

**Lived Experience of Mental Health Problems
among Clinical Psychologists, Stigma and its
Impact on Disclosure and Help-seeking**

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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

Mental health stigma is known to be a key deterrent to the disclosure of and help-seeking for mental health problems. The purpose of this thesis was threefold: (a) to explore the lived experience of mental health problems in clinical psychologists based in the UK, (b) to establish the existence of stigma among mental health professionals and in particular clinical psychologists, and (c) to determine the impact of stigma and stigma-related factors, on disclosure and help-seeking among clinical psychologists. This volume consists of three parts.

Part one presents a systematic literature review of the attitudes of mental health professionals towards mental health problems and the people experiencing them. The findings suggested varying levels of stigma among and within mental health professionals and determined factors that influenced the level of stigma.

Part two presents an empirical paper that investigated the lived experience of mental health problems in clinical psychologists, stigma and the impact of stigma-related variables on disclosure and help-seeking for mental health problems among clinical psychologists. The results identified difficulties that clinical psychologists faced in “coming out of the closet” and highlight the importance of addressing these issues in an effort to ensure and maintain their wellbeing and ability to provide clients with the quality of care required. Directions for future research are also discussed.

Part three is a critical appraisal of the research undertaken in this thesis. It details personal reflections of the research process and considers conceptual and methodological issues that arose. It concludes with a discussion of the study’s clinical and scientific implications.

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Part 1: Literature Review

Mental Health Stigma among Mental Health Professionals: A Systematic Review of the Literature

Abstract

Aim: The extent to which mental health professionals stigmatise mental health problems and the people who experience them is an essential, yet under-researched area. This is especially in light of high levels of experienced discrimination by users of mental health services. This review aimed to fill the gaps in the evidence and determine what is currently known about stigma among mental health professionals.

Method: A systematic search of studies investigating mental health stigma (hereafter referred to as stigma) among mental health professionals was carried out. The electronic databases PsychINFO, PubMed, Scopus and MEDLINE were searched for relevant studies published between 2009 and September 2015.

Results: Nineteen articles met the review's inclusion criteria. Their findings indicated that mental health professionals simultaneously held positive and stigmatising attitudes and that the level of stigma varied not only among, but also within groups of mental health professionals. The level of stigma was also affected by other factors such as type of mental health problem, certain personal characteristics of the mental health professional, work environment, training experience in mental health care and contact with people experiencing mental health problems.

Conclusions: In comparison to that on members of the general population, there is limited research exploring stigma among mental health professionals, in particular psychologists, psychotherapists, counsellors and therapists. Further research is needed to address methodological limitations of previous studies, and to explore both explicit and implicit stigma, specifically among the aforementioned mental health professionals before interventions targeted at reducing stigma among these professionals can be developed.

1. Introduction

It is estimated that a quarter of British adults will experience a diagnosable mental health problem in any given year (McManus, Melzer, Brugha, Bebbington, & Jenkins, 2009). In spite of the high prevalence, more than two-thirds of people with mental health problems in Europe (Wittchen & Jacobi, 2005) and the United States (Kessler et al., 2005) did not seek treatment. A systematic review conducted by Clement et al. (2015), established that the stigma related to having a mental health problem was the fourth highest ranked barrier to disclosing and seeking help.

The input by mental health services has proven helpful for a significant proportion of people and the consequences of those with mental health problems not receiving mental health treatment are manifold. Although research has shown that one can benefit positively from the experience of having a mental health problem (Galvez, Thommi & Ghaemi, 2011), conversely, mental health problems have also been known to significantly affect the individual's quality of life and physical health. They increase morbidity and the costs of mental and physical health treatments for the National Health Services (NHS), add to the burden of state benefits due to increased unemployment and reduced workplace productivity, and account for 23% of reduced quality of life and premature mortality (Centre for Mental Health, 2009).

To curtail the often-negative consequences of mental health problems, it is important that those experiencing mental health problems are made aware of the various avenues of support available to them and how the input of mental health services might be helpful to them. The first step to encourage their engagement with these services is to destigmatise mental health problems and create an environment sufficiently safe and comfortable for them to seek help in. In this respect, mental health professionals play a crucial role in creating such an environment.

1.1. Mental Health Stigma

Although the definition of mental health stigma (hereafter referred to as stigma) is ambiguous and highly variable, the general understanding is that it is a process of cognitively marking an individual as possessing a negative characteristic that is so degrading and discrediting that it consumes the views of others and sets the individual apart (Goffman, 1963; Link & Phelan, 2001).

Elements that contribute to the process of stigmatising someone with mental health problems include problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination) (Thornicroft, Rose, Kassam, & Sartorius, 2007).

Accordingly, stigma involves the recognition and stereotyping of a person based on his/her negative mental health characteristic, forming emotions and beliefs (prejudice) about the person, which in turn trigger a behavioural response (discrimination) towards the person. This process has also been described as labelling individual attributes, evaluating these negatively, with consequent discrimination experienced by the labelled individual (Link & Phelan, 2001). Discrimination can be expressed directly and indirectly through avoidance, hostile behaviours, harassment, status loss and exclusion (Link & Phelan, 2001).

Two common dimensions of stigma include external and self-stigma. External stigma is defined by prejudice and discrimination towards people with mental health problems as a result of the diagnosis they have been given (Link & Phelan, 2001), while self-stigma occurs when the stigmatised person internalises negative stereotypes held within society (Corrigan & Watson, 2002).

The effects of stigma can be devastating. Those with poorer mental health may experience shame, embarrassment, lowered self-esteem, doubts about their competence (Corrigan & Rüsch, 2002), as well as beliefs that they are insignificant

and will ultimately be avoided and rejected by most people (Barney, Griffiths, Jorm, & Christensen, 2006; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Schomerus & Angermeyer, 2008). This may further lead to a fear of identifying with their mental health problems and a reluctance to disclose and seek professional help (Sartorius, 2007; Schomerus & Angermeyer, 2008).

In recent years, initiatives to tackle stigma have gained increasing prominence (Brooks, Gerada, & Chalder, 2011; Evans-Lacko, Henderson, Thornicroft, & McCrone, 2013; Garelick, 2012; Schomerus & Angermeyer, 2008; Wallace, 2010). The last ten years have seen intense destigmatising efforts by the World Health Organisation and World Psychiatric Association through global programmes such as “Open the Doors” and the creation of the Global Anti-Stigma Alliance in June 2012. Moreover, there has been increased government spending in many countries to counter stigma through anti-stigma campaigns. These campaigns include beyondblue (2000) in Australia, Time to Change (2007) in UK, Bring Change 2 Mind (2009) in USA, Opening Minds (2009) in Canada, See Change (2010) in Ireland, En Af Os (2011) in Denmark, Time to Change Wales (2011) and Samen Sterk Tegen Stigma (2013) in The Netherlands. Drivers of these initiatives against stigma include self-advocates, third sector organisations, pressure groups and mental health professionals.

Although these interventions have reportedly improved the public’s sentiments towards people with mental health problems, it is of note that most research conducted on stigma and the effectiveness of stigma-reduction interventions has assessed the attitudes and behavioural responses of the public and mental health professionals through self-report attitude surveys (Link et al., 1987; Penn et al., 1994; Schulze, 2007; Wahl & Aroesty-Cohen, 2010). Most of these self-reports were

not validated by observations of actual behaviours (Corrigan, 2000). Although able to provide useful information regarding the explicit attitudes of the public and mental health professionals, self-report studies are unable to evaluate implicit cognitions (Kopera et al., 2015) that may be more sensitive to detecting subconscious and unconscious attitudes. This might result in the underestimation of levels of stigma (Hinshaw & Stier, 2008) and may reduce predictions of discriminatory behaviours. There has been limited exploration of whether such self-reported attitudes and changes observed over time translate into actual changes in behaviour and a reduction in discriminatory behaviour. Furthermore, the reliance in research on self-reported explicit attitudes can be seen as problematic, and regrettably very few studies have explored implicit attitudes, which are less accessible to conscious manipulation and thus said to be less affected by social desirability (Devos, 2008).

1.2. Mental Health Professionals and Stigma

In the UK, little is known about the effect that anti-stigma efforts, campaigns and measures such as the Time to Change programme (2011) have had on mental health professionals. Even with the improvement of public attitudes, people with mental health problems still report high levels of discrimination when they use mental health services (Corker et al., 2013).

Despite striving for destigmatisation and actively encouraging others to seek professional help, research suggests that mental health professionals, much like the general population, are vulnerable to stigma (Horsfall, Cleary, & Hunt, 2010; Nordt, Rössler, & Lauber, 2006; Schulze, 2007; Servais & Saunders, 2007; Thornicroft, Brohan, Kassam, & Lewis-Holmes, 2008), and have in truth been shown to possess more pessimistic views of recovery from mental health problems (Hugo, 2001). There has also been evidence of different attitudes between different mental health

professional groups and even amongst mental health professionals within the same field due to variations in training and clinical experiences (Ishige & Hayashi, 2005; Magliano et al., 2004b; Nordt et al., 2006; Peris, Teachman, & Nosek., 2008; Tay, Pariyasami, Ravindran, Ali, & Rowsudeen., 2004).

Negative attitudes among mental health professionals have been shown to influence their level of personal engagement with and empathy towards people with mental health problems (Van Boekel, Brouwers, Weeghel, & Garretsen, 2013). In turn, fears of stigmatisation from mental health professionals have been shown to result in the reluctance of people with mental health problems to seek help and feeling disempowered, leading to higher treatment drop-out rates, lack of treatment adherence and subsequent poorer treatment outcomes (Angermeyer, Matschinger, & Riedel-Heller, 1999; Dinos, Stevens, Serfaty, Weich, & King, 2004; Edlund et al., 2002; Tehrani, Krussel, Borg, & Munk-Jorgensen, 1996; Van Boekel et al., 2013). Moreover, low expectations of the abilities of people with mental health problems by mental health professionals have been shown to lead to their diminished promotion of and support for the social and vocational inclusion, ultimately affecting the integration and engagement of service users in the community (Great Britain, 2004).

1.3. Aims and Objectives

The display of stigmatising attitudes and behaviours by mental health professionals towards people with mental health problems can undesirably influence the latter's willingness to seek help, continued contact with mental health services and their ultimate wellbeing and social inclusion. Consequently, it seems pertinent to provide an up to date picture of the attitudes of mental health professionals to those experiencing mental health problems and a better understanding of factors that may contribute to these attitudes.

