45$, 75% respectively), with the lowest level of agreement with the statement *Stigma will have a severe impact on my life* ($n = 29$, 48%). When it came to resourcefulness, participants agreed most with statements regarding their intentions to challenge prejudice, recording the highest level of agreement with the statement *I am prepared to challenge prejudice against people experiencing mental health problems* ($n = 58$, 97%), and agreed least with the statement *I have the resources I need to handle problems posed by prejudice against people experiencing mental health problems* ($n = 20$, 33%).

A multiple regression analysis was run to predict stigma stress from both approach and avoidance goals.

The multiple regression model was not a significant predictor of stigma stress, $F(2, 57) = 2.41$, $p = .09$. There was no correlation between approach goals and stigma stress ($r = .005$, $p = .48$), and a weak significant negative correlation between avoidance goals and stigma stress ($r = -.27$, $p = .01$). Together, approach and avoidance goals explained 7% of the variance in perceived helpfulness ($R^2 = .07$). Approach goals ($\beta = .06$, $t = 0.48$, $p = .63$) did not contribute significantly to the model, however avoidance goals did ($\beta = -.28$, $t = 2.19$, $p = .03$). Since the

confidence limits (see Table 8) for avoidance goals did not cross zero, it can be concluded that the population regression coefficient for avoidance goals is a significant predictor of stigma stress. A standard deviation change in avoidance goals ($SD = 13.56$) saw an increase of stigma stress of -0.28 standard deviations.

4.4.3 Disclosure related distress – finding out.

Investigation of the DRD scale for finding out indicated that participants were most distressed (selecting *Very much*) about their mental health problems being found out in a professional context, being most worried about keeping their mental health problems secret from *Clients* ($n = 22, 37\%$), followed by *Line managers* and *Colleagues* ($n = 10, 17\%$ respectively), and *Clinical supervisors* ($n = 8, 13\%$). *Close friends* and a *Family member* were rated most highly on the response *I've already disclosed to them* ($n = 21, 35\%$ and $n = 16, 27\%$ respectively).

A multiple regression analysis was run to predict disclosure related distress – finding out from both approach and avoidance goals.

The multiple regression model was not a significant predictor of distress associated with being found out, $F(2, 57) = 1.87, p = .16$. There was no correlation between approach goals and distress associated with being found out ($r = -.10, p = .21$), and a weak non-significant positive correlation between avoidance goals and distress associated with being found out ($r = .20, p = .06$). Together, approach and avoidance goals explained 6% of the variance in perceived helpfulness ($R^2 = .06$). Neither approach goals ($\beta = -.15, t = -1.14, p = .25$) nor avoidance goals ($\beta = .23, t = 1.76, p = .08$) contributed significantly to the model.

4.4.4 Disclosure related distress – keeping secret.

As found above, investigation of the DRD scale for keeping secret found that participants were most distress (selecting *Very much*) about keeping their mental

health problems secret in a professional compared to a social context, rating that they were most worried about keeping their mental health problems secret from *Clients* ($n = 20, 33\%$) followed by *Line managers* ($n = 9, 15\%$), *Colleagues* ($n = 7, 12\%$) and *Clinical supervisors* ($n = 6, 10\%$) while they seemed least worried, responding *Not at all*, to keeping secret from a *Health professional* ($n = 18, 30\%$). *Close friends* and a *Family member* were rated most highly on the response *I've already disclosed to them* ($n = 20, 33\%$ and $n = 15, 25\%$ respectively).

A multiple regression analysis was run to predict disclosure related distress – keeping secret from both approach and avoidance goals.

The multiple regression model was not a significant predictor of distress associated with being found out, $F(2, 57) = .60, p = .55$. There was a very weak, non-significant negative correlation between approach goals and distress associated with secrecy ($r = -.06, p = .30$), and a weak non-significant positive correlation between avoidance goals and secrecy ($r = .11, p = .19$). Together, approach and avoidance goals explained 2% of the variance in perceived helpfulness ($R^2 = .02$). Neither approach goals ($\beta = -.09, t = -0.69, p = .49$) nor avoidance goals ($\beta = .13, t = 0.97, p = .33$) contributed significantly to the model.

In sum, antecedent goals were not found to predict two of the disclosure outcomes – stigma stress and disclosure related distress (finding out and keeping secret). However, antecedent goals were found to predict stress associated with secrecy, with avoidance goals predicting higher levels of secrecy stress compared to approach goals, accounting for a moderate amount of variance in stress associated with secrecy.

Table 6

Multiple regression analyses exploring the effect of participant antecedent goals on disclosure outcomes

	B	SE B	β	95% CI for SE B	
				Lower	Upper
Stress associated with secrecy					
Constant	1.28	0.37			
Approach goal	-0.01	0.005	-.24*	-0.02	-0.001
Avoidance goal	0.01	0.004	.51*	0.009	0.02
Stigma stress					
Constant	19.64	9.24			
Approach goal	0.06	0.12	.09	-0.19	0.31**
Avoidance goal	-0.20	0.09	-.28*	-0.39	-0.01
Disclosure related distress – finding out					
Constant	41.68	16.66			
Approach goal	-0.26	0.22	-.15	-0.72	0.19**
Avoidance goal	0.30	0.17	.23	-0.04	0.64**
Disclosure related distress – keeping secret					
Constant	42.28	17.94			
Approach goal	-0.17	0.24	-.09	-0.66	0.32**
Avoidance goal	0.17	0.18	.13	-0.18	0.54**

Note:

* Significant at the level of $p < .05$

** Confidence limits cross zero

4.5 Do disclosure experiences predict disclosure outcomes?

Multiple regression analyses were run to investigate the effect of both the perceived helpfulness of the disclosure process and confidant reaction on stigma stress, disclosure related distress (keeping secret and finding out) and stress associated with secrecy (see Table 7).

4.5.1 Stress associated with secrecy.

As found in the aforementioned section (4.3), the average score for stress associated with secrecy was low suggesting that participants believed that openness regarding mental health problems was preferable to secrecy ($n = 23$, $M = 2.09$, $SD =$

.44). The responses of the 23 participants who had disclosed selectively indicate that secrecy was rated more highly in relation to participants' own mental health problems and treatment (two out of nine questions), compared to beliefs about the need for secrecy in relation to others. The majority of participants agreed with the statement *If you were in treatment for a mental health problem you would worry about certain people finding out about your treatment* ($n = 20, 87\%$), and disagreed most with the statements *In view of society's negative attitudes toward people with mental health problems, you would advise people experiencing mental health problems to keep it a secret* and *You believe that a person who has recovered from a mental health problem experienced earlier in life should not tell other people about it* ($n = 22, 96\%$ respectively).

A multiple regression analysis was run to predict stress associated with secrecy from both the helpfulness of the disclosure process and confidant reaction. The multiple regression model was not a significant predictors of stress associated with secrecy, $F(2, 20) = 0.43, p = .65$. There were very weak, non-significant positive correlations for both the perceived helpfulness of the disclosure process and confidant reaction and stress associated with secrecy ($r = .19, p = .18$ and $r = .12, p = .28$ respectively). Together, perceived helpfulness of the disclosure process and confidant reaction explained 4% of the variance in stress associated with secrecy ($R^2 = .04$). Neither the disclosure process ($\beta = .28, t = 0.75, p = .46$) or confidant reaction ($\beta = -.11, t = -0.29, p = .77$) contributed significantly to the model.

4.5.2 Stigma stress.

The average stigma stress score for the 23 participants who reported past selective disclosure was 5.91 ($SD = 8.52$). Similar to findings in the aforementioned section (4.3), these participants appraised their resourcefulness to manage mental

health stigma slightly higher ($M = 35.26$, $SD = 3.93$) than the harmfulness of such stigma ($M = 29.34$, $SD = 7.82$). Responses also indicated that participants were most concerned that stigma might have a negative impact in a professional context, specifically on their future and career ($n = 18$, 78% respectively). When it came to resourcefulness, 100% of participants agreed with the statements *I am prepared to challenge prejudice against people experiencing mental health problems* and *Within my profession, I will do the best I can to challenge prejudice against members of my profession who experience mental health problems*. The lowest level of agreement with regards harmfulness was recorded in response to the statement that stigma *Will have a severe impact on my life* ($n = 11$, 48%), and with regards resourcefulness in response to the statement *I have the resources I need to handle problems posed by prejudice against people experiencing a mental health problem* ($n = 4$, 17%).

