Mental health disclosure among clinical psychologists in training: Perfectionism and pragmatism

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Abstract

Objectives This study investigated the incidence of lived experience of mental health problems (MHPs) amongst UK-based trainee clinical psychologists, and factors associated with anticipated disclosure for trainees both with and without lived experience.

Methods **A** web-based survey comprising the Multi-Dimensional Perfectionism Scale, an adapted version of the Perceived Devaluation and Discrimination Scale, and questions about lived experience and anticipated likelihood of disclosure.

Results The survey was completed by 348 trainees across 19 UK training institutions. 67% reported lived experience of a MHP. For these trainees, there was no difference in anticipated likelihood of disclosing to different recipient types after controlling for maladaptive perfectionism. However, across all participants, anticipated disclosure was associated with maladaptive perfectionism, temporal proximity, anticipated stigma (past), and recipient type. Anticipated stigma (present) was not associated with anticipated disclosure.

Conclusions Results support an approach to communicating about mental health disclosure that incorporates responsibility, interdependency and transparency. Suggestions for further research are discussed.

Practitioner Points

- Incidence and variety of lived experience of MHPs amongst trainees are potentially substantial.
- Trainees may be selective in disclosure patterns, anticipating reluctance in disclosing mental health problems to course staff and supervisors. This potentially puts affected trainees' and service users' wellbeing at risk.
- Maladaptive perfectionism played a key role in trainees' anticipated likelihood of disclosing and should be considered in professional and training contexts.
- The BPS, training institutions, clinical supervisors and trainees should jointly champion a training environment that encourages openness and transparency relating to mental health. This may also promote wider social acceptance of MHPs.

Introduction

Little research has looked at disclosure of mental health problems (MHPs) among trainee clinical psychologists (hereafter 'trainees'). There is reason to believe that MHPs are equally, if not more, prevalent amongst trainees than in the general population. Brooks, Holttum and Lavender (2002) found that a sample of UK trainees scored higher on measures of self-esteem problems (23% of sample), anxiety (18%) and depression (14%) than normative means, and around one-third reported significant substance misuse. Clinical training itself can be a highly stressful experience. Using the General Health Questionnaire (GHQ), Cushway (1992) found that 59% of trainees were currently at or above caseness for a MHP. Trainees have reported increased problems with depression and an increase in interpersonal difficulties over the course of training (Kuyken, Peters, Power & Lavender, 2003).

As mental health clinicians, trainees adhere to professional guidelines, which include the codes of ethics of the British Psychological Society (BPS), and the Health and Care Professions Council (HCPC). They are also subject to fitness to practice and fitness to study procedures of their own training institution, designed to safeguard their own and their clients' wellbeing. Research has indicated that stress experienced by trainees may negatively affect personal and professional functioning, and quality of care for service users (Myers et al., 2012; Pakenham & Stafford-Brown, 2012; Thomas, Caputi & Wilson, 2014). Notably, research underscores the difficulties relating to accurate self-assessment of psychological needs amongst trainees (Johnson, Barnett, Elman, Forrest & Kaslow, 2012). Disclosure by mental health professionals of their own mental distress may contribute to efforts to destigmatise MHPs, normalising distress and communicating to peers, colleagues, and members of the public that MHPs need not be sources of shame. Corrigan has argued that 'coming out proud' is an important means by which to reduce both internalised and public mental health stigma (Corrigan & Matthews, 2003; Corrigan, Kosyluk & Rüsch, 2013).

Being open about vulnerabilities and experience of mental distress allows trainees to explore the value of lived experience in clinical work, something that is slowly becoming recognised amongst mental health professionals (Huet & Holttum, 2016; Roberts & Boardman, 2014).