While reviews focusing on attitudes of mental health professionals to mental health problems exist (Schulze, 2007; Wahl & Aroesty-Cohen, 2010), to the author's knowledge none have examined differences in such attitudes between different mental health professional groups or considered factors that might contribute to negative attitudes. As research has found varying attitudes between different mental health professional groups, it is important to explore the views of specific mental health professional groups rather than to make generalisations about their sentiments towards people with mental health problems.

The current review, therefore, aims to provide the reader with a clear picture of the current attitudes of specific mental health professionals groups towards mental health problems (and the people who experience them) and to explore factors that may influence attitudes among mental health professionals. This will be done by evaluating articles relating to the attitudes of specific mental health professional group (i.e., psychiatrists, psychiatric nurses, psychologists, psychotherapists, counsellors and therapists).

Specifically, the following questions will be addressed:

- (1) To what extent do mental health professionals still possess stigmatising attitudes?
- (2) What differences in the level of stigma have been observed between different mental health professional groups?
- (3) What are the factors that may influence stigma held by mental health professionals?

2. Method

2.1. Search Strategy

A systematic search of the literature was conducted by searching the

following electronic databases: PsycINFO, PubMed, Scopus and MEDLINE. Search terms focused on three areas: mental health professionals, stigma and mental health problems. Specific search terms were combined in various ways using Boolean terms ‘OR’ and ‘AND’; see Table 1.

Table 1

Literature Review Search Terms

Mental health professionals	Stigma	Mental health problems
“mental health professional*”	stigma*	“mental illness*”
“mental health worker*”	stereotyp*	“mental health problem*”
“mental health personnel”	attitude*	“mental health difficult*”
psychiatrist*	discriminat*	“psych* problem*”
psychologist*	prejudice	“psych* difficult*”
therapist*	“mental health stigma”	“psych* diagnosis”
counsel?or*	“mental health attitude*”	“psych* disorder*”
psychotherapist*		distress
“mental health nurse*”		depression
“psychiatric nurse*”		anxiet*
healer*		schizophrenia
		psychosis
		addiction*
		“eating disorder*”
		patient*

* Truncated terms allowed for multiple endings of words.

“ ” Quotation marks ensured that concepts were searched for as whole/exact phrases.

Limits were set on the databases to include only journal articles published in English. Additionally, as this was a follow up of Wahl and Aroesty-Cohen’s (2010) review, only articles published between January 2009 and September 2015 were included.

2.2. Inclusion and Exclusion Criteria

Inclusion Criteria

- Articles published in English between January 2009 and September 2015.
- Studies in which participants were qualified mental health professionals (i.e., psychiatrists, psychiatric nurses, psychologists, psychotherapists, counsellors

and/or therapists).

- Studies that explored the attitudes of mental health professionals.
- Studies in which the main focus was not on mental health professionals were included if they reported separate analyses on the attitudes of mental health professionals.
- Articles published in peer-reviewed journals.

Exclusion Criteria

- Studies in which the focus was the attitudes of mental health professionals towards service response (e.g., disposal) and/or treatment modalities.
- Studies in which the focus was on the influence of other factors on the attitudes of mental health professionals (e.g., culture, gender, sexuality).
- Studies in which the focus was on the reduction of stigma and/or methods used to reduce stigma.
- Studies in which the focus was on the development of stigma measures/tools.

2.3. Study Selection

Table 2 presents the number of articles identified through the various databases.

Table 2

Number of Papers Retrieved from Each Database Search

Database	Number of articles
PsycINFO	60
PubMed	4
Scopus	43
MEDLINE	39
Total	146

Figure 1 presents an overview of the search strategy, and reasons for the exclusion of studies at each stage. Duplicated articles were deleted from the 146 articles produced from the initial search. Thereafter, titles were read to determine which of the remaining 72 articles met the inclusion criteria. If the suitability and appropriateness of the articles were still unclear, abstracts were read and if any uncertainty remained, the full article was read and thoroughly reviewed against both the inclusion and exclusion criteria. In addition, articles that cited the studies of interest and the reference lists of the latter were reviewed to identify additional publications for inclusion.

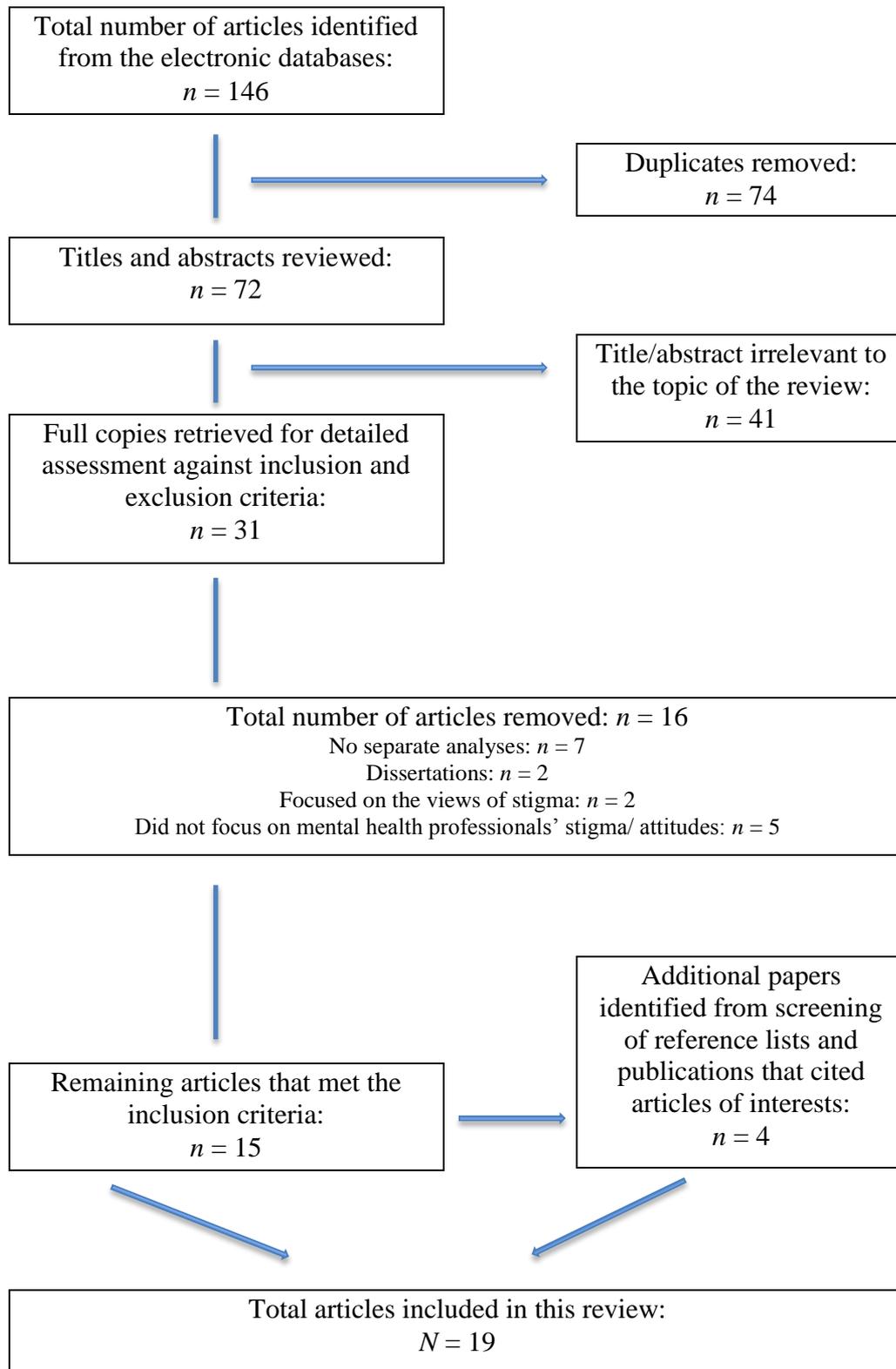


Figure 1: Flowchart of Study Selection

2.4. Definition of Mental Health Problems

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) defined a mental health problem as being ‘a clinically significant disturbance to an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in mental functioning, and is usually associated with significant distress and impairment in social and occupational functioning’.

Including the full range of mental health problems would be beyond the scope of this article. Therefore for the purposes of this review, only highly prevalent mental health problems such as schizophrenia/psychosis, depression, anxiety, addictions (i.e., substance use), OCD and eating disorders were included.

2.5. Quality Assessment

To assess the quality of the articles in the review, a search for an appropriate critical appraisal checklist designed to evaluate cross sectional studies, was carried out. A systematic review of tools used to assess the quality and susceptibility to bias in observational studies in epidemiology (Sanderson, Tatt, & Higgins, 2007), was consulted. Of the five checklists identified from Sanderson et al.'s (2007) systematic review, the Health Evidence Bulletin (2004) checklist (Appendix A) was chosen for the reasons that its development was described and that it had eight checklist items as compared to three items in the other two checklists with development descriptions. The larger number of checklist items were deemed to allow for a more comprehensive and thorough assessment of the articles. The last section on the relevance of the results locally was removed, owing to its lack of relevance to the type of research assessed in this review. Two researchers were used to rate and improve the reliability of the quality assessment.

3. Results

3.1. Overview of Studies included in the Review

In total, 19 articles were included in this review. Four of the 19 articles were acquired through an assessment of publications that cited the 15 articles of interest and the reference lists of these articles of interest. See Table 3 for an overview of the studies.

Table 3*Overview of studies included in the review*

Study & Location	Sample	Design & Method	Type of problem studied	Key findings
Avery et al. (2013) USA	54 addiction psychiatrists, 30 community psychiatrists	Cross-sectional; Web-based survey, attitude questionnaire designed for study (adapted Medical Condition Regard Scale (MCRS))	Schizophrenia, Polysubstance dependence, Comorbid schizophrenia and polysubstance dependence, Major depression	<ul style="list-style-type: none"> Addiction psychiatrists had less negative attitudes towards individuals with polysubstance dependence, while community psychiatrists had less negative attitudes towards individuals with schizophrenia. Both groups had more negative attitudes toward individuals with dual compared to single diagnosis.
Ben-Natan et al. (2015) Israel	108 psychiatric nurses, 108 non-psychiatric nurses	Cross-sectional; Survey (Community Attitudes towards the Mentally Ill (CAMI) scale; Attitudes towards Acute Mental Health Scale (ATAMHS))	Various mental health problems	<ul style="list-style-type: none"> Non-psychiatric nurses had more stigmatising attitudes than psychiatric nurses towards people with mental health problems.
Gilchrist et al. (2011) Southern and Eastern Europe	229 nurses (general and psychiatric), 224 physicians, 181 psychiatrists, 144 psychologists, 67 social workers	Cross-sectional, MCRS	Substance use	<ul style="list-style-type: none"> Psychologists had more interest in working with and higher belief in the treatability of drinkers and drug users than physicians, psychiatrists and nurses; no difference to social workers. They had more interest in working with people with depression than for substance users, specifically drug users.
Hanzawa et al. (2012) Japan	215 psychiatric nurses	Cross-sectional; Questionnaire designed for study (Personal stigma scale; Perceived stigma scale; Social Distance Scale (SDS); Difficulty of Community Living scale; Chronic schizophrenia case vignette)	Schizophrenia	<ul style="list-style-type: none"> Psychiatric nurses had a pessimistic view of people with schizophrenia living in the community. They believed that it was better for them to be hospitalised than to receive outpatient treatment, in order to prevent them from being discriminated against in the community.

