

A guided self-help intervention supporting mental health professionals' decisions regarding sharing of lived experience

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SUMMARY

Mental health professionals with lived experience often experience heightened stigma and fear that their competency may be questioned. We present a new intervention (HOP-MHP) designed to support them in decisions about sharing their lived experience and preliminary results regarding the intervention's acceptability and feasibility.

INTRODUCTION

Clinical psychologists and other mental health professionals may be at least as likely, if not more so, than the general population to experience mental health difficulties (Peckham et al., 2019; Tay, Alcock, Scior, 2018). A systematic review by Brohan et al. (2012) explored the effect of mental health stigma and employment discrimination in the general population and concluded that those affected were often fearful of being treated unfairly and of being seen as less competent. Mental health professionals with lived experience often face stigma and report experiencing embarrassment and shame, alongside increased fear that colleagues and employers will equate their lived experience with a lack of competence or resilience, potentially even calling their fitness to practice into question (Hassan et al., 2013; Tay et al., 2018). In addition, workplace cultures often perpetuate stigma and reinforce a discourse of "impaired healers" (Adame, 2011). To challenge these stigmatising ideas, more needs to be done to 'break the silence' (Hinshaw, 2008) and to support mental health professionals in deciding whether and how to share their lived experience in a professional context.

The *Honest Open Proud* (HOP) programme was designed to support people experiencing mental health challenges with decision-making regarding the disclosure process, with a central emphasis on empowerment and peer support to counter invalidating and stigmatising messages (Corrigan, Kosyluk, & Rüscher, 2013; Scior, Rüscher, White, & Corrigan, 2019). HOP is delivered in a peer-support group setting and encourages participants to consider the potential positive and negative outcomes of sharing across different contexts. HOP has been adapted for various groups, including adolescents and soldiers, as well as parents of children with mental health challenges, suicide attempt survivors, and people living

with dementia (Rüsch & Koestner, 2021)). A recent meta-analysis of randomised controlled trials of HOP showed reductions in stigma-related stress and self-stigma (Rüsch & Koestner, 2021).

The HOP intervention was designed for individuals with lived experience but not those in a dual role as providers of mental healthcare. Concerns about professional standing and frequent fears about “being found out” are likely to render peer-group interventions inaccessible, at least as a first-line intervention for those reluctant or undecided about sharing their lived experience in a work setting. Therefore self-help interventions, which preserve confidentiality, may be a more appropriate and appealing approach for practitioners.

Honest Open Proud for Mental Health Professionals (HOP-MHP) was adapted from the original HOP programme to support providers of mental healthcare with lived experience in deciding whether, how and with whom to share this. The intervention adopts a guided self-help format but retains the element of peer support by including an auxiliary and optional online peer-support forum, which provides a confidential, closed space for discussions among those completing HOP-MHP. The value and importance of peer support is widely recognised, not least in its power to reduce stigma and feelings of isolation and increase perceived coping ability (Corrigan, Watson, & Bar, 2006).

HOP-MHP was developed with the input of stakeholder groups, including mental health professionals with lived experience, to ensure that language, content and structure had a good fit for the target audience. HOP recognises that the decision to share one’s mental health difficulties is personal and unique, and therefore the programme does not impose these decisions on participants. Although sharing may not be the optimal option for all professionals, the process of reaching this decision may nonetheless have a positive impact on well-being by empowering individuals to determine their views on sharing across different settings (Rüsch et al., 2014), in what has been described by Chris White as “empowered non-disclosure” (see Scior et al., 2019).

The three HOP-MHP ‘sessions’, detailed in the self-help guide/workbook, focus on considering the potential benefits and costs of sharing, different approaches to sharing, and

forming personal narratives about one's lived experience. Each session takes about 60 to 90 minutes to complete and users are advised to complete the HOP-MHP self-help guide over an approximate 3-week period, with continued engagement promoted through weekly check-in emails.