Factors Associated with Disclosure

Factors that have been associated with mental health disclosure include type of MHP (Brohan et al., 2012; Jones, 2011), anticipated stigma (Rüsch, Brohan, Gabbidon, Thornicroft & Clement, 2014; Time to Change, 2008), level of trust and emotional rapport with the potential recipient (Ignatius & Kokkonen, 2007), and whether the problem is current or historical (Bushnell et al., 2005). Generally, people are more likely to disclose bipolar disorder or schizophrenia than anxiety or personality disorders (Bos, Kanner, Muris, Janssen & Mayer, 2009) and, in the workplace, they are more likely to disclose schizophrenia than a mood disorder (Brohan et al., 2012). These data are not consistent with research on public stigma, which demonstrates that schizophrenia is more stigmatised than depression or anxiety disorders (Feldman & Crandall, 2007; Jorm & Oh, 2009). This inconsistency may arise because individuals find it easier to conceal depression and anxiety than schizophrenia or because they may be more likely to try to manage depression and anxiety without help from others. Lastly, while people tend to be more open with health professionals and close family members, and more secretive with neighbours and work colleagues (Bos et al., 2009; Pandya, Bresee, Duckworth, Gay & Fitzpatrick, 2011), it is not clear how these patterns translate to trainees, whose colleagues are often fellow trainees and sometimes friends.

Maladaptive perfectionism appears connected with a tendency to conceal mental health problems (Kawamura & Frost, 2004). Perfectionism has been defined as setting excessively high standards for performance, accompanied by overly critical self-evaluation (Frost, Marten, Lahart & Rosenblate, 1990). One study of female undergraduates concluded that perfectionist individuals conceal negative personal information to maintain a flawless

appearance and avoid negative evaluation by others (Kawamura & Frost, 2004). Researchers have named this type of perfectionism 'maladaptive', and distinguish it from 'adaptive' perfectionism, which is associated with positive striving, increased self-esteem, self-efficacy and more functional coping (Ashby, Rice & Martin, 2006). Perfectionism appears highly relevant in the context of clinical training. In the UK, acceptance to clinical training courses is an extremely competitive process that demands high achievements, standards, and personal striving.

Study Aims

Training institutions focus on providing psychological care to "others", with little emphasis on the mental health needs of those providing care. We know little about the incidence of MHPs amongst trainees, and to what extent those affected are likely to disclose these to others. The most recent BPS guidelines on clinical psychology training and disability emphasise the importance of providing multiple opportunities for trainees to disclose, but little guidance is available on how to facilitate this (Harper, Rowlands & Youngson, 2007). By continuing to minimise the significance of trainee mental health, training institutions may collude with self-concealment in the profession. This should be resisted, since self-concealment may negatively affect both trainee and service-user wellbeing, and perpetuate mental health stigma. The first step towards supporting trainees with MHPs is to better understand the nature of these problems and the extent to which trainees are likely to disclose. If training courses are to support the disclosure process, it seems important to understand which factors influence trainees' likelihood of disclosure. This study set out to investigae the incidence of MHPs amongst trainees, and to understand some of the mechanisms that may underlie their decisions about disclosure.

Method

Participants

Participants were 348 trainees (49 males) studying across 19 UK DClinPsy programmes. To preserve anonymity, no further demographic information was collected.

Procedure

Data were collected via an online survey, piloted with ten trainees within the authors' institution and adjusted according to their feedback. Study information was sent to directors of the 30 UK-based training programmes, with a request to disseminate to trainees. Non-responders were followed two months later. Seventeen courses confirmed that they had emailed the survey link to trainees. Two further courses confirmed that they had displayed promotional posters. Ethical approval was granted by the ethics committee at the authors' institution and, in some instances, by participating institutions.

Measures

Perfectionism. Perfectionism was measured using the Multi-Dimensional Perfectionism Scale (MPS; Frost et al., 1990). The MPS comprises 35 statements, scored on a five-point scale ('strongly disagree' to 'strongly agree'). Higher scores indicate higher perfectionism levels. This is one of the most widely used measures of perfectionism (for example, D'Souza, Egan & Rees, 2011; Shafran & Mansell, 2001), has overall internal consistency of alpha 0.9, and is highly correlated with other perfectionism measures (Frost et al., 1990). Maladaptive perfectionism is represented by four subscales (22 items) and adaptive perfectionism is represented by one subscale (seven items) (Kawamura & Frost, 2004).