Study & Location	Sample	Design & Method	Type of problem studied	Key findings
Hori et al. (2011) Japan	197 general population, 100 psychiatric staff (83 nurses, 16 pharmacologists, 1 community health worker), 112 physicians (not psychiatrists), 36 psychiatrists	Cross-sectional; Web-based survey, 18-item questionnaire designed for study (adapted from Ucock et al. 2006)	Schizophrenia	<ul style="list-style-type: none"> • Psychiatrists, followed by the psychiatric staff, had the least stigmatising attitudes toward schizophrenia. • All four groups had the same level of scepticism regarding the treatment of people with schizophrenia. • Despite less negative attitudes overall, psychiatrists and psychiatric staff showed similar or even greater tendency to oppose to the marriage of their relatives and people with schizophrenia.
Hoy and Holden (2014) USA	111 Licensed Professional Counselors (LPCs)	Cross-sectional; Web-based survey (Attribution Questionnaire (AQ-21); SDS; Recovery Belief Scale (RBS))	Schizophrenia	<ul style="list-style-type: none"> • LPCs had low fear of people with schizophrenia, moderate to high interest in providing them with therapy and strong beliefs in their recovery. However, they desired moderate social distance. • Work frequency was positively correlated with positive attitudes.
Hsiao et al. (2015) Taiwan	180 psychiatric nurses	Cross-sectional, descriptive correlation design; Questionnaire (Jefferson Scale of Empathy-Health Profession version (JSE-HP); Attitudes of Mental Illness Questionnaire (AMIQ))	Various mental health problems (substance abuse, schizophrenia, major depression)	<ul style="list-style-type: none"> • Psychiatric nurses had negative attitudes towards people with mental health problems, and in particular substance abusers. • More positive attitudes were expressed by psychiatric nurses who were older, more empathic and had more clinical experience in mental health care. Psychiatric nurses working in acute psychiatric units demonstrated more negative attitudes towards substance abuse and schizophrenia, compared to those working in psychiatric rehabilitation units, outpatient clinics or community psychiatric rehabilitation centres.

Study & Location	Sample	Design & Method	Type of problem studied	Key findings
Jones et al. (2009) New York, USA	24 primary care physicians, 27 psychiatrists	Cross-sectional; Semi-structured survey via interview, Scales designed for study (Stereotypes based on 11 items suggested by Nordt et al. (2006); 6-item scale to assess clinicians' attitude to people with schizophrenia)	Schizophrenia	<ul style="list-style-type: none"> • There was no significant difference between primary care physicians and psychiatrists in reported and anticipated behaviour towards older adults with schizophrenia. • Both groups displayed generally favourable views with slightly negative stereotypes and attitudes.
Jones et al. (2013) UK	126 psychiatrists	Cross-sectional; Online questionnaire	Eating disorders	<ul style="list-style-type: none"> • Most disagreed that people with eating disorders were untreatable and that eating disorders were abnormal behaviours displayed by people with weak, manipulative or inadequate personalities. • Attitudes improved with increasing seniority and clinical experience.
Kopera et al. (2015) Poland	29 psychiatrists and psychotherapists, 28 first-year medical students	Cross-sectional; Questionnaire Go/No-Go Association computer task, Emotion Scale and Opinions about Mental Illness Scale (Cohen and Struening 1962); GNAT (Nosek and Banaji, 2001)	Various mental health problems	<ul style="list-style-type: none"> • Psychiatrists and psychotherapists reported significantly more positive explicit attitudes (i.e. compassion, interest, sadness and acceptance), less tendency to discriminate and less restrictive attitudes) than medical students towards people with mental health problems. • Long-term contact with people with mental health problems did not influence the negative implicit attitudes of both groups.
Kusalaruk et al. (2015) Thailand	91 psychiatrists	Cross-sectional; Questionnaire	OCD	<ul style="list-style-type: none"> • Most psychiatrists had more positive than negative attitudes toward people with OCD, but still thought they were difficult to treat (>80%), needed more patience than those with other mental health problems and had poor treatment compliance (>50%). • Psychiatrists' experience, confidence and proficiency with Exposure Response Prevention, workplace and workload were significantly associated with psychiatrists' attitudes.

Study & Location	Sample	Design & Method	Type of problem studied	Key findings
Lampe et. al. (2013) Sydney	44 GPs, 37 psychiatrists	Cross-sectional; Case presentations, Depression Attitude Questionnaire	Depression	<ul style="list-style-type: none"> Psychiatrists reported greater satisfaction and positive attitudes towards depressed people than GPs. They also believed more than GPs in the treatability of depression. Extraversion was positively associated to treatment belief and satisfaction.
Linden and Kavanagh (2012) Ireland	66 student psychiatric nurses, 121 qualified psychiatric nurses (68 inpatient, 32 community)	Cross-sectional; Survey (CAMI scale; Social Interaction scale)	Schizophrenia	<ul style="list-style-type: none"> Psychiatric nurses in community settings had more positive attitudes than those in inpatient settings. Community psychiatric nurses were more accepting of social interaction, while inpatient psychiatric nurses held more socially restrictive attitudes.
Loch et al. (2011) Brazil	1414 psychiatrists	Cross-sectional; Face-to-face interviews using scales adapted for study (Stigma scales on stereotypes; SDS; Social Acceptance scale; Social Stigmatisation scale; Opinions on psychotropic drugs.)	Schizophrenia	<ul style="list-style-type: none"> Brazilian psychiatrists tended to negatively stereotype individuals with schizophrenia, had lower social distance scores and higher prejudice scores. Higher age was significantly correlated with positive stereotyping, less prejudice and lesser social distance. Social distance was also significantly associated with sex and working in a psychiatric university hospital.
Loch et al. (2013a) Brazil	1414 psychiatrists	Cross-sectional; Face-to-face interviews using adapted SDS	Schizophrenia	<ul style="list-style-type: none"> Level of stigma towards schizophrenia varied in psychiatrists (mix of positive and negative views). Majority negatively stereotyped people with schizophrenia, agreed with restrictions and had high perceived prejudice. Contact with a family member suffering from a psychiatric disorder was not associated with psychiatrist's attitudes.

Study & Location	Sample	Design & Method	Type of problem studied	Key findings
Loch et al. (2013b) Brazil	1414 psychiatrists, 1015 general population	Cross-sectional; Case vignette, Questionnaire designed for study (Adapted social acceptance and social stigmatisation scales (Link et al., 1991); SDS (Link et al., 1987))	Schizophrenia	<ul style="list-style-type: none"> • Lower age in psychiatrists was associated with negative stereotyping and perceived prejudice. • Psychiatrists showed higher scores in negative stereotypes and perceived prejudice and significantly lower social distance scores than the general population. • Knowledge about schizophrenia was positively correlated with stigma (specifically perceived prejudice). Psychiatrists were most pessimistic regarding society's stigma.
McNicholas et al. (2015) Ireland	60 counsellors/therapists, 30 psychiatrists, 23 GPs, 21 psychologists, 16 others (dieticians, social workers)	Cross-sectional, between subjects design; Survey designed for study (adapted 12-item version of the Illness Perceptions Questionnaire (Moss-Morris et al. 2002); 8-item long-term outcome; 3-item feelings about interaction)	Eating disorders	<ul style="list-style-type: none"> • Healthcare professionals were more stigmatising towards eating disorders than to other health problems (mental and physical). • Psychiatrists were most pessimistic about the long-term life prospects of people with eating disorders and projected poorer outcomes than counsellors/therapists. • On personal control, there was no significant difference between psychiatrists and GPs. • Professionals viewed eating disorders as chronic disorders but held optimistic beliefs regarding their controllability and treatability.
Mittal et al. (2014) USA	205 mental health providers (62 psychiatrists, 76 psychologists, 67 psychiatric nurses); 146 primary care providers (PCP) (91nurses and 55physicians))	Cross-sectional; Survey (Bogardus SDS; Characteristic scale; Attribution Questionnaire AQ-9)	Schizophrenia	<ul style="list-style-type: none"> • Mental health providers did not significantly differ in their stereotyping and attribution of mental health problems toward clients with and without schizophrenia. • PCPs and psychiatrists showed significantly more social distance toward the individual with schizophrenia than toward the individual without schizophrenia. The difference was not significant for primary care nurses, psychiatric nurses, or psychologists.

Study & Location	Sample	Design & Method	Type of problem studied	Key findings
Sun et al. (2014) Guangzhou, China	79 psychiatrists, 162 psychiatric nurses, 137 family members, 149 friends, social acquaintances and their families	Cross-sectional; Survey designed for study (Adapted version of Fear and Behavioural Intentions toward the mentally ill (FABI); Additional items from CAMI; Questions from a modified version of a questionnaire developed from the World Psychiatric Association Program on stigma and mental health problems)	Various mental health problems	<ul style="list-style-type: none"> • Both psychiatrists and psychiatric nurses showed greater support for community-based treatment and social integration than the public. • Psychiatrists and psychiatric nurses had more positive attitudes towards direct personal interactions and relationships with people with mental health problems than family members but no significant difference to the public. • No significant difference was found between psychiatrists, psychiatric nurses, public and family members regarding fear-free and positive view of specific interactions with people with mental health problems. • Psychiatrists and psychiatric nurses with knowledge of mental health problems tolerated less social distance with people with mental health problems.

3.2. Quality Appraisal of the Studies Reviewed

Table 4 outlines the studies' quality ratings. The primary methodological weaknesses of these publications concern sampling methods, sample size as well as biases. The samples used in many of these studies were not representative of their target populations as many employed convenience sampling. Response rates in many of these studies were low. Furthermore, the use of self-report methods such as questionnaires, surveys and interviews as means of collecting data in most studies could have given rise to social desirability biases, which may have skewed the results.