A multiple regression analysis was run to predict stigma stress from both the helpfulness of the disclosure process and confidant reaction.

The multiple regression model was not a significant predictor of stigma stress, $F(2, 20) = 0.39$, $p = .68$. There were very weak, non-significant negative correlations for both the perceived helpfulness of the disclosure process and stigma stress and the perceived helpfulness of the confidant reaction and stigma stress ($r = -.18$, $p = .19$ and $r = -.12$, $p = .29$ respectively). Together, perceived helpfulness of the disclosure process and confidant reaction explained 4% of the variance in stigma stress ($R^2 = .03$). Neither the disclosure process ($\beta = -.26$, $t = -0.69$, $p = .20$) nor confidant reaction ($\beta = .09$, $t = 0.24$, $p = .80$) contributed significantly to the model.

4.5.3 Disclosure related distress – finding out.

A multiple regression analysis was run to predict disclosure related distress – finding out from both the helpfulness of the disclosure process and confidant

reaction. The multiple regression model was not a significant predictor of distress associated with being found out, $F(2, 20) = 2.05, p = .15$. There was a significant moderate negative correlation between both the perceived helpfulness of the disclosure process and confidant reaction and distress at being found out ($r = -.40, p = .02$ $r = -.36, p = .04$ respectively). Together, perceived helpfulness of the disclosure process and confidant reaction explained 17% of the variance in the level of distress at being found out ($R^2 = .17$). Neither the disclosure process ($\beta = -.33, t = 0.93, p = .36$) nor confidant reaction ($\beta = -.09, t = 0.27, p = .79$) contributed significantly to the model.

4.5.4 Disclosure related distress – keeping secret.

A multiple regression analysis was run to predict disclosure related distress – keeping secret from both the helpfulness of the disclosure process and confidant reaction.

The multiple regression model was not a significant predictor of distress associated with being found out, $F(2) = 0.92, p = .41$. There was a non-significant small negative correlation between both the perceived helpfulness of the disclosure process and confidant reaction on distress at keeping secret ($r = -.26, p = .10$ and $r = -.28, p = .09$ respectively). Together, perceived helpfulness of the disclosure process and confidant reaction explained 8% of the variance in the level of distress at being found out ($R^2 = .08$). Neither the disclosure process ($\beta = -.11, t = -0.30, p = .76$) or confidant reaction ($\beta = -.19, t = -0.51, p = .61$) contributed significantly to the model.

As such, the hypothesis that disclosure experiences, specifically the perceived helpfulness of the disclosure process and confidant reaction, would predict disclosure outcomes, specifically stigma stress, disclosure related distress (keeping secret and finding out) and stress associated with secrecy was not supported.

Table 7

Multiple regression analysis exploring the effect of disclosure experience on disclosure outcomes

	B	SE B	B	95% CI for SE B	
				Lower	Upper
Stress associated with secrecy					
Constant	1.64	0.56			
Helpfulness of disclosure process	0.99	1.33	.28	-1.77	3.77*
Helpfulness of confidant reaction	-0.36	1.24	-.11	-2.96	2.24*
Stigma stress					
Constant	14.32	10.92			
Helpfulness of disclosure process	-17.63	25.72	-.26	-71.42	35.90*
Helpfulness of confidant reaction	5.96	24.14	.09	-44.39	56.31*
Disclosure related distress – finding out					
Constant	97.74	20.95			
Helpfulness of disclosure process	-46.04	49.33	-.33	-148.94	56.86*
Helpfulness of confidant reaction	-12.49	46.28	-.09	-109.05	84.06*
Disclosure related distress – keeping secret					
Constant	84.49	24.37			
Helpfulness of disclosure process	-17.20	57.37	-.11	-136.89	102.48*
Helpfulness of confidant reaction	-27.70	53.84	-.19	-140.01	84.60*

Note:

* Confidence limits cross zero

5. Discussion

The aim of this research was to understand the disclosure experiences of participants in the HOP-MHP pilot study through an application of the theoretical framework set out in the DPM (Chaudoir et al., 2010). This was thought to be an important component of the pilot study as there has been little theorising regarding how mental health professionals with lived experience make decisions about disclosure and how these decisions may affect the outcomes of disclosure and wellbeing.

Based on the DPM framework, using the baseline data for all 60 participants taking part in the study, this study examined whether the nature of participants'

antecedent goals (approach or avoidance) predicted a disclosure event, the perceived helpfulness of the disclosure event (process and confidant reaction), and disclosure outcomes (stigma stress, stress associated with secrecy and disclosure related distress – keeping secret and finding out) and finally whether the perceived helpfulness of the disclosure event (process and confidant reaction) predicted disclosure outcomes (stigma stress, stress associated with secrecy and disclosure related distress – keeping secret and finding out). Overall, the results from these investigations were not significant, suggesting that the proposed model did not help to explain participants' disclosure experiences and outcomes. However, the nature of antecedent goals were found to predict stress associated with secrecy with avoidance goals being associated with higher levels of secrecy stress. These findings are explored in more detail below followed by a discussion of study limitations, conclusions and suggestions for future research.

5.1 Relationship between antecedent goals and disclosure

As theorised in the DPM, participants' antecedent goals are hypothesised to predict the likelihood of a disclosure event occurring. The present results did not indicate that participants' antecedent goals predict the likelihood of a disclosure event. Overall, participants rated avoidance goals more highly than approach goals suggesting that reasons for concealment outweighed reasons for disclosure when it came to disclosure decision-making. However, it is important to consider that this outcome is likely to be influenced by the fact that the study was recruiting participants who had not disclosed at all or only selectively, indeed the majority of participants reported very limited past disclosure. Fear of potential negative professional consequences of disclosure was rated most highly as a reason for concealment, whereas concerns about personal safety were rated as least important.

This is in line with previous studies which found a range of fears about the perceived negative consequences of workplace disclosure including discrimination, limited job opportunities, limited career progression, loss of credibility, and gossip and judgement by colleagues (Brohan et al., 2012; Cohen et al., 2016; Tay et al., 2018; Zerubavel et al., 2012).

Educating others regarding mental health was the most frequently cited reason for past and future disclosure, similar to previous studies which have suggested that many persons with lived experience believe that they have a duty to educate others and act as role models (Brohan et al., 2012). For mental health professionals, having an in-depth knowledge of mental health and acting as advocates against stigma in relation to service users may shape these responses, as found by Grice (2018) and Tay (2018) in their recent respective studies of disclosure amongst trainee and qualified clinical psychologists. Participants were least in agreement with statements regarding the purpose of disclosure as to gain acceptance or broaden social networks. This is in line with recent studies which found that motivations for disclosure centred on support seeking, to secure workplace accommodations, to increase awareness of the effect of mental health problems on work performance, and the extent to which problems were concealable, with people more likely to conceal if problems were not easily detectable (Boyd, Zeiss, Reddy, & Skinner, 2016; Grice et al., 2018; Tay et al., 2018).

5.2 Relationship between goals and the nature of the disclosure event

The DPM theorises that antecedent goals shape the content and style of a disclosure event, and therefore how such events will be experienced and perceived by the discloser. It was hypothesised that approach goals would predict the perceived helpfulness of the disclosure process and confidant reaction more than avoidance

goals would amongst participants who reported any past disclosure. The results indicate that the nature of participant goals did not predict the perceived helpfulness of the disclosure event. There was no difference on average in how helpful participants scored the process and confidant reaction. Participants rated disclosure to close friends as most helpful for both categories and disclosure in a professional context as least helpful, specifically to line managers and clinical supervisors, as echoed in existing research (Cohen et al., 2016; Grice et al., 2018; Huet et al., 2016; Tay et al., 2018). This analysis may have been limited by the fact that the outcome measures used for the study did not gather detail on the nature of disclosure events, specifically details of the breadth, depth and content of disclosure, which the DPM theorises would affect the nature and experience of a disclosure event. Furthermore, the majority of participants reported limited disclosure experiences, favouring concealment, which limited the sample size in the analyses and may have also skewed responses to questions about the helpfulness of the disclosure process.