Anticipated stigma. Anticipated stigma was measured using an adapted version of the Perceived Devaluation and Discrimination scale (PDD; Link, 1987). The PDD asks respondents to rate 12 statements on a six-point scale ('strongly agree' to 'strongly disagree'). Higher scores indicate increased anticipation of devaluation and discrimination. The PDD has been used in 82% of studies on perceived stigma and has demonstrated internal consistency

of alpha 0.86 to 0.88, and adequate construct validity (Brohan, Slade, Clement & Thornicroft, 2010).

To understand whether trainees anticipated differing levels of stigma according to type of MHP, they were asked about three MHPs representing a range of severity and level of stigmatisation. On the basis of research by Feldman and Crandall (2007), specific phobia represented a less stigmatised MHP; major depression represented a moderately stigmatised MHP; and schizophrenia represented a highly stigmatised MHP. To account for the distinction between current and historical mental health problems, the survey included two versions of the PDD – one asking respondents to imagine how they would feel if they were to experience these three problems in the present, and one if they had experienced them in the past. Original terminology, including the phrase 'psychiatric patient' was adapted to be more acceptable to trainees.

Anticipated likelihood of disclosure. Anticipated likelihood of disclosing was measured using a question from previous studies by Rüsch and colleagues (e.g. Rüsch, Evans-Lacko, Henderson, Flach & Thornicroft, 2011). In these studies, participants were asked to rate on a seven-point scale ('very uncomfortable' to 'very comfortable') how comfortable they would feel talking to a friend or family member about their mental health, for example, telling them about their diagnosis and how it affects them. For the present study, this question was adapted to ask about anticipated likelihood of disclosure rather than comfort. Trainees were asked to rate anticipated likelihood of disclosing to the following six recipients: 1) friends, 2) family, 3) member of training cohort, 4) placement supervisor, 5) course staff and 6) health professional. The question was also adapted to allow for the distinction between the three MHPs detailed above, and whether these were current or historical.

Lived experience of mental health problems. After participants had responded to the aforementioned measures, they were asked 'Have you ever experienced a mental health

problem? This includes but is not limited to mental health problems as defined by DSM and ICD criteria, whether or not you have received a diagnosis. For the purpose of this question 'mental health problems' refer to psychological and behavioural difficulties that have diminished your capacity for coping with the ordinary demands of life'. For those who responded 'no', the survey ended here. Trainees who responded 'yes' were given a list of MHPs and asked to indicate which they had experienced, and whether this was past and/or current. Multiple responses were possible and space was provided to add additional MHPs.

Disclosure by trainees with lived experience. For trainees with lived experience, likelihood of disclosing MHP was measured using the same question about likelihood of disclosure included earlier in the survey (adapted from Rüsch et al., 2011), retaining the six recipient types. The question was related to the MHP(s) of which the trainee had lived experience. Participants were asked separately about each MHP they had experienced.

Statistical Analysis

An exploratory factor analysis was conducted to determine whether responses to the MPS fell into the six factors identified by Frost et al. (1990), and to distinguish between maladaptive and adaptive perfectionism. To clarify levels of anticipated stigma towards specific phobia, major depression and schizophrenia, a two-way repeated measures ANOVA was conducted. For the hypothetical disclosure scenarios, a multilevel linear model analysis was used to understand, for each of the three mental health problems, the relative contributions to anticipated likelihood of disclosing of i) adaptive and maladaptive perfectionism; ii) anticipated stigma; iii) temporal proximity and; iv) recipient type. For trainees with lived experience, one-way repeated measures ANOVAs were conducted to understand how the likelihood of disclosure differed by recipient type.

Results

Results Pertaining to All Trainees

Perfectionism. Principal axis factor analysis was conducted of the 35 MPS items using orthogonal rotation (varimax). All items except two loaded onto the same six factors identified by Frost et al. (1990). Item four ('If I do not set the highest standards for myself, I am likely to end up a second-rate person') loaded on to the factor 'concern over mistakes', whereas item 18 ('I hate being less than the best at things') loaded on to the factor 'personal standards'. In the original study, these loadings were reversed. For the purposes of the present study, the loadings from the current analyses were retained. All subscales had high internal reliability, with alphas ranging from .83 to .91. Table 1 shows factor loadings and reliability statistics.