Of the 19 quantitative papers included in this review, six papers were rated as high quality, 12 papers as medium quality and one as low quality. These studies were conducted in various countries including UK (1), Ireland (2), Poland (1), multiple countries of Southern and Eastern Europe (1), the United States (4), Brazil (3), Australia (1), Israel (1), Japan (2), Taiwan (1), China (1) and Thailand (1).

Two researchers rated 10 of the papers. The degree of agreement between the two raters was assessed using Cohen's Kappa. As there was substantial agreement (Landis & Koch, 1977) between the two researchers' appraisal of the papers, $k = .61$, $p < .0005$, the remaining nine papers were rated solely by the main researcher.

Table 4

Quality Assessment Ratings of Studies included in the Review

Author (s) & Date	Methodological items								Overall assessment
	Aim of study Q1	Focus of study Q2	Method Q3	Population Q4	Bias Q5	Cohort study Q6	Tables & graphs Q7	Analysis Q8	
Avery et al. (2013)	+	+	+	-	-	N/A	+	+	+
Ben-Natan et al. (2015)	+	+	+	-	+	N/A	+	+	+
Gilchrist et al. (2011)	+	+	+	?	+	N/A	+	+	++
Hanzawa et al. (2012)	+	+	+	-	+	N/A	+	+	+
Hori et al. (2011)	+	+	+	-	?	N/A	+	+	+
Hoy and Holden (2014)	+	+	+	-	+	N/A	+	+	+
Hsiao et al. (2015)	+	+	+	?	+	N/A	+	+	++
Jones et al. (2009)	+	+	+	-	+	N/A	+	+	+
Jones et al. (2013)	+	+	+	?	?	N/A	?	+	+
Kopera et al. (2015)	+	+	+	-	?	N/A	?	+	+
Kusalaruk et al. (2015)	+	+	+	-	-	N/A	+	+	+
Lampe et al. (2013)	+	+	+	-	?	N/A	+	+	+
Linden and Kavanagh (2012)	+	+	+	?	+	N/A	+	+	+
Loch et al. (2011)	+	+	+	?	+	N/A	+	+	++
Loch et al. (2013a)	+	+	+	?	+	N/A	+	+	++
Loch et al. (2013b)	+	+	+	?	+	N/A	+	+	++
McNicholas et al. (2015)	+	+	+	-	+	N/A	+	+	++
Mittal et al. (2014)	+	+	+	-	+	N/A	+	+	+
Sun et al. (2014)	+	+	+	-	?	N/A	+	+	-

Note. Ratings: + (yes); - (no); ? (can't tell); Overall assessment: ++ (high quality); + (medium quality); - (low quality).

See Appendix A for the full checklist.

3.3. Main Results

The results of these 19 publications are summarised by profession.

3.3.1. Psychiatrists

Fourteen studies explored stigma among psychiatrists. Of these 14 publications, five were assessed as high quality (Gilchrist et al., 2011; Loch et al., 2011, 2013a, 2013b; McNicholas, O'Connor, O'Hara, & McNamara, 2015), one as low quality (Sun et al., 2014) and the remaining eight papers as medium quality. Five studies explored the attitudes of psychiatrists independent of other populations (Avery et al., 2013; Jones, Saeidi, Morgan, 2013; Kusalaruk, Saipanish, & Hiranyatheeb, 2015; Loch et al., 2011; 2013a) while the remaining compared their attitudes to that of others (i.e., healthcare professionals, family members of those with mental health problems and the general population).

Studies that looked solely at the attitudes of psychiatrists independent of other populations found mixed results. Studies conducted in Brazil (Loch et al., 2011) and the USA (Avery et al., 2013) found that psychiatrists had more negative stereotypes and perceived prejudice towards individuals with schizophrenia. These negative attitudes were also observed towards substance users and people with depression in the latter study. Despite an overall stigmatising attitude, Avery et al. (2013) found that the levels of stigma varied amongst psychiatrists. In their study, addiction psychiatrists had less stigmatising attitudes than community psychiatrists towards individuals with substance use, while the reverse was noted towards individuals with schizophrenia. It was also established that the attitudes of both addiction and community psychiatrists became more stigmatising when individuals had dual diagnoses. In line with findings from Avery et al. (2013), a later study (Loch et al., 2013a) that reanalysed the data from Loch et al. (2011) showed that the

level of stigma varied among psychiatrists. Some psychiatrists viewed people with schizophrenia positively, disagreed with restrictions and desired less social distance while the reverse was seen in others. Despite the large sample of 1414 psychiatrists in Loch et al.'s (2011) study, the representativeness of the study is questionable owing to its high attrition rate of 33.7% and utilisation of face-to-face interviews, which might have led to selection and social desirability biases. Similarly, findings from Avery et al.'s (2013) study may not be representative due to its low response rate of 12% and small sample size.

In contrast, more recently conducted studies suggested that psychiatrists had more positive attitudes (Jones et al., 2013; Kusalaruk et al., 2015). The majority of psychiatrists in these studies had more positive than negative views towards people with eating disorders and OCD respectively. They disagreed that eating disorders were “essentially untreatable” and “represented abnormal behaviour in the context of a weak, manipulative or inadequate personality”. In addition, their attitudes became less stigmatising with increased seniority and clinical experience. In the latter study conducted in Thailand, despite generally positive attitudes, psychiatrists concomitantly held some negative views (e.g., people with OCD wasted a lot of time, were difficult to treat (>80%), had poor compliance with behaviour therapy (>50%) and required more patience when compared to people experiencing other mental health problems) (Kusalaruk et al., 2015). Both studies had relatively low response rates of 38.3% and 50.7% and had used measures that were not validated, raising questions about their representativeness.

Similar to studies that exclusively explored the attitudes of psychiatrists, a combination of positive and negative attitudes was found in studies that investigated the attitudes of psychiatrists in relation to those of other population groups (i.e.,

mental health professionals, health professionals and general population). The attitudes of psychiatrists were measured by their desire for social distance, stereotypes, perceived prejudice, and attitudes about treatment efficacy, controllability and the long-term prospects of the mental health problem. Studies that explored attitudes towards people with schizophrenia (Jones, Vahia, Cohen, Hindi, & Nurhussein, 2009), depression (Lampe et al., 2013) and various mental health problems (Sun et al., 2014) found that psychiatrists had more favourable attitudes, while other studies had mixed results.

Mixed results were found in studies comparing the attitudes of psychiatrists and primary care providers towards people with schizophrenia. In an earlier study (Jones et al., 2009), no significant difference was found, with both groups displaying generally positive attitudes. A later study (Mittal et al., 2014) found that mental health providers (i.e., psychiatrists, psychologists and mental health nurses), unlike primary care providers, did not significantly differ in their stereotypical attitudes towards people with and without schizophrenia. Nevertheless, more social distance was desired from people with schizophrenia than from those without (Mittal et al., 2014). The findings from both studies may not be generalisable and representative of psychiatrists. Both studies had small samples of 27 and 62 psychiatrists respectively and those who had participated in Jones et al.'s (2009) study were recruited from one geographical area, while the participants in Mittal et al.'s (2014) study were providers working specifically in Veterans Affairs. Furthermore, Jones et al.'s (2009) study had a low response rate of 39% and conducted their survey via interviews, which might have potentially resulted in social desirability bias. Nonetheless, it is worth noting that Jones et al.'s (2009) study was adequately powered. Similar results of lower external stigma and underestimation of the abilities of people with

schizophrenia were found in a study that compared psychiatrists to the general population, physicians and other psychiatric staff (nurses, pharmacologists, community health workers) (Hori, Richards, Kawamoto, & Kunugi, 2011). Despite these generally positive attitudes, psychiatrists did not differ significantly in their desire for social distance and scepticism regarding treatment (Hori et al., 2011). Additionally, although it was shown in another study that they desired significantly lower social distance, they held more negative stereotypes and perceived prejudice than the general population in another study (Loch et al., 2013b). Both studies are problematic with regards to their generalisability. The sample sizes of the different populations in Hori et al.'s (2011) study were not similar, especially in relation to the small sample of 36 psychiatrists. Comparisons may therefore be unreliable. Loch et al.'s (2013b) study had a high attrition rate of 33.7% of psychiatrists, with potential selection and social desirability biases.

Studies that explored the attitudes of psychiatrists, other psychiatric staff, medical staff (students and physicians), family members and the general population, towards people with various mental health problems, established that psychiatrists desired lower social distance (Kopera et al., 2015; Sun et al., 2014). They had more compassion, interest, sadness and acceptance of people with mental health problems, were more willing to have direct personal relationships and showed greater support for social integration and held less restrictive attitudes and discriminatory tendencies. A study that compared the attitudes of psychiatrists to that of GPs (Lampe et al., 2013) found that psychiatrists derived more satisfaction working with people with depression and also believed more than GPs in the treatability of depression. All three studies employed convenience sampling and had small samples of psychiatrists. Furthermore, it was noted that the mental health professionals and

medical students in Kopera et al.'s (2015) study were not demographically matched, while the sample sizes of the different populations in Sun et al.'s (2014) study were not similar, especially in relation to the small sample of 79 psychiatrists. This might have made comparisons unreliable.

The above studies demonstrated the explicit attitudes of psychiatrists. Despite the positive explicit attitudes found in Kopera et al.'s (2015) study, it was established that psychiatrists held contradictory negative implicit attitudes towards people with mental health problems. Furthermore, studies that explored the views on substance users (alcohol and drugs) (Gilchrist et al., 2011) and eating disorders (McNicholas et al., 2015) found that psychiatrists had significantly more negative views than other health professionals. Psychiatrists had lesser interest in working with and lower belief in the treatability of substance users than psychologists and in general, lesser interest in working with substance users as compared to working with people with depression. They were also found to be significantly more cynical than counsellors and therapists about the long-term outcomes of people with eating disorders. Similar to the studies above, findings from both studies may not be generalisable and representative of psychiatrists compared to other health professionals (including mental health professionals). Different sampling methods used for different entry points and difficulties with recruitment across all countries in Gilchrist et al.'s (2011) study resulted in an unbalanced study design. Moreover, small sample sizes may have affected statistical power and the reliability of interactions. Likewise, McNicholas et al.'s (2015) statistical power was compromised by their small sample size and low response rate of 9%.