5.3 Relationship between antecedent goals and outcomes

The DPM theorises that antecedent goals predict the outcome of the disclosure event, specifically that the nature of the goal (approach or avoidance) moderates the magnitude of the effect of disclosure on outcomes, and consequently discloser wellbeing. For the purpose of this study, disclosure outcomes were assessed using measures of stigma stress, disclosure related distress (finding out and keeping secret), and stress associated with secrecy. Against predictions, antecedent goals were not found to predict stigma stress and disclosure related distress. Approach goals were not found to predict stress associated with secrecy, however avoidance goals were.

Overall, when it came to secrecy, participants rated openness as more important than secrecy when asked how they would advise others. However, when it came to their own mental health problems this was not the case and nearly all participants indicated that they were concerned about keeping their problems secret. Avoidance goals were found to predict higher levels of stress associated with secrecy compared to approach goals and the model accounted for a moderate amount of variance in stress associated with secrecy. This finding echoes evidence on the negative effects of secrecy on wellbeing (Corrigan et al., 2010; Pachankis, 2007; Rüsçh et al., 2014a; Rüsçh et al., 2009a; Rüsçh et al., 2009b).

Against predictions, antecedent goals were not found to predict stigma stress. However, there was a weak negative correlation between avoidance goals and stigma stress, and avoidance goals were found to contribute to the model suggesting that as avoidance goals increase so too does stigma stress. Further exploration suggests that participants rated their perceived resourcefulness to cope with stigma higher than stigma's perceived harmfulness. However, while they did not believe that stigma would have a significant impact on their life generally, they were concerned that stigma might negatively affect their career and professional reputation.

Furthermore, while participants displayed a strong commitment to tackling prejudice and stigma including at work, they rated themselves as uncertain that they had the resources available to manage this. This concern may be affected by various factors. Just over half of the participants were trainees, and may thus be uncertain about the resources available to them or the perceived appropriateness, given their trainee status, of tackling issues of stigma and prejudice in a professional setting. Equally, those respondents who were qualified may have come from varied work

settings with differing experiences regarding their ability to tackle stigma and prejudice, which may also be influenced by their length of time qualified.

Goals were similarly found not to predict disclosure related distress – specifically the level of distress at being found out or keeping mental health problems secret. Across both of these categories, participants rated distress highest in relation to secrecy/being found out in professional settings, with the greatest concern expressed in relation to clients followed by line managers, and lowest in relation to friends who most participants had already disclosed to. Nearly all participants had disclosed to health care professionals, and the vast majority had received a mental health diagnosis, suggesting that participants were able to seek help from health care professionals outside of work.

These findings reflect existing research which evidences concerns amongst mental health professionals about the potential negative consequences of disclosure in professional settings (see Brohan et al., 2012; Cohen et al., 2016; Edwards & Crisp, 2017; Huet et al., 2016; Sawyer, 2011; Zerubavel et al., 2012). However, the high level of help-seeking suggests that participants perhaps took a more pragmatic approach, able to moderate fears about stigma in order to seek help where necessary, and disclosing in contexts deemed supportive and appropriate.

These findings may also mirror recent studies which suggest that mental health professionals may not internalise stigma as extensively as the general population due to their training and professional roles, and thus may be able to balance fear of perceived stigma with a sense of professional responsibility and duties and an assessment of their fitness to practise (Tay et al., 2018).

5.4 Relationship between disclosure event and outcomes

Finally, the study explored whether the perceived helpfulness of the disclosure event (process and confidant reaction) predicted disclosure outcomes, specifically that higher ratings of helpfulness would predict lower levels of disclosure related distress (finding out and keeping secret), stigma stress and stress associated with secrecy. The helpfulness of the disclosure event was not found to predict any of the outcomes of disclosure and the findings for participant ratings of stress associated with secrecy, stigma stress and disclosure related distress mirror those described above.

5.5 Study limitations

There were a number of significant issues relating to the design and running of the study, and in the application of the DPM, which limit the study's findings and generalisability. Although the study was designed to maximise participation and reduce selection bias, the use of convenience sampling for recruitment while necessary to aid recruitment opened the study to selection bias which may have limited the representativeness and generalisability of the findings. This is reflected in the fact that by far the dominant professions represented in the sample were clinical psychologists, and thus the sample is not representative of a cross-section of UK mental health professionals. Similarly, participants were predominantly female and white, which while representative of clinical psychology in the UK (BPS, 2004; Scior, Gray, Halsey, & Roth, 2007) is not representative of mental health professionals more broadly. Although the study, by design, was selectively recruiting professionals who had limited previous disclosure experience and past or current mental health problems, self-selection bias may also have skewed the results

particularly if participants signed up due to their prior disclosure experiences or a sense of investment in the questions being addressed.

Finally, in light of the aforementioned research on institutional stigma (Peterson, 2017; Sawyer, 2011; von Peter et al., 2018; Zerubavel et al., 2012), it may also have been the case that mental health professionals may have been reluctant to come forward to take part in the study, even where confidentiality and anonymity were assured. Reluctance to take part in a study of this nature may have also been prompted by pressures and workplace burdens UK health workers feel themselves to be under (Health Education England, 2019).

The sample size and drop-out rate of the HOP-MHP pilot placed further significant limitations on the present study. The original aim of the study was to assess whether the DPM could explain changes in disclosure decision-making over time – at baseline and following completion of the HOP-MHP intervention – specifically whether the intervention led to a change in participant antecedent goals, subsequently shaping post intervention disclosure events and outcomes. However, the high drop-out rate meant that there were not sufficient participants moving through from baseline to the second and third time points to allow for this analysis. As such, it was only possible to explore baseline data and participants' prior disclosure experiences and replication in a larger study is needed.

Finally, this study was not able to measure all aspects of the DPM, specifically factors which may moderate the strength of outcomes or the feedback loop, and was also not able to evaluate discrete disclosure events in detail which weakened the analysis. This was in part due to the survey design taking place prior to this researcher joining the project, and there was limited capacity to further amend the surveys. The nature of the DPM itself also produced challenges for analysis as it

is a circular model where goals are influenced by outcomes via a feedback loop. Previous applications of the model have involved the evaluation of existing studies via a literature review for components of the DPM and in relation to HIV (Chaudoir et al., 2011), and no quantitative analysis with an empirical study has been attempted thus far.

5.6 Conclusions

This is the first study to apply the DPM to a sample of mental health professionals in an effort to understand when and why disclosure may be beneficial for them. It is also the first study to attempt to statistically explore the relationships between some of the key components of the DPM. Aforementioned findings regarding the mental health of mental health professionals, stigma and concealment suggests that such research is timely. Prior application of the DPM has found it helpful in elucidating when and why disclosure may be helpful in relation to people living with HIV. The application of this theoretical framework to further understand when and why disclosure may be helpful in relation to the mental health of mental health professionals could therefore prove important in reducing the negative outcomes associated with mental health stigma and concealment. Given the small sample size in the present study, this exploratory analysis has limited application. As such, further research with a larger sample would be valuable for assessing whether the model can accurately account for disclosure experiences.

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Part 3: Critical Appraisal

1. Overview

This paper forms a reflection on the project and focuses on three key areas. A reflection on the author's personal beliefs and values regarding disclosure, stigma and discrimination, alongside prior research experience and expectations, and how these have influenced the research process. This will be followed by a critique of key methodological issues, focusing on recruitment and the implications of recruitment problems for the study, and the use of outcome measures, locating these issues in the broader social context within which the research took place. The final section will summarise the key implications arising from this study and suggestions for future research.

2. Personal reflections on the research process

2.1 Researcher stance

As a mature student, I was drawn to involvement in *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) and attended an early stakeholder consultation meeting before being accepted as a researcher on the project. My interest was driven by my lived experience, reflecting my own struggle to recovery. It also reflected my involvement in social and political equality and liberation movements, including in the struggle against apartheid in South Africa as a student in the late 1980s early 1990s, my work on the South African constitution, and my involvement in the South African lesbian, gay, bisexual and transgender (LGBT) rights movement.

I brought my personal history to my work on this project, although my own views on the subject of disclosure have changed over the course of the work. I initially took the stance that disclosure of a concealable stigmatised identity was always beneficial for individuals in terms of alleviating the psychological distress

associated with concealment, allowing relief from secrecy, and thus improving mental health and overall wellbeing and quality of life (see for example, Pachankis, 2007). I also believed that disclosure served an important function of making visible concealable stigmatised identities, and that increased visibility can challenge social attitudes, reducing stigma and discrimination. I practised this in my own life, choosing to live openly as a lesbian at a time when homosexuality was still illegal in South Africa, openly campaigning for equal rights and against discrimination. I also chose over the decades which followed to begin to speak more openly about my own mental health problems, and the impact of my childhood on my mental health, and my fears of stigmatisation and discrimination.