[Insert Table 1 here]

Factors were separated into the same 'maladaptive' and 'adaptive' groupings as in previous research (Kawamura & Frost, 2004). The following factors were deemed maladaptive: 'concern over mistakes', 'parental expectations', 'parental criticism', and 'doubts about actions'. The factor 'personal standards' was used as a proxy for adaptive perfectionism. Means for maladaptive and adaptive perfectionism were compared using a paired sample t-test with bias corrected and accelerated confidence interval (BCa) bootstrapping (Field, 2013). Trainees overall scored higher on adaptive perfectionism (M = 3.58, SD = 0.73) than on maladaptive perfectionism (M = 2.66, SD = 0.68), $t(347) = 25.9$, $p <$ .01, with Cronbach's alphas of .84 and .92 respectively.

Anticipated stigma. Type of mental health problem showed a significant main effect on anticipated stigma, $F(1.52, 527.18) = 1340.43$, $p < .001$. Trainees anticipated the most stigma for schizophrenia, followed by major depression, then specific phobia. A significant main effect for temporal proximity was observed, with trainees anticipating more stigma for current than past MHPs, $F(1, 347) = 830.4$, $p < .001$. This difference was greater for depression and schizophrenia than for specific phobia. Thus, there was a significant

interaction between type of MHP and temporal proximity, $F(1.76, 608.88) = 103.66$, $p < .001$. For past and current MHPs, trainees anticipated the highest level of stigma for schizophrenia, followed by major depression, then specific phobia.

Anticipated likelihood of disclosing. Schwarz's Bayesian Criterion was used to assess the overall fit of each multilevel linear model, aiming to balance best fit with parsimony when assessing the relative contributions to anticipated likelihood of disclosing of anticipated stigma, recipient type, temporal proximity, and maladaptive and adaptive perfectionism. In all three models *subject* was included as a random intercept and *recipient* as a random slope. A compound symmetry covariance structure was used, since it was hypothesised that there would be covariance within levels of the random effect 'recipient' (Kincaid, n.d; Littell, Pendergast & Natarajan, 2000). Non-significant predictors were removed from the models. Tables 2 to 4 display parameter information for the three models.

[Insert Tables 2 to 4 here]

The models demonstrated that trainees anticipated being more likely to disclose each problem if it was current rather than historical. Furthermore, as maladaptive perfectionism increased, anticipated likelihood of disclosure decreased and, as anticipated stigma associated with a past mental health problem increased, anticipated likelihood of disclosure decreased. Additionally, for schizophrenia, as adaptive perfectionism increased, anticipated likelihood of disclosure increased. The effect of recipient type on anticipated likelihood of disclosure was significant for all three MHPs. Anticipated likelihood of disclosure differed depending on recipient and the pattern for this differed according to MHP. To better understand the interaction between recipient type and the other variables, a mixed model analysis was run for each recipient type and MHP. To correct for multiple comparisons, the significance value was Bonferroni adjusted ($p < .0083$). Table 5 displays the predictors that were significant for each recipient type according to MHP.

[Insert Table 5 here]

Trainees anticipated being most likely to disclose specific phobia and major depression to friends and least likely to disclose to course staff and supervisors. They anticipated being most likely to disclose schizophrenia to a family member and least likely to a supervisor. Maladaptive perfectionism negatively predicted anticipated disclosure of all three MHPs to all recipient types, with the exception of disclosure of a specific phobia to friends. Adaptive perfectionism positively predicted anticipated disclosure of a specific phobia to a cohort member and schizophrenia to a family member. Anticipated stigma related to a past MHP negatively predicted anticipated disclosure of schizophrenia and major depression to a health professional, and of specific phobia to a cohort member. Anticipated likelihood of disclosing any of the three MHPs to a health professional was higher if the problem was current. Anticipated likelihood of disclosing schizophrenia or major depression to course staff or a supervisor was higher if the problem was current.