3.3.2. *Psychiatric Nurses*

Six studies (Ben-Natan, Drori, & Hochman, 2015; Hanzawa et al., 2012; Hsiao, Lu, & Tsai, 2015; Linden & Kavanagh, 2011; Mittal et al., 2014; Sun et al., 2014) explored the attitudes of psychiatric nurses. Of these six publications, one was assessed as high quality (Hsiao et al., 2015), one as low quality (Sun et al., 2014) and four as medium quality. Of the six studies, two explored the attitudes of psychiatric nurses independent of other populations (Hanzawa et al., 2012; Hsiao et al., 2015) while the remainder compared them to other healthcare professionals, the family members of those with mental health problems and the general population. Studies that looked at the independent attitudes of psychiatric nurses found that they had stigmatising attitudes.

A study conducted in Japan (Hanzawa et al., 2012) found that psychiatric nurses had very negative views regarding community living of people with schizophrenia. They believed that it was better for them to be hospitalized as opposed to being treated as outpatients. This was related to their beliefs that doing so would protect them from experiencing discrimination and would reduce the “burden” on their families. Likewise, a recent study conducted in Taiwan (Hsiao et al., 2015) highlighted the existence of stigma among psychiatric nurses. They were most negative about people with substance abuse, followed by people with major depression and schizophrenia. Findings from both studies may not be wholly representative as they had employed convenience sampling. Nevertheless, it was noted that Hsiao et al.’s (2015) study was sufficiently powered.

Contrary to the above two studies, other studies that compared the attitudes of psychiatric nurses to other healthcare professionals showed a combination of negative and positive attitudes. In a study conducted in Ireland (Linden & Kavanagh,

2012), no significant difference was found between the attitudes of student nurses and qualified psychiatric nurses towards people with schizophrenia. However, the attitudes of qualified psychiatric nurses differed by work settings. Those who worked in community settings held more positive attitudes, were more willing to socially interact with and had less socially restrictive attitudes compared to those who worked in inpatient settings. The latter felt that people with schizophrenia were dangerous and should not be given responsibility. This study was not representative of psychiatric nurses in Ireland as nurses were recruited from only one out of 26 Irish counties. Moreover, convenience sampling and self-report could have resulted in selection and social desirability biases, further limiting the generalisability of findings.

More recent studies by Mittal et al. (2014), Sun et al. (2014) and Ben-Natan et al. (2015) highlighted more positive attitudes among psychiatric nurses. Mittal et al. (2014) found that although psychiatric nurses desired significantly more social distance from clients with schizophrenia compared to those without mental health problems, there were no significant differences in their stereotyping of these two groups. A study conducted in China (Sun et al., 2014) found positive attitudes in mental health professionals, with psychiatric nurses showing greater support for community-based treatment and social integration and more positive and fear-free attitudes towards having personal interaction and relationships with people with mental health problems than family members, although their attitudes were not significantly different to those of the general public. It was also shown that increased knowledge of mental health problems resulted in less social distance and more positive attitudes towards personal interaction with people with mental health problems. When compared to non-psychiatric nurses, psychiatric nurses expressed

less stigma and more positive attitudes (Ben-Natan et al., 2015). All three studies employed convenience sampling. As such, findings may not be generalisable and representative of psychiatric nurses. The small sample of 67 psychiatric nurses in Mittal et al.'s (2014) study coupled with the fact that they worked specifically in Veterans Affairs, limits the generalisability of findings. The survey used in Sun et al.'s (2014) study was not validated and thus further limits the representativeness of their findings.

3.3.3. Psychologists

Three studies included psychologists in their sample. However, only two explored their attitudes towards people with mental health problems. One of these (Gilchrist et al., 2011) was rated as high quality and the other as medium quality (Mittal et al., 2014). These studies found that psychologists held both positive and negative attitudes. Psychologists in Gilchrist et al.'s (2011) study showed more interest in working with and higher belief in the treatability of substance users than physicians, psychiatrists and nurses, but did not significantly differ from social workers. They had more interest in working with people with depression than for substance users. No significant difference was found in psychologists' attitudes (stereotyping, attribution of mental health problems and social distance) towards people with and without schizophrenia (Mittal et al., 2014). Findings from both studies may not be representative of psychologists' attitudes towards people with mental health problems. The study design used in Gilchrist et al.'s (2011) study was unbalanced owing to difficulties with recruitment across all countries and different sampling methods used for different entry points. This reduced the reliability of interactions. Moreover, small sample sizes may have affected statistical power. Similarly, the small sample of 76 psychologists in Mittal et al.'s (2014) study,

coupled with the fact that they worked specifically in Veterans Affairs, limits the finding's generalisability.

3.3.4. Psychotherapists

Only one study rated as medium quality (Kopera et al., 2015) explored the attitudes of psychotherapists. This study compared the attitudes of psychiatrists and psychotherapists with at least two years of contact with people with mental health problems to those of medical students with no previous contact. It was found that despite having more positive explicit attitudes (significantly more compassion, interest, sadness, acceptance and lesser discrimination and restrictive attitudes) than medical students, psychotherapists simultaneously held negative implicit attitudes. Mental health professionals and medical students in Kopera et al.'s (2015) study were not demographically matched. This taken together with their small sample size of psychotherapists makes it difficult for a reliable comparison and limits the representative of their findings.

3.3.5. Counsellors

Two studies explored the attitudes of counsellors. One of these (Hoy & Holden, 2014) was rated as medium quality, and the other as high quality (McNicholas et al., 2015).

The former study investigated the attitudes of licensed professional counsellors (LPCs) towards people with schizophrenia. It found that the majority of LPCs held positive attitudes (e.g., low fear and low to moderate stigmatising attitudes) towards them. They believed in the recovery prospects of people with schizophrenia and had moderate to high interest in providing therapy to them. Although adequately powered, the low response rate of 11.1%, potential social

desirability bias, different state licenses and lack of geographical diversity limit the generalisability and representativeness of the study's findings.

In the latter study (McNicholas et al., 2015), counsellors and therapists were significantly more optimistic than psychiatrists with regard to the long-term outcomes of people with eating disorders. However, the statistical power and generalisability and representativeness of findings were compromised and limited by their small sample of 60 counsellors/therapists and low response rate of 9%.

3.4. Factors that May Influence Stigma

From the above-mentioned studies, it was established that certain factors influenced stigma among mental health professionals. These included personal characteristics and traits, work environment (work settings and demands), training in and knowledge of mental health problems, clinical experience, contact with people with mental health problems, and the type of mental health problem.

Personal characteristics and traits. Gender and age were found to have significantly influenced the attitudes of psychiatrists towards people with schizophrenia (Loch et al., 2011, 2013b) but not towards people with OCD (Kusalaruk et al., 2015). Female and/or older psychiatrists desired less social distance from people with schizophrenia, while male and/or older psychiatrists had less perceived prejudice and fewer negative stereotypes (Loch et al., 2011, 2013b). Similarly, age was found to significantly influence the attitudes of psychiatric nurses towards people with substance use, schizophrenia and major depression (Hsiao et al., 2015). Older age resulted in more positive attitudes (Hsiao et al., 2015), less social distance (Loch et al., 2011), fewer stereotypes and perceived prejudice (Loch et al., 2013b). Finally, extraversion in psychiatrists was associated with increased

satisfaction in treating people with depression and belief in the treatability of depression (Lampe et al., 2013).

Work environment. Where work settings and demands were concerned, both psychiatrists (Kusalaruk et al., 2015; Loch et al., 2011) and psychiatric nurses (Hsiao et al., 2015; Linden & Kavanagh, 2011) working in acute psychiatric units, general provincial hospitals and inpatient settings, had more negative attitudes than those working in medical university hospitals, outpatient settings and community settings. A reduced workload resulted in more positive attitudes (Kusalaruk et al., 2015).

Training and knowledge. More mental health training improved psychologists' understanding of, interest in working with and belief in the treatability of substance users (Gilchrist et al., 2011), while better knowledge of mental health problems in psychiatrists and psychiatric nurses resulted in less social distance from people with mental health problems (Sun et al., 2014). In the study conducted by Loch et al. (2013b), better recognition of mental health problems increased perceived prejudice of psychiatrists towards people with schizophrenia.

Seniority, clinical experience and contact. In line with the influence of training, increased seniority and clinical experience in mental health, and contact with people with mental health problems were also associated with decreased social distance and an increase in positive attitudes in psychiatric nurses (Ben-Natan et al., 2015; Hsiao et al., 2015, Linden & Kavanagh, 2011), psychiatrists (Jones et al., 2013; Kusalaruk et al., 2015) and LPCs (Hoy & Holden, 2014). Increased contact between LPCs and people with schizophrenia increased LPCs' beliefs in the latter's recovery and their interest in providing them with therapy. Similarly, increased experience as psychiatrists and increased proficiency in Exposure Response Prevention brought about increased confidence in treating people with OCD, which

in turn increased psychiatrists' positive attitudes and reduced their feelings of annoyance towards people with OCD. Another study found a lack of significant difference between the explicit attitudes of psychiatrists and psychotherapists with at least two years of professional contact with people with mental health problems, and those of medical students with no previous contact (Kopera et al., 2015). The findings from Kopera et al.'s (2015) study might have been affected by the study's small sample size and the lack of demographical match between mental health professionals and medical students.

Type of mental health problem. Psychologists had more interest in working with and higher belief in the treatability of people with depression than substance users (Gilchrist et al., 2011), while there was some indication that psychiatric nurses demonstrated more stigmatising attitudes towards eating disorders compared to other mental health problems (McNicholas et al., 2015) and towards substance abuse and schizophrenia compared to depression (Hsiao et al., 2015).

4. Limitations of the Studies

A minority of the studies in this review used random sampling. Most of the studies employed convenience sampling, which might have introduced selection and non-response biases, which, when coupled with small sample sizes may limit the generalisability of the findings. Of the 19 studies reviewed, only nine had reported their response rates. Three studies had achieved response rates above 70%, while the other six achieved response rates that were lower than optimal (9-50.7%). These low response rates may further compromise the representativeness of the sample and generalisability of the findings. Moreover, it was noted that only three out of the four studies that made reference to statistical power, met statistical power. As many of the studies were self-report, their results are likely to be affected by social desirability

biases. In addition, some studies did not assess the validity or reliability of the measures used. For further details about limitations of the individual studies, please refer to [Table 5](#).