My views were partly influenced by the relief brought by my own disclosure, reducing the anxiety I carried in relation to concealment and reducing my own shame and self-stigma. My attitude to disclosure was also significantly influenced by the socio-political environment in South Africa, where disclosure was being actively encouraged on a national scale. The Truth and Reconciliation Commission of South Africa (TRC) had been established to receive evidence about atrocities committed under the apartheid regime, taking testimony in hearings from both victims and perpetrators. The ethos of the TRC was for all voices to be heard, and central to this was the belief that through disclosure national wounds could be healed, bringing peace and reconciliation to a deeply divided nation (Vora & Vora, 2017).

Commenting on the importance of the TRC, the then Archbishop of South Africa, Desmond Tutu, wrote:

Since that day, our nation has sought in various ways to rehabilitate and affirm the dignity and personhood of those who for so long have been

silenced, have been turned into anonymous, marginalised ones (Tutu, 1999, p. 58).

There was another important aspect to disclosure running through this process which began to influence my thinking. During this time I happened to meet Dr Wendy Orr, a medical doctor who was the first and only doctor under the apartheid regime to speak up publically about the evidence of state torture she witnessed as a then district surgeon (Orr, 2015). She spoke of the professional responsibility she felt to break the silence regarding torture, and the implications for her of doing so, and she later went on to become a commissioner for the TRC. This brought into my mind an awareness of the dual role of professionals, as witnesses and participants, bringing our own positions and experiences to our work, breaking down in my mind the idea that professionals are somehow separated from the rest of society.

During this time I was privileged to be employed to work on the new South African constitution and subsequently as a parliamentary researcher. Part of my role was organising stakeholder testimony on a range of subjects, including sexual violence and child abuse, and my weekly experience was of brave people from all backgrounds coming forward to speak openly about their experiences. These experiences, in a climate of disclosure and a discourse of ‘national healing’, profoundly influenced my own attitude to disclosure and still do today.

Taking my experiences into consideration, what further attracted me to HOP-MHP was the writing of Corrigan and colleagues who applied the principles of the LGBT ‘coming out’ movement to mental health. They argued that, aside from the individual benefits of disclosure, being out about mental health problems can help to tackle stigma and discrimination in a broader social context, indeed the original

Honest, Open, Proud (HOP) intervention was called *Coming Out Proud* (Corrigan, Kosyluk, & Rüsck, 2013).

Interestingly, the original HOP programme evolved from taking a ‘coming out’ position to one advocating the benefits of considering the pros and cons of disclosure, and coming to terms with mental health problems, whether or not disclosure behaviour changed. Evaluations of HOP indicate that the benefits from the programme arise from a reduction in stigma stress – how an individual appraises the harmfulness of stigma and their perceived resources to cope with stigma-related harm (Mulfinger et al., 2018).

This subtle shift away from full to selective disclosure (Bos, Kanner, Muris, Janssen, & Mayer, 2009), and the benefits of thinking about disclosure and mental health, whether or not disclosure occurs, mirrors changes in my own views on disclosure over the course of the project, throughout my training and in the context of my own personal therapy. Reading the literature from HOP and the Disclosure Process Model (DPM; Chaudoir & Fisher, 2010), I began to consider my own motivations for disclosure, considering what I wanted from disclosure and the best way to achieve this. The idea of selective disclosure reflected two important interconnected processes. Firstly, allowing myself to be more in touch with my reasons for disclosure, for example, as a defence against fear of failure rather than something which might be personally helpful in a particular context. Secondly, I became aware of increasing pressure within my clinical placements to not acknowledge the mental health problems of professionals, despite huge advances in campaigns to tackle stigma. This was particularly evident when working with peer support workers who described feeling like outsiders within mental health services, caught in-between the world of the patient and the world of the mental health

professional. I expound on institutional culture further in section 3.3. Thus, while I actively chose to consider disclosure in a reflective way rather than simply something I must do at all times, I still believe that within professional settings, particularly in conversations with colleagues, professionals with lived experience can actively challenge stigma by speaking openly about their experiences, and can act as role models particularly to trainees, helping to de-stigmatise mental health problems. This is reflected in my decision to speak openly regarding my own difficulties in this paper. However, I continue to believe that it is important for others to consider the potential benefits and harms of disclosure, making thought out and informed decisions in each instance.

2.2 Development of the study

My initial aim in getting involved in this research project was to conduct qualitative interviews with participants who had completed HOP-MHP to better understand their experiences of disclosure. However, due to numerous issues including working with a second researcher and needing to divide the research tasks, I agreed to take on a different piece of research involving quantitative analysis. This was a difficult process as I was less familiar with quantitative methods, and had never conducted or written a paper involving regression analysis. I was initially concerned that I would be unable to complete this work, a fear that remained with me throughout the project. It became clear very early on that my thesis supervisors were going to be an essential source of support and guidance during this process. Indeed, Bird speaks to the significant role that thesis supervisors play in the development of both the research and the researcher (Bird, 2001). I experienced this in numerous ways. Both individual and joint research meetings proved invaluable in the design, implementation and writing up of this work, helping to build an openness

to empirical enquiry while nurturing the development of my own confidence to step up and lead in my own research area. The guidance covered an array of issues, from awareness and management of institutional requirements to seeking out collaborations and additional support, for example, for specific statistical analysis questions, alongside guidance on reading, writing and analysis. Most importantly I felt, my supervisors were able to pay attention to my wellbeing throughout this process, a difficult time during which I was managing significant personal losses.

3. Critique of the research process

3.1 Recruitment and data analysis

There were significant difficulties with recruitment across both phases of the project. This affected the representativeness of the sample, and consequently its generalisability, and the subsequent data analysis for this study.

The original target population for the study was clinical psychologists (qualified and in training). The British Psychological Society's Division of Clinical Psychology (BPS DCP) had agreed to disseminate the study to all of their members, and the DCP had agreed to fund the project. However, difficulties with finalising the contract meant that neither dissemination nor funding went ahead. As recruitment during phase one was slower than anticipated, the target population was expanded to include other mental health professionals. This occurred prior to my involvement in the research. As the study had planned recruitment via the BPS and not the NHS and as such had not secured NHS ethical approval, it was also not possible to disseminate the study to NHS networks. As such, recruitment proved challenging.

Recruitment drives attempted to expand the sample, however with limited success; by far the overwhelming majority of participants were clinical psychologists and therefore not representative of UK mental health professionals. Furthermore,

participants were predominantly white and female. While representative of the socio-demographic profile of clinical psychology (BPS, 2004; Scior, Gray, Halsey, & Roth, 2007), this raises questions of whether the study failed to reach professionals from Black, Asian and Minority Ethnic (BAME) backgrounds. Future research may want to take an intersectional approach (Kelly, 2009; Yuval-Davis, 2006), considering the interrelationship of social divisions (such as class, race, ethnicity and gender) and whether these influence whether people from BAME and other minority backgrounds might participate in similar research, and how this could be approached in relation to recruitment.

Difficulties with recruitment had a further significant impact on data collection and subsequently analysis. The initial aim of this study was to apply the DPM to data gathered at all three time points of the HOP-MHP intervention. The plan was to use structural equation modelling to assess whether participants' antecedent goals, disclosure behaviour and disclosure outcomes changed from baseline, through the course of the intervention and following completion. This was not possible due to the low numbers of participants joining and completing all time points of the study, and as such a less ambitious project was constructed to assess whether the DPM could further understanding of participants' prior disclosure experiences using baseline data only. Given the aforementioned concerns regarding the representativeness of the sample, I considered only analysing the data for clinical psychologists. However, this would have further weakened my analysis by reducing the sample size, and as such I treated this as an exploratory study with full awareness of the limitations this imposed on any findings.

It is difficult to ascertain whether a larger sample, with data completed at all time points, would have changed the outcomes of this study. However, given the

importance of this research in furthering our understanding of when and why disclosure of mental health problems may be beneficial for mental health professionals, it would be important to consider an application of the DPM with a larger and more representative sample.