Anticipated likelihood of disclosing a current MHP. When asked about a hypothetical current MHP, trainees anticipated being most likely to disclose to a family member, friend or health professional and least likely to disclose to a placement supervisor, and in the case of schizophrenia, a cohort member (see Table 6).

[Insert Table 6 here]

Trainees with Lived Experience of MHPs

Of respondents, 67% reported lived experience (see Figure 1) and 29% (n = 100) were experiencing at least one MHP at the time of completion.

[Insert Figure 1 here]

Disclosure by trainees with lived experience.

Table 7 displays means for likelihood of disclosing lived experience of depression and anxiety according to recipient. Anxiety and depression were chosen because they were the

most frequently reported lived experiences (see Figure 1). There was a main effect of type of recipient on likelihood of disclosing lived experience of both depression, $F(3.97, 539.85) = 30.23$, $p < .001$, and anxiety, $F(3.92, 584.73) = 40.73$, $p < .001$. To control for maladaptive perfectionism, likelihood of disclosing lived experience of (a) depression and (b) anxiety was compared across types of recipient using repeated measures ANOVAs with 'maladaptive perfectionism' as a covariate. After controlling for maladaptive perfectionism, there was no significant effect of type of recipient on likelihood of disclosing depression, $F(3.99, 539.23) = 1.92$, $p = .11$, or anxiety, $F(3.91, 578.74) = 2.14$, $p = .08$.

[Insert Table 7 here]

Discussion

This study sought to investigate the incidence of MHPs among trainees in the UK. We also examined factors associated with anticipated likelihood of disclosure, for trainees with and without lived experience. Results demonstrate that 67% of participants reported at least one past or current MHP, with anxiety (43%) and depression (39%) the most common. A considerable number indicated lived experience of social phobia (16%) and eating disorders (14%), and 29% were experiencing at least one MHP at the time of survey completion. These high rates may be due to an interplay of complex factors including those with lived experience being attracted to a career in the mental health professions and stress related to the practical and emotional demands of training. Self-selection bias is also likely, rendering those with lived experience more likely to participate in a study about lived experience and stigma. Of note though, our findings regarding current MHPs are lower than those observed in some previous studies (Brooks et al., 2002; Cushway, 1992).

Analysis of factors associated with disclosure revealed a number of significant patterns. Anticipated likelihood of disclosing hypothetical MHPs was predicted by recipient type, whether the problem was past or current, anticipated stigma associated with a past MHP, and

maladaptive perfectionism. This indicates that, for trainees, decision-making around disclosure is a complex process dependent on multiple factors that weigh differently depending on the disclosure scenario. In particular, we identified an apparent disjuncture between trainees' anticipation of stigma and their anticipated likelihood of disclosing. Trainees anticipated being more likely to disclose a current MHP than a historical one, despite anticipating greater stigma associated with the former. This finding could be seen as consistent with evidence of greater willingness to disclose more heavily stigmatised conditions, such as schizophrenia, than problems that may be easier to conceal, such as anxiety (Bos et al., 2009; Jorm & Oh, 2009; Brohan et al., 2012). We must therefore consider the possibility that anticipated stigma is not the overriding factor in trainees' decision-making process.

Trainees appear to judge different types of people to vary in their suitability as disclosure recipients. For example, while they anticipated being more likely to disclose a specific phobia to friends than to a health care professional, the reverse is seen for schizophrenia. This suggests that for trainees, who have a good understanding of interventions, support needs and risks regarding different MHPs, the practical value of disclosure may be a significant consideration. Furthermore, while trainees anticipated being more likely to disclose depression to course staff, supervisors, and health professionals if this was a current as opposed to past problem, the current/past distinction did not affect anticipated likelihood of disclosing depression to friends, family members or fellow trainees. Trainees may view disclosure to course staff, supervisors and health professionals as serving a different purpose, perhaps being a means to secure professional *and* practical support, which is not relevant in the case of historical MHPs. Disclosing to family, friends and fellow trainees may be seen as a route to emotional support. Further research should seek to shed light on the factors motivating disclosure by trainees and their actual experiences of disclosure.