Table 5*Limitations of Studies included in the Review.*

Study	Study Limitations
Avery et al. (2013)	<ul style="list-style-type: none"> • Low response rate of 12% and non-response bias • Degree to which psychiatrists were trained in each specialty was not assessed • Sample representativeness is questionable
Ben-Natan et al. (2015)	<ul style="list-style-type: none"> • Potential social desirability bias and convenience sampling may limit the generalisability of the findings
Gilchrist et al. (2011)	<ul style="list-style-type: none"> • Convenience sampling potentially limits generalisability of the findings and increases the potential selection bias • Different sampling methods was used for the different entry points, thus affecting the comparability of results • Difficulties with recruiting a multidisciplinary sample across all countries, resulted in an unbalanced study design and small sample sizes which could have affected statistical power and the reliability of interactions • MCRS was not validated for this study's sample
Hanzawa et al. (2012)	<ul style="list-style-type: none"> • Sample and target population might not be representative of the general population due to convenience sampling • Cross-sectional • Lack of suitable comparison group
Hori et al. (2011)	<ul style="list-style-type: none"> • Web-based method of data collection might have led to a sampling bias • Participants had internet access which meant that they might have had more information about schizophrenia than average and this could have affected their attitudes • Some participants might have provided false or misleading information • Sample sizes of the different populations were not similar, especially in relation to psychiatrists, therefore comparisons might not have been reliable • Gender distribution was not balanced in the four participant groups • Response format (binary-scaled) does not allow for "in between" answers and may be susceptible to floor and ceiling effects
Hoy and Holden (2014)	<ul style="list-style-type: none"> • Low response rate of 11.1% limits generalisability of results • Potential social desirability bias • LPCs who took part may have had more interest or experience with schizophrenia, thus possibly positively skewing the results • Sample may not be representative and generalisable due to different state licenses and lack of geographic diversity
Hsiao et al. (2015)	<ul style="list-style-type: none"> • Participants were not randomly selected and majority of sample was female
Jones et al. (2009)	<ul style="list-style-type: none"> • Measures may not be valid • Convenience sampling from one geographical area as well as small sample might have potentially resulted in sampling biases. This may limit the generalisability of findings. Possibility of interviewer, recall and social desirability biases due to administration by an interviewer and self-report

Study	Study Limitations
Jones et al. (2013)	<ul style="list-style-type: none"> • Relatively low response rate of 38.3% • Questionnaire used in this study was not validated
Kopera et al. (2015)	<ul style="list-style-type: none"> • Small sample size • Mental health professionals and medical students were not demographically matched • Convenience sampling could have resulted in sampling biases and affected sample representativeness and generalisability of findings
Kusalaruk et al. (2015)	<ul style="list-style-type: none"> • Convenience sampling could have affected sample representativeness and generalisability of findings • The questionnaire was not standardised nor validated
Lampe et. al. (2013)	<ul style="list-style-type: none"> • Small sample size and convenience sample • GPs who participated may have had a greater interest in mental health issues, thus skewing the results and limiting sample representativeness • Case studies which are not wholly representative of actual situations and practice were used.
Linden and Kavanagh (2012)	<ul style="list-style-type: none"> • Convenience sampling and self-report could have resulted in potential social desirability bias, hence limiting generalisability of results
Loch et al. (2011)	<ul style="list-style-type: none"> • Convenience sampling and self-report/ face-to-face interviews could have resulted in selection bias and social desirability bias, thus limiting sample representativeness and generalisability of results
Loch et al. (2013a)	<ul style="list-style-type: none"> • Convenience sampling and self-report/ face-to-face interviews could have resulted in selection bias and social desirability bias, thus limiting sample representativeness and generalisability of results • Attrition rate (37.5%) was high
Loch et al. (2013b)	<ul style="list-style-type: none"> • Convenience sampling and self-report/ face-to-face interviews could have resulted in selection bias and social desirability bias, thus limiting sample representativeness and generalisability of results • Attrition rate (37.5%) was high
McNicholas et al. (2015)	<ul style="list-style-type: none"> • Low response rate (9%) may have introduced non-responder bias, thus limiting generalisability • Small sample size compromised the statistical power of the analysis • Vignettes were used and results might thus reflect the specific features of the mental health problem in the vignette, rather than a more generalisable representation of the mental health problem
Mittal et al. (2014)	<ul style="list-style-type: none"> • Specific to providers working in Veterans Affairs and may not generalise to providers working in other settings
Sun et al. (2014)	<ul style="list-style-type: none"> • Convenience sample • Response format (binary-scaled) does not allow for "in between" answers and may be susceptible to floor and ceiling effects • Survey was not validated

5. Discussion

5.1. Summary of Findings

This review summarised the key findings from research published over the past seven years regarding the attitudes of mental health professionals and in so doing, the extent to which they stigmatise. It has also explored attitudinal differences among different mental health professions, and factors that may influence stigma. All of the studies included in this review were quantitative and cross-sectional in design. They employed self-report methods such as questionnaires, surveys and face-to-face interviews, to gather relevant data about the explicit attitudes of mental health professionals. Only one study (Kopera et al., 2015) looked into the implicit attitudes of psychiatrists and psychotherapists.

Studies that explored the attitudes of psychiatrists and psychiatric nurses in comparison to other population groups and the attitudes of psychiatrists alone revealed a combination of positive and stigmatising attitudes. Studies that explored the attitudes of psychiatric nurses independent of other population groups found that psychiatric nurses held stigmatising attitudes.

Where the attitudes of only psychiatrists are concerned, studies conducted more recently in Thailand (Kusalaruk et al., 2015) and the UK (Jones et al., 2013) revealed more positive attitudes towards people with OCD and eating disorders than those conducted earlier in Brazil (Loch et al., 2011) and the USA (Avery et al, 2013) towards people with schizophrenia, substance use and depression. This improvement in attitudes might have been an outcome of more recent intense efforts to challenge stigma, or conversely may simply reflect difference in levels of stigma between these countries. Furthermore, the fact that these studies utilised different measures and explored responses to different types of mental health problems make comparisons

more difficult. In addition, it is likely that the varying attitudes of psychiatrists across the different studies result from cultural variations and beliefs, different types of education and training.

Comparison of the attitudes of psychiatrists to other populations including health professionals (i.e. primary care providers, physicians, psychiatric nurses, pharmacologists, community health workers), medical students, family members and the general population, revealed that psychiatrists on the whole had more positive explicit attitudes towards people with schizophrenia, depression and various mental health problems. This was seen across countries including the USA, Australia, China, Japan, Poland and Brazil and may suggest that more clinical experience, better knowledge in mental health and contact with people with mental health problems may improve attitudes towards people with mental health problems.

Nonetheless, it is important to acknowledge that the study conducted in Poland found that psychiatrists concurrently held positive explicit attitudes and negative implicit attitudes towards people with various mental health problems (Kopera et al., 2015). These implicit attitudes were not modified by long-term contact with people with mental health problems. This difference in explicit and implicit attitudes suggests that while psychiatrists report favourable views of people with various mental health problems, they may still experience unconscious negative attitudes. Furthermore, in spite of the overall positive attitudes, studies that explored attitudes towards substance users and people with eating disorders revealed that psychiatrists had more negative attitudes than other mental health professionals (i.e. psychologists, counsellors and therapists) (Gilchrist et al., 2011; McNicholas et al., 2015).

Studies that looked solely at the attitudes of psychiatric nurses revealed that psychiatric nurses in Japan and Taiwan had stigmatising attitudes towards people with schizophrenia, major depression and substance use (Hanzawa et al., 2012; Hsiao et al., 2015). These studies support evidence of high levels of stigma in Asian countries (Gervais & Jovchelovitch, 1998; Lin, 1981; Tien, 1985) and shed light on the potential influence of culture on attitudes towards mental health. The literature on culture and mental health problems suggests that beliefs about the origins and nature of mental health problems shape attitudes towards people with mental health problems (Nieuwsma, Pepper, Maack, & Birgenheir, 2011). Mental health problems in Asian culture are often perceived to be the consequence of a lack of emotional control and/or character and personality flaws, rather than a real illness (Gervais & Jovchelovitch, 1998; Lin, 1981; Tien, 1985). As such, blame is situated in the individual, with mental health problems being heavily stigmatised and generating much shame in the individuals and their family members (Angermeyer, Schulze, & Dietrich, 2003; Goffman, 1963; Schulze, 2007; Verhaeghe & Bracke, 2012). In contrast, Western cultures are more likely to attribute mental health problems to biological factors outside of the person's influence and control, thereby resulting in less stigma towards the person with mental health problems.

Studies that compared the attitudes of psychiatric nurses to other populations found that their disposition towards people with schizophrenia were not different to those of student nurses, suggesting that more exposure to the aforementioned people may not improve attitudes. In fact, community psychiatric nurses had more positive attitudes than those working in inpatient settings, which might suggest that increased contact may bring about more negative attitudes. More recent studies revealed that psychiatric nurses had more positive attitudes than family

members towards people with various mental health problems. This improvement in attitudes, like that of psychiatrists, may similarly be attributed to recent intense anti-stigma efforts.

Similar to psychiatrists and psychiatric nurses, studies conducted with psychologists and psychotherapists demonstrated that they held both positive and stigmatising attitudes. Psychologists did not discriminate between people with or without schizophrenia, although their interest in working with and belief in the treatability of substance users was lower than that for people with depression. They had more interest in working with and higher belief in the treatability of substance users than physicians, nurses and psychiatrists. The different attitudes that psychologists had towards substance users and people with depression may contribute to existing research that has found different levels of stigma attached to various mental health problems (Angermeyer & Matschinger, 2003; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Griffiths et al., 2006; Marie & Miles, 2008). In relation to psychotherapists, it was shown that while they had significantly more positive explicit attitudes than medical students with no previous contact with people with mental health problems, they simultaneously held negative implicit attitudes. This finding suggests that knowledge of mental health problems and contact with people with mental health problems did not modify the implicit attitudes that psychotherapists held and that, similar to psychiatrists, they may still experience unconscious negative biases towards people with various mental health problems despite reporting favourable explicit views.

This finding of concurrent positive explicit and negative implicit attitudes in psychiatrists and psychotherapists is substantial on a few accounts. Firstly, it shows that knowledge of mental health problems and contact with people with

various mental health problems did not improve implicit attitudes, thereby demonstrating the persistence of implicit attitudes and highlighting how deeply entrenched stigma may be. Secondly, numerous studies have shown that implicit attitudes, more so than explicit attitudes, have a direct effect on behavioural predispositions (Chen & Bargh, 1999; Devos, 2008; Bessenoff & Sherman, 2000; McConnell & Leibold, 2001), suggesting the need for future research in this area as findings of positive explicit attitudes may not necessarily translate to favourable behaviours.