Acceptability, feasibility & preliminary evaluation

A pilot study was conducted to assess the feasibility and acceptability of HOP-MHP and to collect preliminary outcome data with a sample of trainee and qualified clinical psychologists, and other mental health professionals. Participants who met the inclusion criteria for the study (current and/or past mental health difficulties not or only partially disclosed to others, and not actively suicidal at present) and completed the baseline measures were randomly allocated to the intervention (n = 30) or control arm (n = 30).

Acceptability of the HOP-MHP intervention was assessed through an anonymous survey of participants in the intervention arm and interviews with a subset of five participants. The survey used the *Satisfaction with Treatment* measure (SAT; adapted from Richards & Timulak, 2013), employing 5-point Likert scales to measure participants' experiences of the self-help guide, peer forum, and outcome measures, with higher scores indicating greater satisfaction. Feasibility was assessed using indicators outlined by Sidani and Braden (2011), including feasibility of the intervention (material resources, context), feasibility of implementation (clarity, comprehensiveness, ease of use), and feasibility of research methods across all participants in the intervention and control arms (recruitment, screening, randomisation, retention and data collection).

Preliminary outcomes were explored in this pilot, using adapted versions of the *Stigma Stress Scale* (SSS; adapted from Rüsçh et al., 2009a, 2009b), and *Coming Out with Mental Illness Scale* (COMIS; adapted from Corrigan et al., 2010). Participants completed measures at three time points: baseline (T0), 4-6 weeks from baseline (T1), and 10-12 weeks from baseline (T2).

RESULTS

Acceptability

Regarding feelings of satisfaction with the intervention, SAT ratings at T1 indicated that 84.6% of participants felt 'satisfied' or 'very satisfied' ($M = 4.08/5$, $SD = 0.64$), and 92.3% said they would recommend the intervention to others ($M = 4.31/5$, $SD = 0.63$). Regarding convenience of the intervention, 92.3% of responders at T1 indicated that they found the intervention easy to access ($M = 4.38/5$, $SD = 0.87$), 76.9% found it easy to complete ($M = 4/5$, $SD = 1.08$), and 53.8% were satisfied with the recommended time frame to complete sessions ($M = 3.46/5$, $SD = 1.20$). Regarding perceived benefits of the different components of the intervention, 92.3% at T1 rated the HOP-MHP self-help guide as helpful ($M = 3.08/4$, $SD = 0.91$), 72.2% rated the peer forum as 'very useful' or 'useful' as a potential separate resource ($M = 3.00 / 4$, $SD = 1.00$), and 54.5% rated the self-help guide in combination with the peer forum as useful ($M = 2.64/4$, $SD = 1.12$).

More detailed qualitative feedback obtained through interviews indicated that participants enjoyed the content of the guide ($n = 3$), valued the opportunity to reflect on personal experiences of sharing ($n = 2$), and flexibility of completion ($n = 2$). The peer support forum was deemed an integral element alongside the self-help guide ($n = 3$) and the process of sharing was reported as beneficial ($n = 2$). The least liked aspects were the content being repetitive in places, the sessions being seen as overly time-consuming and therefore difficult to juggle with work and other commitments, and some worksheets being perceived as not applicable.

Feasibility

Although feedback from participants indicated that overall the intervention was feasible, the evaluation procedure was found not to be feasible. Recruitment was much slower than anticipated. Furthermore, although 74 eligible individuals consented to participating, only 60 completed baseline measures and were subsequently randomised, indicating that the length and content of the outcome measures may have been a barrier.

Among those randomised, overall attrition was 19.6%, with attrition higher in the intervention group (30.8%) compared to the control group (8%). The higher dropout in the

intervention arm may reflect concerns about the acceptability of the intervention, specifically the time needed to complete sessions. The time required to complete sessions varied greatly across participants, with some taking the recommended three weeks and others taking much longer.

Preliminary outcomes

Results pertain only to those participants who provided data at all three time points (intervention: $n = 10$, control: $n = 20$). In mixed 2x3 ANOVAs (2 groups, 3 time points), a medium size, significant main effect of time was observed for stigma stress, $F(2,56) = 3.74$, $p = .03$, $r = .25$, with higher stigma stress scores in both groups at T2 ($M = 8.88 \pm 2.4$) compared to baseline ($M = 4.28 \pm 1.9$). A medium size main effect of time for 'reasons for staying in' scores on the COMIS approached significance, $F(2, 52) = 3.19$, $p = .064$, $r = .24$. The perceived benefits of 'staying in' (i.e. not sharing) decreased in both groups between baseline (84.6 ± 2.4) and T2 (78.9 ± 3.1). Due to difficulties with recruitment and slower progression through the study than anticipated, the analyses were mostly underpowered and should be interpreted with caution.