For trainees with and without lived experience, maladaptive perfectionism was most consistently associated with anticipated likelihood of disclosure. This finding supports and extends literature that highlights the tendency of people high in maladaptive perfectionism to conceal information that may be evaluated negatively (Kawamura & Frost, 2004). It is apparent that trainers and trainees must take notice of perfectionism as a construct. In the past decade, researchers have started to develop interventions for perfectionism (Flett & Hewitt, 2008; Shafran, Egan & Wade, 2010). Self-help, web-based and group interventions offer some promise, and provide a range of options to training institutions. Clearly, there is scope for better understanding of how we can monitor and reduce maladaptive perfectionism. Research examining the positive and protective elements of adaptive perfectionism in the context of healthcare provision would also be helpful.

In sum, the findings should motivate training institutions and trainees to focus more closely on trainees' psychological wellbeing. When thinking about mental health disclosure by trainees, their personal motivations appear key. The evidence is that trainees' decisions are guided by the perceived value of disclosure, perhaps influenced by personality traits, such as maladaptive perfectionism. While fear of stigmatisation may motivate trainees to conceal lived experience, the current results suggest that trainees will consider disclosure, even if fearful of stigma, if motivated by other factors, including a perceived need to disclose. The challenge for trainees is in understanding what constitutes 'need', and where their clinical responsibilities lie. In a study by Johnson et al. (2012), 59% of psychologists continued to see clients when too distressed to be effective, while 30% recognised that personal problems decreased the quality of care they provided. It is crucial that trainees do not overlook their own responsibilities as clinicians working within established ethical frameworks. Fitness to practice should be one of the factors motivating trainees to consider disclosure within the training environment, and this should be a process that is supported by the training system

(Forrest, Shen Miller & Elman, 2008). Another motivating factor should be the understanding that, as the next generation of clinicians, supervisors, and managers, trainees have a responsibility to pioneer openness and transparency when communicating about mental health. Trainees should be at the forefront of reducing societal stigma, even where this is uncomfortable and at odds with their immediate goals. Finally, benefits of disclosure and the value of lived experience in working in the mental health field should be discussed more openly among the profession and training providers.

Limitations

We acknowledge that, in part, this study measured anticipated likelihood of disclosure in a hypothetical scenario. Hence trainees' responses may not reflect how they would behave if that scenario were to arise in the future. Research restricted to trainees with lived experience would help to overcome this limitation, but it would fail to gather information about the attitudes of all trainees towards lived experience and disclosure. We also acknowledge that the data presented here do not allow causal links to be made between the factors investigated. Future research should use longitudinal, as well as qualitative, methodologies to identify factors influencing disclosure decisions. Further, trainees may not have found it meaningful to distinguish between 'current' and 'historical' schizophrenia, for which there is not always a clear temporal distinction. This is likely to have impacted on responses to questions about disclosure of and anticipated stigma towards schizophrenia. Finally, likely self-selection bias means that the present sample may not accurately represent the UK trainee population.

Conclusion

This study indicates that there may be substantial incidence and variety of lived experience of MHPs among trainees. Trainees anticipate being much less likely to disclose to others within the training environment than to family and friends. Reluctance to disclose particularly current MHPs is cause for concern as it puts not only affected trainees' but also

service users' wellbeing at risk. Given the strong associations between anticipated likelihood of disclosure and personal factors, such as maladaptive perfectionism, it seems essential that trainees acknowledge their own responsibility for disclosing. The BPS and training institutions should champion a training environment that encourages trainees and trainers to acknowledge their role in pioneering openness and social acceptance of mental health problems. In parallel, much greater consideration about the impact *and* potential value of lived experience is called for. A paradigm shift on this level would require a significant sea-change, with trainees, course staff and supervisors communicating transparently about their own vulnerabilities and psychological wellbeing. This may cultivate a training system that produces psychologists who take the lead in demonstrating the value of mental health disclosure and truly challenging societal stigma.