3.2 Outcome measures

In order to ensure consistency in the evaluation of the HOP-MHP trial, the outcome measures used were based on those used in the original HOP intervention (Rüsch et al., 2014). Although attempts were made to reflect the core aspects of the DPM in these measures through the addition of certain questions, my ability to amend or add measures was limited. This was particularly important as stakeholder consultation had already occurred and the study piloted. As such, it was not possible to measure all aspects of the DPM, specifically moderating factors. It was noted in the evaluation of HOP-MHP (Hildebrand, 2018) that some participants would have welcomed the opportunity to explain some of their responses in more detail, rather than be limited to responses on Likert scales. The use of qualitative methods may therefore be an important consideration for future studies wishing to capture the detailed aspects of the DPM, for example in understanding why participants rate the process of disclosure as they do. This could include both space for participants to elucidate survey responses, and qualitative interviews to further understand participants' disclosure experiences.

3.3 Locating HOP-MHP and the DPM in social and institutional contexts

Aforementioned questions relating to recruitment, diversity and representativeness reflect broader issues of institutional culture and social context. These issues were evident in the literature review in Part One of this thesis, and speak to some of the wider limitations of HOP-MHP and the DPM.

Despite the advances of recent anti-stigma campaigns and interventions to tackle mental health stigma and discrimination (see Gronholm, Henderson, Deb, & Thornicroft, 2017; Henderson et al., 2012), disclosure of mental health problems, particularly in professional or workplace settings, remains complex for individuals who fear multiple negative consequences (Brohan et al., 2012). So too with mental health professionals, as highlighted in both the Conceptual Introduction and Empirical Paper, who fear that disclosure might negatively influence career progression, relationships with colleagues, and their professional standing (see for example, Cohen, Winstanley, & Greene, 2016; Huet & Holttum, 2016; Sawyer, 2011; Tay, Alcock, & Scior, 2018). While literature on the ‘wounded healer’ – professionals with lived experience (Zerubavel & Wright, 2012) – is growing, it remains contentious, with many professionals feeling that disclosure leaves them vulnerable to discrimination. Furthermore, many of these professionals struggle to acknowledge their own vulnerability within their professions (Zerubavel et al., 2012). Indeed, many of the articles included in the literature review spoke to the presence of an institutional culture within health services which reflects the dominant discourses in society that professionals working in these services must themselves be well. This serves to silence professionals who may wish to speak out, which can heighten self-stigma and discourage help-seeking, leading to poorer mental health outcomes (Pachankis, 2007; Quinn & Chaudoir, 2009).

Furthermore, the disclosure-concealment dilemma faced by mental health professionals reflects the dominant social view that mental health is an individual issue, separated from broader contexts and social factors, such as poverty and discrimination (Tribe & Bell, 2018). This creates numerous difficulties when considering the design and implementation of an intervention like HOP-MHP and

indeed the application of the DPM. The stakeholder consultation phase of the project elicited strong feedback that a group intervention, as with the original HOP programme, would not be feasible. This reflected the fear mental health professionals have about disclosure (Hildebrand, 2018; Mills, 2018). As such, HOP-MHP was devised as an individual guided self-help intervention with a peer forum, to provide an aspect of group support which was seen as valuable by those who participated in it (Hildebrand, 2018; Mills 2018). However, this reduced HOP-MHP to a largely individual level intervention, and as such some of the benefits of group engagement in this context were lost, namely the normalisation of mental health difficulties, reducing self-stigma and the burden of concealment (Corrigan & Matthews, 2003).

Similarly, the DPM is very much a framework for understanding a unique individual disclosure process. Although each disclosure event is nested within previous disclosure events, and the framework does consider mediating factors, there is no consideration of broader socio-demographic and cultural factors, such as ethnicity, religion, class, age and so on, and how these intersect and might influence the disclosure decision making process. These remain important considerations for disclosure research. It may too be helpful for future studies to consider the broader institutional pressures brought to bear on mental health professionals, for example, through cost-cutting, and how this intersects with mental health and wellbeing.

4. Conclusions

This study has attempted to further understanding of the factors influencing disclosure and disclosure processes amongst mental health professionals with lived experience. This was the first study to apply the DPM to a sample of mental health professionals in an effort to understand when and why disclosure may be beneficial.

It has highlighted numerous issues affecting disclosure, including feared negative consequences of disclosure and the role of institutional culture and social discourses in disclosure, and how together these might influence disclosure decision-making. Although the findings were limited, and the study exploratory given the sample size, it is hoped that the appraisal of the study would assist future researchers in designing and exploring further disclosure decision-making amongst mental health professionals. This could prove important in reducing the negative outcomes associated with mental health stigma and concealment.

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Appendix 1: Trainee contribution to project

Trainee contribution to project

This was a joint project with another trainee clinical psychologist at University College London (UCL). We worked jointly on the second phase of the HOP-MHP trial, specifically a second recruitment drive and the ongoing running and completion of the trial. This followed phase one of the trial which was run by two previous trainee clinical psychologists at UCL who established and started the trial. For the second phase, tasks were divided between the two researchers. I was responsible for initial contact with participants – responding to email queries from potential participants, receiving consent and screening forms and checking eligibility, randomly allocating participants to a study arm, disseminating the baseline survey and allocating participants their unique identifiers. I also generated the surveys for distribution to each participant as they progressed through the trial. My colleague was responsible for remaining in contact with participants as they progressed through the study, distributing surveys at time one and two, sending follow up emails and setting up, conducting and analysing the qualitative telephone interviews. We also divided various tasks, for example, taking on different aspects of recruitment and study dissemination. Data for both projects was collected from the same participants. Both researchers attended joint research meetings together with our supervisors, Dr Katrina Scior and Dr Henry Clements, and as such contributed to each other's work through discussions. However, separate research questions were assigned and the analysis of outcome data was allocated accordingly. The analysis and write up was also done completely independently.

Appendix 2: HOP-MHP self-help guide

HONEST, OPEN, PROUD

To Eliminate the Stigma of Mental Health Problems

A Self-Help Guide for Mental Health Professionals



**Katrina Scior, Henry Clements, Anna Hildebrand,
Harriet Mills, and Patrick W. Corrigan**

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<https://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop-docs>

For more information about the original Honest, Open, Proud programme visit:

www.hopprogram.org

All illustrations by Ashley Boscoe: ashley.boscoe.15@ucl.ac.uk

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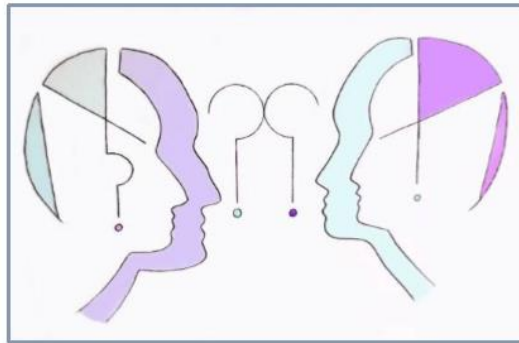
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HONEST, OPEN, PROUD

To Eliminate the Stigma of Mental Health Problems

A Self-Help Guide for Mental Health Professionals


FOLLOW-UP



**Katrina Scior, Henry Clements, Anna Hildebrand,
Harriet Mills, and Patrick W. Corrigan**

ILLINOIS INSTITUTE
OF TECHNOLOGY 

 The British
Psychological Society
Promoting excellence in psychology

 Division of
Clinical Psychology

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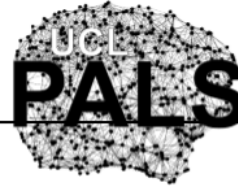
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Appendix 3: Consent form and brief screening measure



INFORMED CONSENT FORM FOR PARTICIPANTS IN THE PILOT RCT OF THE HOP-MHP SELF-HELP GUIDE (PHASE 2)

This consent form is in line with new data protection requirements in place from May 2018 – please forgive the level of detail required under the new regulation.

Please complete this form and the screening questions after you have read the Information Sheet about the research (available to download at <http://www.ucl.ac.uk/pals/research/cehp/stigma-research/research>).

Title of Study:

Supporting disclosure related decisions among clinical psychologists experiencing mental health problems: a feasibility and pilot study.

Department:

Research Department of Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher(s):

Julie Evans, Trainee Clinical Psychologist and Vivienne Smith, Trainee Clinical Psychologist
Research Department of Clinical & Health Psychology, UCL, Gower Street, London, WC1E 6BT.