Contrary to the mixed attitudes seen in the aforementioned mental health professionals, the two studies that explored the attitudes of counsellors and therapists revealed more positive attitudes. Majority of counsellors held positive attitudes towards people with schizophrenia. They had low to moderate stigmatising attitudes, moderate to high interest in treating them and strong beliefs in their recovery. In addition, another study showed that counsellors and therapists were significantly more optimistic than psychiatrists with regard to the long-term outcomes of people with eating disorders. Both studies had low response rates and their findings are unlikely to be representative of counsellors and therapists in general. Consequently, it is recommended that more studies be conducted on the attitudes of counsellors and therapists towards people with mental health problems before firm conclusions are made.

The studies reviewed provided insight into the attitudes of mental health professionals independent of and in comparison to other groups of population. They also highlighted attitudes within individual mental health professional groups. On the whole, it was established that there were different levels of stigma among and within

the mental health professional groups and they varied according to the type of mental health problem.

In addition to providing a richer understanding into the attitudes of mental health professionals, the studies provided information on factors that may influence stigma. Aside from the type of professional group and mental health problem, other factors include certain personal characteristics (i.e. gender, age and extraversion), working environment, training and number of years of clinical experience in mental health care, and contact with people with mental health problems.

5.2. Limitations of the Review

The selection criteria of this review prevented the inclusion of studies that were not published in peer-reviewed journals, not written in English, and/or did not present separate analyses of findings pertaining to mental health professionals. Additionally, while relevant references and publications that cited the articles of interest were included in this review, there might have been other articles that were missed. These include references of and articles that cited publications (from the initial database search) that were excluded following thorough assessment against the inclusion and exclusion criteria.

It is significant to note that all studies solely explored explicit attitudes with the exception of Kopera et al. (2015), who also measured implicit attitudes. Consequently, although this review gives us insight into the current attitudes of mental health professionals towards people with mental health problems, it is unknown whether these attitudes translate into corresponding behaviours.

Another significant limitation relates to the level of education and mental health knowledge among these different professions. As the studies included in this

review were conducted in various countries, what in one country qualifies as a ‘mental health professional’ might not be recognized as such in a different country.

Owing to the variability in beliefs between different cultures and countries about people with mental health problems (Angermeyer & Dietrich, 2006; Chambers et al., 2010; Corrigan & Watson, 2007; Hansson, Jormfeldt, Svedberg, & Svensson, 2013), and previously mentioned limitations, conclusions drawn by this review may not be wholly representative and generalisable. Nevertheless, while it is important to consider these limitations, it should be acknowledged that this review allows for a deeper understanding of the current explicit attitudes of specific groups of mental health professionals and factors that may influence their attitudes. It also provides a helpful starting point from which further critical analyses may be conducted.

6. Conclusions and Recommendations for Future Research

Stigma is not only prevalent in the general population but also in mental health professionals, the very people who provide mental health treatment and are likely to be in the forefront of anti-stigma campaigns. This review provides an overview of stigma and its varying levels among and within mental health professionals, as well as the factors that may influence stigma among mental health professionals.

Although the findings suggest that mental health professionals still possess stigmatising attitudes, they also express positive attitudes. In comparison to earlier studies, research conducted in recent years has revealed that psychiatrists hold more positive attitudes. Results for psychiatric nurses are mixed, while attitudes seen in other mental health professionals (i.e., psychologists, psychotherapists, counsellors and therapists) are generally positive.

It is noteworthy that stigmatising attitudes vary in magnitude between the

different mental health professional groups, as well as within each respective group and are influenced by the type of mental health problem as well as other factors including personal characteristics, work environment, training and number of years of clinical experience in mental health care, as well as contact with people with mental health problems.

Research in this area is important given the potential consequences of stigma among mental health professionals on those experiencing mental health problems. The focus of most of the studies reviewed has been on explicit attitudes. There appears to be a lack of research on implicit attitudes, studies that explore whether self-reported attitudes actually translate into corresponding behaviours, and the actual behaviours of mental health professionals, all of which require further exploration. Furthermore, most research appears to be on psychiatrists and psychiatric nurses. Further research should investigate other mental health professionals, namely psychologists, psychotherapists, counsellors and therapists.

To counteract the methodological limitations of these studies and allow for greater generalisability of findings, it is recommended that future research employ validated attitudinal measures. Furthermore, varying levels of education, training and cultural beliefs across countries may influence the attitudes of mental health professionals towards mental health problems and impinge on the comparability of findings across countries. It is therefore recommended that more studies be carried out within each country in order to allow for comparability of findings within each respective country, rather than across countries. Lastly, it may be helpful for studies to be longitudinal, so as to verify factors that influence stigma among mental health

professionals and to allow for action to be taken towards improving their attitudes, and ultimately enhancing the wellbeing of people with mental health problems.

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Part 2: Empirical Paper

**Lived experience of Mental Health Problems among Clinical Psychologists,
Stigma and its Impact on Disclosure and Help-seeking**

Abstract

Background: Mental health stigma has received much attention in terms of research, policy and action. However, little is known about lived experience among clinical psychologists, and to what extent stigma is a concern.

Objective: This study set out to assess the extent of lived experience of mental health problems among clinical psychologists, and their perceptions related to stigma, disclosure and help-seeking.

Method: A national survey of clinical psychologists was conducted in collaboration with the Division of Clinical Psychology. Detailed responses from the 678 UK-based clinical psychologists were collected through an anonymous web survey.

Results: Two-thirds of participants reported having experienced a significant mental health problem at some point in their lives. This study found a high level of perceived stigma and low levels of external and self-stigma among participants. All aspects of stigma and factors closely related to stigma were negatively associated with disclosure and help-seeking for mental health problems. The level of stigma attached to mental health problems, however, did not influence participants' disclosure and previous help-seeking rates, although it was negatively associated with the willingness to seek help for future mental health problems. Participants preferred to disclose in their social circles than in their work settings, and reported more positive experiences of disclosing to the former.

Conclusions: This study established the extent to which stigma was of concern among clinical psychologists and identified the need for addressing the difficulties they faced in relation to disclosing and help-seeking for mental health problems. Further research exploring the positive aspects of lived experience of mental health

problems and the extent of implicit stigma and discriminatory behaviours among clinical psychologists is indicated and will be beneficial.

1. Introduction

Results from the latest Health Survey for England indicated that 26% of British adults have been diagnosed with at least one mental health problem (Bridges, 2014). An earlier household survey indicated that 7.2% of British adults had two or more diagnosable mental health problems (McManus, Melzer, Brugha, Bebbington, & Jenkins, 2009).

Although mental health problems experienced by the general population have been studied extensively, few studies have looked specifically at such difficulties experienced by clinical psychologists. The limited literature could indicate a wish to portray clinical psychologists as being less vulnerable to mental health problems than the general population. This may be compounded by the emphasis that is placed during clinical training on the fortitude of a clinical psychologist to manage the challenges of treating people with mental health problems, and an implicit belief that one must be “mentally healthy” in order to practice as a clinical psychologist (Davidson & Patel, 2009; Skorina, 1982). Nonetheless, despite limited literature, clinical psychologists too are vulnerable to stress and mental health problems. In addition to the stressors from daily living and work, they also experience specific occupational vulnerabilities (Cushway & Tyler, 1994, 1996). These include the isolated nature of the profession, demands of clinical and professional responsibilities, the confidential and nonreciprocal nature of the therapeutic relationship, stressors related to working with people in distress (e.g., repeated exposure to emotionally intense material and the need to contain their emotional response), and other role characteristics which may increase the likelihood of burnout (e.g., limited control over outcomes and the changing climate of the National Health Service (NHS), high level of involvement) (Smith & Moss, 2009).

1.1. Distress and Mental Health Problems in Applied Psychologists

It has been suggested that mental health professions attract people who have suffered in one way or another (i.e., directly and/or indirectly through caring for others who experienced mental health problems), and that clinical psychologists go into the field to better understand themselves and manage their own mental health problems (Bowlby, 1977; Huynh & Rhodes, 2011; Murphy & Halgin, 1995; Sussman, 2007; Tillet, 2003). Furthermore, Malan's 'helping profession syndrome' suggests that the caregiving nature of clinical psychologists might engender a tendency to focus on the needs of others while neglecting one's own (American Psychological Association [APA], 2000; Malan, 1979). An early study by Steppacher and Mausner (1973) found that the rate of suicide in female psychologists was nearly triple that of the general population, while research conducted by Guy, Poelstra, and Stark (1989) found that 74.3% of psychologists had experienced personal distress in the past three years. Of these psychologists, 3.1% reported that a mental health problem was the cause of their distress. Another study found that 84% of psychologists were in therapy (87% voluntarily and 13% required by their graduate program) and that 61% of those in therapy had experienced at least one episode of clinical depression, 29% had felt suicidal and 4% had attempted suicide (Pope & Tabachnick, 1994) at some point in their lives. More recently, the results from an APA Colleague Assistance and Wellness Survey (2009) suggested that psychologists had experienced disruptions to their professional functioning due to an overly challenging work-life balance (72%), worries about client safety (63%), burnout or compassion fatigue (59%), anxiety (51%) and professional isolation (46%). Where suicide was concerned, 18% had experienced suicidal thoughts while dealing with both personal and professional stressors, and almost half (43%) of these had not

disclosed or sought help for their suicidal ideations (APA, 2010). The rate of suicidal thoughts in psychologists was nearly five times higher than that of the adult (≥ 18 years) general population of the United States, with 3.7% of them having reported suicidal thoughts between 2008 and 2009 (Crosby, Han, Ortega, Parks, & Gfroerer, 2011).

In the UK, research conducted by Cushway and Tyler (1994) revealed that 75% of clinical psychologists were moderately to severely stressed and 29.4% had experienced a mental health problem. In the last year, the British Psychological Society (BPS) and New Savoy Partnership provided further evidence of the continuing and increasing levels of distress among psychological professionals (i.e., psychological therapies staff, managers and leaders) working for the NHS. Of those surveyed, 46% reported depression and 70% stated that their jobs were stressful, a 12% increase in reported work stress over the past year. The survey also revealed that incidents of bullying and harassment had more than doubled. Nonetheless, it is worth exercising caution when considering the findings of depression, as depression was defined according to the amount of time in the past week that one had felt depressed. Frequent service redesigns and increasing pressure to meet service targets and outcomes were identified as themes related to the high levels of stress and burnout, lower levels of morale, and mental health problems in clinical psychologists (Cushway & Tyler, 1994; Rao et al., 2016).