DISCUSSION

This study set out to conduct an initial evaluation of the acceptability, feasibility and preliminary outcomes of an adaptation of the HOP intervention, specifically for mental health professionals. Whilst the original HOP programme uses a peer group format, which is seen as central to the intervention, encouraging mental health professionals who feel ambivalent about sharing their lived experience to join a peer-group intervention is paradoxical. Accordingly, we developed HOP-MHP as a guided self-version of HOP. Participant feedback indicated that HOP-MHP was seen as an acceptable intervention, with the optional web-based peer forum seen as a valuable aspect of the intervention. Feedback on the content of the HOP-MHP guide was varied, particularly regarding what participants found most helpful. Those who completed the intervention appreciated the opportunity to consider disclosure in depth. However, high attrition rates indicate that in its current format the intervention and

outcome evaluation is not feasible, with high drop-out in the intervention arm. This may be due to issues of time constraints as many participants required more time to complete the intervention than anticipated. Furthermore, between sign-up and baseline, 14 participants dropped out, suggesting that demands and contents of the outcome measures need reviewing.

There are clear benefits to self-help interventions, including their accessibility to individuals who would otherwise avoid or reject group interventions due to fears about disclosure (Lewis et al., 2002). A recent review outlined the potential benefits of self-help interventions for people with mental health problems, specifically relating to self-stigma (Mills et al., 2019). Self-help materials enable individuals to take responsibility for self-management, working through resources at a time and place more convenient for them. Given the preliminary nature of the outcome evaluation and the attrition in the intervention arm, great caution needs to be exercised in interpreting the findings from this pilot. While it is encouraging that participants, regardless of study arm, came to view secrecy as less beneficial over time, the finding of increased stigma stress in both the intervention and control groups is of concern. It is likely that completing measures relating to stigma and the potential risks associated with sharing lived experience increased participants' sense of threat and awareness of stigma within the mental health professions. In contrast, all three randomised controlled trials of HOP published to date observed reductions in stigma stress (Corrigan et al., 2015; Mulfinger et al., 2018; Rüsçh et al., 2014). It is conceivable that these trials' positive results are at least partly due to the strong peer support focus in the original HOP programme, in contrast to the optional and anonymous and peer support offered in HOP-MHP. Furthermore, in our adaptation of HOP the community-based participatory model and emphasis on empowerment, central to the ethos of HOP (Scior et al., 2019), were very much diminished. Going forward, how to make peer support more central to the HOP-MHP intervention from early on without inadvertently exposing participants to the potential risks of disclosure or playing into their fears of 'being found out' will need careful thought. A positive example of peer support is In2gr8mentalhealth (<https://www.in2gr8mentalhealth.com>), which advocates for the valuing and destigmatising of

lived experience. It combines an online peer forum with regular blog posts to bring together a network of mental health professionals with lived experience. However more active engagement with In2gr8mentalhealth is contingent on self-disclosure, so may not be suitable for those who do not yet feel ready to share their lived experience.

CONCLUSION

Efforts to challenge the silence and stigma surrounding lived experience among mental health professionals are much needed. HOP-MHP offers an intervention that seeks to empower mental health professionals to weigh up the costs and benefits of sharing and to reach decisions about when, how and with whom to share. However, the high attrition rates in our pilot suggest that the benefits of the self-help format we adopted may be outweighed by the shortcomings of not providing more active peer support. The high value that participants who used the peer forum placed on the peer support element of HOP-MHP suggests that practitioners may particularly benefit from peer support spaces. The qualitative results were encouraging and indicate that the HOP-MHP intervention may offer a helpful opportunity to explore sharing but that peer support needs to be much more central to this or similar interventions.

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