Name and Contact Details of the Principal Researcher:

Katrina Scior, Research Department of Clinical & Health Psychology, UCL, Gower Street, London, WC1E 6BT.

Name and Contact Details of the UCL Data Protection Officer:

Lee Shailer, data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee [Project ID: 9297/002]

Thank you for your interest in taking part in this research study. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you to decide whether to join in. Please retain a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	<p>*I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction</p> <p><i>[and would like to take part in (please tick one or more of the following)</i></p> <ul style="list-style-type: none"> - <i>the pilot randomized controlled trial of HOP-MHP</i> - <i>an individual interview at the three month follow-up time point (if randomized to the intervention arm)]</i> 	
2.	*I understand that I will be able to withdraw my data up to 4 weeks after completing my participation	
3.	*I consent to the processing of my personal information (i.e. demographic information and questionnaire responses) for the purposes explained to me. I understand that such information will be handled in accordance with all applicable data protection legislation.	
4.	<p>Use of the information for this project only</p> <p>*I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified.</p> <p>I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications.</p>	
5.	*I understand that my information may be subject to review by responsible individuals from the University.	
6.	<p>*I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.</p> <p>I understand that if I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise.</p>	
7.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
8.	I understand the direct/indirect benefits of participating.	
9.	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	
10.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
11.	I agree that my anonymised research data may be used by others for future research. No one will be able to identify you when this data is shared.	
12.	I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No	
13.	If participating in interviews: I consent to my interview being audio recorded and understand that the recordings will be destroyed immediately following transcription.	
14.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
15.	<p>I hereby confirm that:</p> <p>(a) I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and</p>	

	(b) I do not fall under the exclusion criteria.	
16.	I have informed the researcher of any other research in which I am currently involved or have been involved in during the past 12 months.	
17.	I am aware of who I should contact if I wish to lodge a complaint.	
18.	I voluntarily agree to take part in this study.	
19.	Use of information for this project and beyond I would be happy for the data I provide to be archived at UCL in accordance with data protection laws. I understand that other authenticated researchers will have access to my anonymized data.	
20.	I understand that it is my choice whether to use a personal email address or to set up a new Gmail address for the purpose of the study to help protect my confidentiality. The email address I would like to be used for the purpose of this research is: _____ (please print very clearly)	

_____ _____ _____
 Name of participant Date Signature

Please ensure you also complete the screening questions on the next page.

HOP-MHP Screening Questions

Please answer all four questions below to ensure that you meet the inclusion criteria for the HOP-MHP study. For each item please place a tick under yes or no.

1. Are you a mental health professional (whether qualified or in training)?

Yes No

2. Do you think of yourself as experiencing a mental health problem that has affected your functioning in some way either at present, or have you experienced such problems in the past?

Yes No

3. Are you fully 'out' about your experiences of mental health problems, that is have you widely disclosed these (so that there is little place for thinking about future disclosure)?

Yes No

4. Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

Please select one of the following options:

- 0 – Not at all
 1 – Several days
 2 – More than half the days
 3 – Nearly every day

If you have selected 3 (nearly every day) on item 4, we advise that you should seek urgent support, either through NHS services or through crisis services – you can find more information about accessing support on our web page:

http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp At the present time, we think this needs to be a priority and that engaging with this study is not in your best interests.

If you have answered 'no' to items 1 and 2, or 'yes' to item 3, you do not meet the inclusion criteria for this study.

Thank you for your interest in our research study.

Appendix 4: Study information sheet



Participant Information Sheet for pilot RCT of the HOP-MHP Self-Help Guide
This study has been approved by the UCL Research Ethics Committee [Project ID: 9297/002]

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study:

Supporting disclosure related decisions among clinical psychologists experiencing mental health problems: a feasibility and pilot study.

Department:

Research Department of Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher(s):

Julie Evans and Vivienne Smith, Clinical & Health Psychology, UCL, Gower Street, London, WC1E 6BT.

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1. Introduction

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss with others if you wish. Please contact us if there is anything that is not clear or if you would like more information.

We are currently recruiting participants to take part in a pilot RCT of the new HOP-MHP self-help guide. The project is carried out by a team at UCL involving, in addition to the two project leads, research staff as well as trainee clinical psychologists.

This study will test the delivery and impact of a new self-help intervention (HOP-MHP, short for *Honest Open Proud for Mental Health Professionals*) designed to support mental health professionals (including those in training) in reaching decisions relating to the disclosure of mental health problems they may be experiencing or may have experienced in the past. If you personally have lived experience of mental health problems and you are not currently completely 'out' about this in both your social and work circles, you may find this intervention helpful.

Using the self-help guide will help you personally consider whether, where and how you may want to disclose your own lived experience. For the duration of the study, you will also have access to an anonymous peer forum where you can discuss your experiences and thoughts regarding disclosure with other mental health professionals with lived experience.

2. What is the project's purpose?

The aim of the HOP-MHP project is to test the feasibility, acceptability and effectiveness of a self-help intervention to support mental health professionals (qualified and still in training) in reaching decisions relating to the disclosure of mental health problems they may be experiencing or may have experienced in the past. The aims of the intervention are to reduce stigma stress, disclosure-related distress and empower participants in deciding for themselves if and how they want to talk about their lived experience. Through access to a peer forum we are also looking to provide opportunities for support from colleagues with lived experience. HOP-MHP is based on a manualised group intervention called Honest, Open, Proud (HOP), which was developed by Professor Patrick Corrigan and colleagues at the Illinois Institute of Technology, as part of the US National Consortium on Stigma and Empowerment.

The project follows on from research that shows that significant proportions of mental health professionals have lived experience but that many are reluctant to disclose their experience, particularly in a work and professional context, due to fears about negative consequences and a perceived lack of appropriate support.

3. Why have I been chosen?

Anyone interested in participating in this project must meet *all* of the following criteria:

- (1) They are a qualified or trainee mental health professional and a UK national or resident;
- (2) They have current or past lived experience of mental health problems;
- (3) They would like an opportunity to consider whether or not they would like to be (more) open about their lived experience in social and/or work settings. The intervention is designed for anyone who up to this point has chosen either to keep their lived experience private in all or some settings and relationships and who would welcome an opportunity to consider in depth whether to disclose their lived experience more widely or in different contexts. As such it is not suitable for anyone who is already entirely open about their lived experience in their social *and* professional circles.

4. Do I have to take part?

Participation is entirely voluntary and choosing not to take part will not disadvantage you in any way. If you do decide to take part please keep a copy of this information sheet. You will be asked to sign a consent form. You can withdraw at any time without giving a reason. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up until that point.

5. What will happen to me if I take part?

If you decide to take part in this pilot RCT, please return the completed consent form and screening questionnaire to the research team. If you meet the project's inclusion criteria you will then be asked to complete a number of outcome measures through a web survey – these relate to mental health stigma, disclosure, past and present mental health problems you may have experienced, and demographics. The survey will take approximately 15 to 20 minutes to complete. Once you have completed the survey and it has been confirmed that you meet the inclusion criteria, you will be informed whether you have been randomly allocated to the intervention or control arm. You will have a 50:50 chance of being allocated to either the intervention or the control/delayed intervention arm.

If you are assigned to the intervention arm, you will be sent the HOP-MHP self-help guide. This consists of three sessions and some follow-up activities. You will be asked to complete the three sessions and follow-up at a time and place of your convenience - each session is expected to take approximately 1 to 1.5 hours to complete. You will be asked to complete the initial three sessions within around 3 weeks, i.e. one session per week. We will send you reminders and will be available throughout to respond to any queries you may have. You will also have access to information relevant to mental health professionals with lived experience including resources providing support and advice.

After completing the three sessions you will be asked to complete the survey again. We will then send you the follow up session of the HOP-MHP guide one month later. After completing the follow up session, you will be asked to complete the survey one final time. Three months after receiving the follow-up session, you will be invited to take part in a one-to-one semi-structured interview about your experiences since using the HOP-MHP self-help guide and whether you have disclosed or not disclosed since. These interviews will take place over the telephone or skype. You can choose whether or not to participate in the interview after completing the intervention.

While you are using the HOP-MHP guide you will also have the opportunity to use an anonymous online peer forum for the duration of the study. Our choice of an anonymous web based peer support forum is based as much on our belief in the value of peer support as it is on evidence on the benefits of peer support.