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Table 1
Factor Loadings for Exploratory Factor Analysis of the Multidimensional Perfectionism Scale

Items	Factor Loadings					
	CM	Org	PE	PS	DA	PC
4. If I do not set the highest standards for myself, I am likely to end up a second-rate person	.568					
9. If I fail at work/school, I am a failure as a person	.703					
10. I should be upset if I make a mistake	.583					
13. If someone does a task at work/school better than I, then I feel like I failed the whole task	.574					
14. If I fail partly, it is as bad as being a complete failure	.606					
21. People will probably think less of me if I make a mistake	.682					
23. If I do not do as well as other people, it means I am an inferior human being	.753					
25. If I do not do well all the time, people will not respect me	.680					
34. The fewer mistakes I make, the more people will like me	.641					
2. Organisation is very important to me		.747				
7. I am a neat person		.827				
8. I try to be an organized person		.697				
27. I try to be a neat person		.799				
29. Neatness is very important to me		.865				
31. I am an organised person		.780				
1. My parents set very high standards for me			.743			
11. My parents wanted me to be the best at everything			.716			
15. Only outstanding performance is good enough in my family			.656			
20. My parents have expected excellence from me			.808			
26. My parents have always had higher expectations for my future than I have			.585			
6. It is important to me that I be thoroughly competent in everything I do				.425		
12. I set higher goals than most people				.749		
16. I am very good at focusing my efforts on attaining goals				.389		
18. I hate being less than the best at things				.475		
19. I have extremely high goals				.700		
24. Other people seem to accept lower standards from themselves than I do				.617		
30. I expect higher performance in my daily tasks than most people				.550		

Table 1 (continued)

Items	CM	Org	PE	PS	DA	PC
17. Even when I do something carefully, I often feel that it is not quite right					.596	
28. I usually have doubts about the simple everyday things I do					.466	
32. I tend to get behind in my work because I repeat things over and over					.753	
33. It takes me a long time to do something "right"					.826	
3. As a child, I was punished for doing things less than perfectly						.590
5. My parents never tried to understand my mistakes						.592
22. I never felt like I could meet my parents' expectations						.751
35. I never felt I could meet my parents' standards						.690
Cronbach's alpha (α)	.89	.91	.87	.84	.83	.86

CM = concern over mistakes; Org = organisation; PE = parental expectations; PS = personal standards; DA = doubts over actions; PC = parental criticism.

Table 2
Parameter Information for Significant Predictors of Anticipated Likelihood Disclosing a Diagnosis of Specific Phobia

Variable	*B*	*SE B*	*95% CI of B*
Baseline likelihood of disclosure	7.52***	0.27	6.97, 8.06
Temporal proximity to MHP			
Past[A]	.	.	.
Current	0.17***	0.03	0.10, 0.23
Recipient			
Family[A]	.	.	.
Friends	0.15[ns]	0.10	-0.03, 0.34
Course staff	-1.84***	0.10	-2.03, -1.66
Supervisor	-1.83***	0.10	-2.02, -1.65
Cohort	-0.73***	0.10	-0.92, -0.54
HCP	-0.93***	0.10	-1.12, -0.74
Maladaptive perfectionism	-0.43***	0.08	-0.60, -0.27
Anticipated stigma (past)	-0.02***	0.01	-0.04, -0.01

*** $p < .001$; [A] Reference category; [ns] Not significantly different to reference category.

Table 3
Parameter Information for Significant Predictors of Anticipated Likelihood Disclosing a Diagnosis of Major Depression

Variable	*B*	*SE B*	*95% CI*
Baseline likelihood of disclosure	7.60***	0.28	7.04, 8.16
Temporal proximity to MHP			
Past[A]	.	.	.
Current	0.23***	0.03	0.17, 0.29
Recipient			
Family[A]	.	.	.
Friends	0.04 [ns]	0.10	-0.15, 0.23
Course staff	-1.20***	0.10	-1.39, -1.01
Supervisor	-1.53***	0.10	-1.72, -1.34
Cohort	-1.00***	0.10	-1.19, -0.81
HCP	-0.01 [ns]	0.10	-0.20, 0.19
Maladaptive perfectionism	-0.03***	0.00	-0.03, -0.02
Anticipated stigma (past)	-0.02***	0.01	-0.04, -0.01