If you are assigned to the control arm, you will have access to information that is relevant to mental health professionals with lived experience including information about resources providing support and advice. You will also be asked to complete the second survey six weeks after completing the baseline survey and the final survey six weeks after this. Once you have completed all three surveys you will be sent the HOP-MHP self-help guide and will also be given access to the anonymised online peer forum at that point.

6. Will I be recorded and how will the recorded media be used?

If you agree to take part in an interview as part of the intervention arm of the study, this interview will be audio recorded and transcribed in order to be analysed. These audio recordings will be used only for analysis and will be destroyed once transcribed. Transcribed interviews will be anonymised and you will not be identifiable from them. No other use will be made of the recordings and no one outside the project will be allowed access to the recordings.

7. What are the possible disadvantages and risks of taking part?

It is possible that reflecting on your mental health problems and thinking about disclosure may cause you some distress. If you do experience distress and would like support, then please contact us and we will be happy to speak with you on a confidential basis.

8. What are the possible benefits of taking part?

Whilst there are no explicit benefits for those participating in the project, we anticipate that participating in the project will be helpful in supporting you to make decisions in relation to disclosure or non-disclosure of lived experience. We also anticipate publishing the outcome of the completed study, and we hope that it will have a positive impact on encouraging greater openness to lived experience and in tackling mental health stigma within the mental health professions and beyond.

9. What if something goes wrong?

If you have any concerns or need support in the first instance you should contact the Principal Researcher. However, should you feel your complaint or concern has not been handled to your satisfaction you can contact the Chair of the UCL Research Ethics Committee by emailing ethics@ucl.ac.uk

10. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

The project will be carried out in a way that strictly protects participant confidentiality by storing any personal identifiable data securely in the UCL Data Safe Haven. All project data will be stored according to the Data Protection Act 1998.

The outcome measures will be completed through a web survey using a programme called Qualtrics. You will not be asked to provide any of the completed worksheets that are part of the HOP-MHP self-help guide. Your contributions to the peer forum are anonymous (as long as you sign up using an alias e-mail address and user name) and may be used as data in future research - you can opt out of your data being used in this way by sending an e-mail to hoppoject@ucl.ac.uk. This will not affect your access to or ability to engage with the peer forum in any way.

11. Limits to confidentiality

Please note that confidentiality will be maintained as far as it is possible – if, on the basis of anything you express in an interview or on the HOP peer forum, we feel that you may be at risk we will signpost you towards relevant avenues of support; if we feel that someone might be in danger of harm, we may have to inform relevant agencies of this.

12. What will happen to the results of the research project?

We intend to publish the results of the research in due course. If you would like to be contacted when the results are published please indicate this on the consent form. Individuals will not be identified in any report or publication. The data collection during the course of the project might be used for additional or subsequent research within the department but will remain anonymous and unidentifiable.

13. Data Protection Privacy Notice

Notice:

The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk. UCL's Data Protection Officer is Lee Shailer and he can also be contacted at data-protection@ucl.ac.uk.

Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data will be the provision of your consent. You can provide your consent for the use of your personal data in this project by completing the consent form that has been provided to you.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: <https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/>

14. Who is organising and funding the research?

This research is sponsored by University College London and supported with funding from the British Psychological Society.

15. Contact for further information

If you require any further information about the study please contact:

Dr Katrina Scior and Dr Henry Clements

Research Department of Clinical & Health Psychology, UCL, Gower Street, London, WC1E 6BT.

+44 (0)20 7679 1897

k.scior@ucl.ac.uk henry.clements@ucl.ac.uk

Thank you for reading this information sheet and for considering taking part in this research study.

Please retain a copy of this information sheet and the completed consent form for your information.

Appendix 5: Advertising poster



UCLUS
UCL Unit for Stigma Research

HOP-MHP

HONEST, OPEN, PROUD
FOR MENTAL HEALTH PROFESSIONALS

PILOT STUDY RCT NOW RECRUITING



For more information google 'HOP-MHP' or visit:

<https://www.ucl.ac.uk/pals/hop-mhp-project-0>

Or can scan this QR code with your smartphone to access the website:



UCLUS Research



@Uclusresearch

HOP-MHP is a guided self-help intervention designed to support mental health professionals in reaching decisions around disclosure of their own current or past mental health problems in personally meaningful and empowering ways.

It is a 3-session (plus booster) guided self-help intervention adapted from the original evidence based HOP group programme, plus access to a closed web based peer forum.

HOP-MHP aims to reduce the stress and distress often associated with feeling one needs to keep one's experiences secret, and to encourage more open conversations about lived experience among mental health professionals.

This project is still accepting participants.

Appendix 6: Example email invitation to course directors

Dear [NAME],

We are contacting you about a current study we are conducting, and which may well be helpful to some of your trainees. We are testing a new intervention designed to support mental health professionals, qualified and in training, in reaching decisions around disclosure of their own current or past lived experience of mental health problems in ways that are personally meaningful and empowering. We would be grateful if you could share this invitation with your trainees.

The intervention is called *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) and aims to reduce depression, stigma stress and disclosure related distress. It is a 3-session (plus follow-up) guided self-help intervention adapted from the original evidence-based HOP group programme. This project is informed by evidence that many mental health professionals have lived experience of mental health problems but are fearful of talking to others about their experiences, particularly within a work and training context. This project aims to address this by supporting mental health professionals in reaching balanced decisions around disclosure across different settings. Ultimately the project seeks to tackle the dichotomy of 'us and them' (providers versus users of mental health services) and to encourage more open conversations about lived experience and stigma among mental health professionals.

The project is supported by the British Psychological Society, is a pathfinder project for the BPS/New Savoy Conference Charter on Psychological Wellbeing and Resilience, and has ethical approval from the UCL Research Ethics Committee (Project ID No.: 9297/002).

Anyone interested in taking part can find more information, including the information sheet and consent form, on our project website:

<https://www.ucl.ac.uk/pals/hop-mhp-project-0>

We are more than happy to respond to any queries you may have. Thanks a lot in advance for supporting this project.

Kind Regards,

Katrina & Henry
Katrina Scior & Henry Clements
University College London

Appendix 7: Confirmation of ethical approval



Amending an Approved Application

Should you wish to make an amendment to an approved study, you will need to submit an 'amendment request' for the consideration of the Chair of the UCL Research Ethics Committee. Applications can only be amended **after** ethical approval has been granted.

You will need to apply for an amendment approval if you wish to:

1. Add a new participant group;
2. Add a new research method;
3. Ask for additional data from your existing participants;
4. Remove a group of participants or a research method from the project, and have not yet commenced that part of the project;
5. Apply for an extension to your current ethical approval.

If you need to apply for an amendment approval, please complete the Amendment Approval Request Form on the next page.

When completing the form, please ensure you do the following:

- Clearly explain what the amendment you wish to make is, and the justification for making the change.
- Insert details of any ethical issues raised by the proposed amendments.
- Include all relevant information regarding the change so that the Chair can make an informed decision, and submit a copy of the sections of your application that have changed with all changes highlighted/underlined for clarity.
- You do not need to submit your original application in full again. However, if the changes you wish to make alters several sections of your application form, you are advised to submit this.

One signed hard copy of the form (and any amended documents), as well as an electronic copy of these same documents must be submitted to the REC Administrator to the address detailed below:

Administrator of the UCL Research Ethics Committee
Academic Services
1-19 Torrington Place
UCL
London
WC1E 6BT

Email: ethics@ucl.ac.uk

Amendment requests are generally considered within 5-7 days of submission.



Amendment Approval Request Form

1	<p>Project ID Number: 9297/002</p>	<p>Name and Address of Principal Investigator:</p> <p>Dr Katrina Scior, Research Dept of Clinical Educational & Health Psychology, UCL, Gower Street, London WC1E 6BT</p>
2	<p>Project Title: Supporting disclosure related decisions among clinical psychologists experiencing mental health problems: a feasibility and pilot study</p>	
3	<p>Type of Amendment/s (tick as appropriate)</p> <p>Research procedure/protocol (including research instruments) <input checked="" type="checkbox"/></p> <p>Participant group <input type="checkbox"/></p> <p>Sponsorship/collaborators <input type="checkbox"/></p> <p>Extension to approval needed (extensions are given for one year) <input checked="" type="checkbox"/> To 01/01/2019*</p> <p>Information Sheet/s <input checked="" type="checkbox"/></p> <p>Consent form/s <input checked="" type="checkbox"/></p> <p>Other recruitment documents <input type="checkbox"/></p> <p>Principal researcher/medical supervisor* <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p> <p><small>*Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request.</small></p>	
4	<p>Justification (give the reasons why the amendment/s are needed)</p> <p>We are looking to extend the research to encompass a follow-up period, three months after completion of the current study.</p> <ol style="list-style-type: none"> 1. We will ask current participants already engaged with this project whether they would be willing to complete the project outcome measures at one additional time point (T3 -3 months post T2). We will also ask participants in the intervention group whether they would be happy to be contacted about engaging in qualitative one-to-one semi-structured interviews about their experiences and disclosure related actions since engaging in the intervention. Current participants will be given information about these follow-up procedures and asked to consent to be contacted for the additional measures (and interviews for the intervention group) at the end of the T2 measures survey. 2. We are also looking to commence a 'phase two' of the project whereby all participants will be informed of the follow-up as part of the information sheet and consent at the point of signing up to the trial. In phase two, the T2 measures would no longer be administered to reduce the burden on participants. T3 measures and interviews would be conducted as described above. The amended information sheet and consent form are attached. 	

5	<p>Details of Amendments (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation)</p> <p>1. To add collection of measures at T3 in both intervention and control groups. To add conducting one-to-one interviews with intervention participants at T3. To add the following information to the end of the T2 questionnaire measures to gain informed consent to contact participants at T3:</p> <p>Intervention Group:</p> <p><i>Thank you very much for taking part in the study so far. We greatly appreciate your input and would like to invite you to take part in the follow-up section of the study.</i></p> <p><i>To further assess the effectiveness of the HOP-MHP intervention we would like to follow-up with you in another three months' time. This would involve completing the outcome measures through the web survey one last time, which take around 15-20 minutes to complete.</i></p> <p><i>We would also like to speak to participants about their experiences since using HOP-MHP and whether they have disclosed or not disclosed since. This would be in the form of one-to-one semi-structured interviews which will take place at University College London or by telephone or Skype.</i></p> <p><i>Please indicate below whether you are willing for us to contact you again in three months' time to ask you to complete the surveys, and to invite you to take part in an interview about your experiences.</i></p> <p><input type="checkbox"/> I am happy to be contacted in three months' time to complete one last set of outcome measures via a web survey.</p> <p><input type="checkbox"/> I am happy to be contacted in three months' time to be invited to take part in an interview about my experiences.</p> <p>Control Group:</p> <p><i>Thank you very much for taking part in the study so far. We greatly appreciate your input and would like to invite you to take part in the follow-up section of the study.</i></p> <p><i>To further assess the effectiveness of the HOP-MHP intervention we would like to follow-up with you in another three months' time. This would involve completing the outcome measures through the web survey one last time, which take around 15-20 minutes to complete.</i></p> <p><i>Please indicate below whether you are willing for us to contact you again in three months' time to ask you to complete the surveys.</i></p> <p><input type="checkbox"/> I am happy to be contacted in three months' time to complete one last set of outcome measures via a web survey.</p> <p>2. To drop measures collection at T2. To add collection of measures at T3 instead in both groups. To add conducting one-to-one interviews with intervention group at T3. To amend information sheet and consent form (as attached) to reflect these changes.</p>
6	<p>Ethical Considerations (insert details of any ethical issues raised by the proposed amendment/s)</p> <p>Participants will be asked to engage in the study for longer and the control group will have to wait longer to receive the intervention to conduct the T3 follow-up. However participants will be informed of this and all participants will continue to be able to access other sources of support via the project website.</p> <p>Participants may experience some distress when reflecting on their mental well-being before, during or after measure completion, including T3, and taking part in any qualitative interview. Participants are informed from the outset that they can contact us on a confidential basis if they experience distress and they are also encouraged to access one or more suggested sources of support listed on the research project webpages: www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp and http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop_additional_resources. The qualitative interviewer will remind each participant about these support procedures and resources both when arranging the interview and when conducting it.</p>

7 **Other Information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)
none

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects I confirm that my supervisor has approved my proposed modifications.

Signature: [Redacted]

Date: 23.11.2017

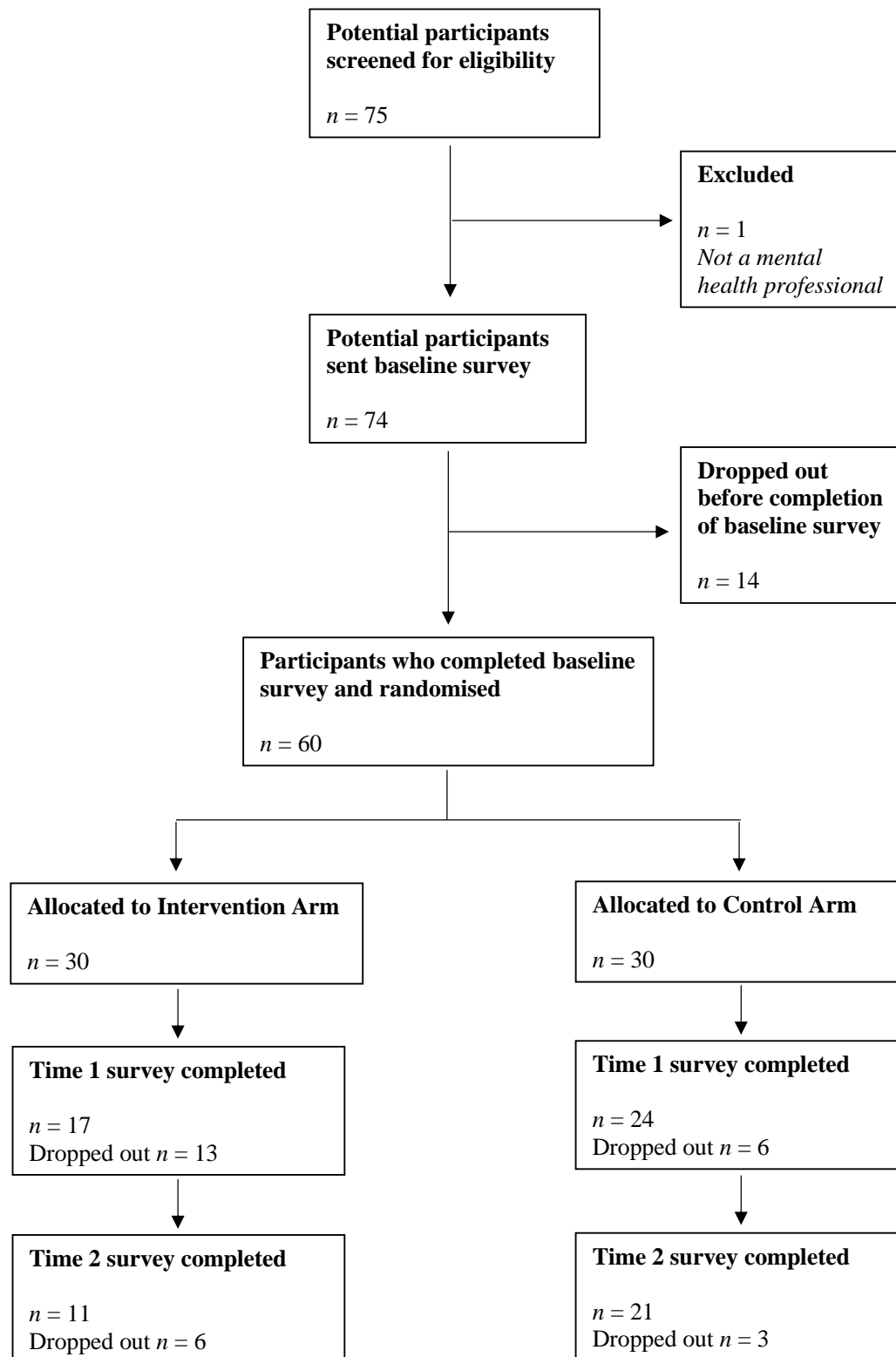
FOR OFFICE USE ONLY:

Amendments to the proposed protocol have been *approved* by the Research Ethics Committee.

Signature of the REC Chair: [Redacted] (*Dr. Lynn Ays*)

Date: *28/11/2017*

Appendix 8: Consort flow diagram for the HOP-MHP pilot RCT



Appendix 9: HOP-MHP baseline survey

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