*** $p < .001$; [A] Reference category; [ns] Not significantly different to reference category.

Table 4
Parameter Information for Significant Predictors of Anticipated Likelihood Disclosing a Diagnosis of Schizophrenia

Variable	*B*	*SE B*	*95% CI*
Baseline likelihood of disclosure	7.36***	0.39	6.60, 8.12
Temporal proximity to MHP			
Past[A]	.	.	.
Current	0.35***	0.03	0.29, 0.42
Recipient			
Family[A]	.	.	.
Friends	-0.52***	0.10	-0.71, -0.33
Course staff	-1.32***	0.10	-1.51, -1.13
Supervisor	-1.68***	0.10	-1.87, -1.49
Cohort	-1.59***	0.10	-1.78, -1.40
HCP	-0.11 [ns]	0.10	-0.31, 0.08
Maladaptive perfectionism	-0.03***	0.00	-0.04, -0.02
Adaptive perfectionism	0.04**	0.01	0.01, 0.07
Anticipated stigma (past)	-0.03***	0.01	-0.04, -0.02

*** $p < .001$; ** $p < .01$; [A] Reference category; [ns] Not significantly different to reference category.

Table 5
Rankings of Disclosure Recipient by Anticipated Likelihood of Disclosure and Predictors Significant to Disclosure

	Type of mental health problem		
	Phobia	Major Depression	Schizophrenia
1. (Most likely)	Friends	Friends[A]	Family[A,C,D]
2.	Family[A]	Family[A]	HCP[A,B,C]
3.	Cohort[A,B,C,D]	HCP[A,B,C]	Friends[A]
4.	HCP[A,C]	Cohort[A]	Course staff[A,C]
5.	Supervisor[A]	Course staff[A,C]	Cohort[A]
6. (Least likely)	Course staff[A]	Supervisor[A,C]	Supervisor[A,C]

Significant predictors are denoted by superscript letter: [A]Maladaptive perfectionism (all negative correlations). [B]Anticipated stigma (past)(all negative correlations). [C]Temporal proximity (for all, current = more likely). [D]Adaptive perfectionism (all positive correlations).

Table 6
Mean Likelihood of Anticipated Disclosure for Hypothetical Current Mental Health Problems

Recipient	Type of mental health problem			Rüsch et al. (2012)†
	Specific phobia	Major Depression	Schizophrenia	
Family	5.89[A]	5.40[A]	5.61[A]	5.10
Friends	6.05[A]	5.40[A]	4.96	5.10
HCP	5.25	5.59[A]	5.54[A]	-
Member of cohort	5.33	4.35	3.88[B]	-
Course staff	4.14[B]	4.38	4.37	-
Placement supervisor	4.16[B]	4.03[B]	3.96[B]	-
Prospective or current employer	-	-	-	3.70

Higher scores indicate higher anticipated likelihood of disclosing. 1 = very unlikely, 7 = very likely. [A] Statistically significant as highest mean for anticipated likelihood of disclosure (column only). [B] Statistically significant as lowest mean for anticipated likelihood of disclosure (column only). In each column, means with the same superscript are not significantly different from one another. † Study used as a comparison, data based on survey of general adult UK population.

Table 7
Mean Likelihood of Disclosure for Trainees with Lived Experience of Depression and Anxiety

Recipient Type	Likelihood of disclosure	
	Depression (*N*=137)	Anxiety[†] (*N*=150)
Friends	4.96 (1.74)[A]	5.59 (1.42)
Health care professional	4.52 (1.93)[AB]	4.73 (1.94)[A]
Family member	4.29 (2.26)[B]	4.97 (2.04)[A]
Member of cohort	4.02 (1.81)[B]	4.64 (1.80)[A]
Course staff	3.39 (1.93)[C]	3.76 (1.88)[B]
Placement supervisor	3.11 (1.79)[C]	3.53 (1.81)[B]

Standard deviations are shown in parentheses. All means are significantly different at $p < .01$ except for those sharing the same letter superscript (within columns only), [†]Excludes social phobia, specific phobia, OCD and panic disorder. Where trainees had both current and past experience of the mental health problem, means were taken from responses relating to current experience.