By downplaying or ignoring signs of mental health problems and/or distress, thereby circumventing appropriate help seeking, the distress might be intensified and lead to damaging consequences, affecting not only the clinical psychologist, but also his/her clients and the profession (APA, 2000, 2010; Smith & Moss, 2009). Damage to the clinical psychologist might include the exacerbation of pre-existing or

development of new mental health problems (e.g., depression, anxiety, and maladaptive coping through substance abuse, self-harm and suicide), which could subsequently result in professional impairment where the clinical psychologist's ability to function and provide quality care is compromised. In a study by Pope, Tabachnick, and Keith-Spiegel (1987), 59.6% of psychologists reported having worked despite being too distressed to be helpful, while 36.7% indicated that the quality of care they provided was affected by their distress. In the study by Guy et al. (1989), 4.6% of psychologists said that the treatment they provided was inadequate.

It is critical that clinical psychologists maintain standards of proficiency and fitness to practice in order to provide satisfactory care to their clients (Health Professions Council, 2015). This requires them to recognise and acknowledge signs of stress in a timely manner, and take necessary actions to manage their own mental health. However, the role of clinical psychologists as helpers might make it difficult for them to accept their occasional need for help and, even when acknowledged, clinical psychologists may feel apprehensive about crossing over and adopting the role of a client. Furthermore, research has highlighted the existence of various barriers to disclosure and help-seeking for mental health problems in the general population, with mental health stigma (hereafter referred to as stigma) being one of the most significant and frequently reported barrier (Barney, Griffiths, Jorm, & Christensen, 2006; Clement et al., 2015; Henderson, Evans-Lacko, & Thornicroft, 2013).

1.2. Stigma

Nearly nine out of ten people with mental health problems experience stigma and discrimination (Time to Change, 2008). For many years, mental health problems have been shrouded in shame and secrecy as a result of the attached stigma and

discrimination (Horsfall, Cleary, & Hunt, 2010). Although ambiguous and highly variable, the general understanding of stigma is of it being a process of cognitively marking an individual as possessing a negative characteristic so degrading and discrediting that it consumes the views of others and sets the individual apart (Goffman 1963; Link & Phelan, 2001).

Stigma is multifaceted and three distinct dimensions include: external stigma, perceived stigma and self-stigma. External stigma is characterised by prejudice and discrimination towards people with mental health problems as a result of the psychiatric label they have been given (Link & Phelan, 2001). Perceived stigma, on the other hand, is characterised by one's beliefs that society/others hold negative stereotypes about mental health problems (Barney et al., 2006). Lastly, self-stigma occurs when the person with mental health problem(s) internalises the negative stereotypes held by society and similarly adopts negative attitudes about him/herself (Corrigan & Watson, 2002).

Most research conducted on mental health stigma assessed stigma through attitude surveys (Schulze, 2007; Wahl & Aroesty-Cohen, 2010), with few studies exploring stigmatising behaviours, i.e. discrimination. Significantly, even when studies focused on attitudes, the emphasis has been on exploring explicit rather than implicit attitudes, the latter of which are known to be better predictors of corresponding behaviours (Devos, 2008).

Research has shown that the level of stigma can vary according to its dimension. Psychiatrists who had more training and clinical experience in mental health care, and therefore more in-depth and accurate knowledge of mental health problems, were shown to have less desire to distance themselves from people with mental health problems and a higher belief that others would have prejudiced

attitudes towards these people with mental health problems. This was in comparison to members of the general population (Loch et al., 2013b). These findings suggest that the psychiatrists in Loch et al.'s (2013b) study had lower external stigma and higher perceived stigma when compared to the general population.

1.2.1. Stigma and Different Types of Mental Health Problems

Some mental health problems appear to be more stigmatised than others (Avery et al., 2013; Gilchrist et al., 2011; Hsiao, Lu, & Tsai, 2015). Research has identified various constructs that could either independently or concurrently contribute to the level of stigma attributed to different types of mental health problems (Feldman & Crandall, 2007; Jones et al., 1984). These constructs include concealability (detectability and visibility of the problem to others), aesthetics (how unpleasant the problem appears), rarity, course (curability, permanence and chronicity of the problem), disruptiveness (how much the problem affects life, in particular social interactions and relationships) and dangerousness (unpredictability and potential to do harm).

Higher levels of stigma are attributed to mental health problems that are more visible, unpleasant, rare, perceived to be more dangerous, disruptive and/or have lower levels of curability. People with schizophrenia, bipolar disorder, alcoholism and drug addictions have been shown to be more heavily stigmatised than people with anxiety, depression and eating disorders (Angermeyer & Matschinger, 2003; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Griffiths et al., 2006; Marie & Miles, 2008).

1.2.2. Stigma among Mental Health Professionals

Initiatives to tackle stigma and its associated discrimination have gained increasing prominence more recently (Brooks, Gerada, & Chalder, 2011; Garelick,

2012; Schomerus & Angermeyer, 2008; Evans-Lacko, Henderson, Thornicroft, & McCrone, 2013; Wallace, 2010). Drivers of these initiatives against stigma include self-advocates, third sector organisations, pressure groups and mental health professionals. Despite striving for destigmatisation and actively encouraging others to seek professional help, research suggests that mental health professionals (i.e., psychiatrists, psychiatric nurses, therapists and counsellors) simultaneously hold stigmatising attitudes towards people with mental health problems (Avery et al., 2013; Hanzawa et al., 2012; Hsiao et al., 2015; Linden & Kavanagh, 2012; Loch et al., 2011, 2013a, 2013b). In addition, they have been shown to possess more pessimistic views of their recovery from certain types of mental health problems than the general population (Hugo, 2001; McNicholas, O'Connor, O'Hara, & McNamara, 2015).

In addition to stigmatising, mental health professionals are also at risk of being stigmatised as a result of associative/courtesy stigma, that is stigma experienced because of their association with people with mental health problems (Goffman, 1963; Schulze, 2007; Verhaeghe & Bracke, 2012). Angermeyer, Schulze, and Dietrich (2003) found three areas in which mental health professionals in the United States were confronted with stigma and discriminatory behaviours as a direct result of the stereotypical public images of psychiatry/psychology. Their friends and family had certain reservations towards them, while their children were ridiculed. Moreover, stigma and discrimination towards mental health problems led to a biased distribution of healthcare funds, which resulted in a limited budget for mental health professionals to work with people with mental health problems. Insurance companies considered the treatment of mental health problems to be “non-medical interventions” and resisted covering this expense. Whilst insurance coverage is less

of an issue within the NHS context, concern about the disparity between physical and mental health needs certainly applies in the UK.

1.2.3. Stigmatising Attitudes among Applied Psychologists

Studies that explored the attitudes of applied psychologists in Europe and the United States found that psychologists held more positive attitudes than members of other populations towards people with mental health problems. They held less negative stereotypes than psychiatrists about people with schizophrenia and/or major depression, and were less likely than the general public to favour restricting their rights to vote and the revocation of their driver's license (Nordt, Rössler & Lauber, 2006). Similarly, it was shown that they had more interest in working with and higher belief in the treatability of substance users than physicians, psychiatrists and nurses (Gilchrist et al., 2011). Studies that compared diagnoses (or the lack of) found that psychologists had less interest in working with substance users in comparison to people with depression (Gilchrist et al., 2011) and that their attitudes (e.g., stereotyping and social distance) did not significantly differ towards people with and without schizophrenia (Mittal et al., 2014).

Studies explicitly focusing on clinical psychologists found a combination of positive and negative attitudes towards people with mental health problems. A study conducted in Australia found that clinical psychologists and the public had more positive attitudes than GPs and psychiatrists towards people with depression. However, they had more negative attitudes than the public when it concerned people with schizophrenia (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999). Similarly, a study conducted by Servais and Saunders (2007) found that clinical psychologists emotionally and intellectually distanced themselves from people with psychosis and personality disorders.

1.2.4. Consequences of Stigma among the General Population

Stigma can result in discrimination, status loss, hostile behaviours and exclusion (Link & Phelan, 2001). Those with poorer mental health may experience shame and embarrassment (Corrigan & Rüsch, 2002), as well as beliefs that they are incompetent, insignificant and will ultimately be avoided by and/or rejected by most people (Barney et al., 2006; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Schomerus & Angermeyer, 2008). Other studies have found that stigma can be more incapacitating and challenging to overcome than the mental health problem itself (Wallace, 2010), and may lead to a fear of acknowledging their mental health problems, as well as a reluctance to disclose and seek professional help (Corrigan, 2004; Sartorius, 2007; Satcher, 2000; Schomerus & Angermeyer, 2008; Vogel, Wade, & Hackler, 2007). This may particularly be the case for more heavily stigmatised mental health problems (i.e., psychosis, bipolar disorder and addictions), which are associated with higher levels of anticipated discrimination (Crisp et al., 2000).

1.3. Attitudes towards Disclosure and Help-seeking among Clinical Psychologists

It is notable that the majority of the research undertaken in relation to clinical psychologists and mental health has been conducted in the United States. These studies showed that clinical psychologists found the idea of seeking help psychologically threatening, self-indulgent and stigmatising (Walsh & Cormack, 1994). They feared adopting the role of the client and being viewed as being professionally incompetent compared to their colleagues, who they perceived as “perfect copers” (Dearing, Maddux, & Tangney, 2005; Walsh & Cormack, 1994). Similarly, Digiuni, Jones and Camic (2013) found that trainee clinical psychologists

in England held relatively less positive attitudes towards seeking therapy than trainees in the United States and Argentina. They also found that perceived social stigma predicted the attitudes of English trainees towards seeking therapy, with lower stigma leading to more positive attitudes.

1.3.1. Barriers to Disclosure and Help-seeking

Research revealed that medical and mental health professionals viewed having a mental health problem(s) as a weakness and avoided disclosure and appropriate help-seeking for various reasons related to the stigma of having a mental health problem. These included feelings of shame, embarrassment, fears of being judged negatively, lack of confidentiality, impact on one's career progression, impact on self-image, reservations about the effectiveness of therapy and previous negative experiences with personal therapy (Corrigan, 2004; Garcia & Crocker, 2008; Garelick, 2012; Guy & Liaboe, 1986; Hassan, Ahmed, White & Galbraith, 2009; Kessler et al., 2001). The literature on shame, embarrassment and stigma suggests that emotions of shame and embarrassment are central to self-stigma and can have adverse consequences for the stigmatised person (Barney et al., 2006; Corrigan, 2004; Scheff, 1998; Verhaeghe & Bracke, 2012) and their family as a result of associative stigma (Corrigan & Miller, 2004). Shame and embarrassment have been shown to have significantly affect disclosure and help-seeking, with people with mental health problems avoiding disclosure and treatment seeking/participation in order to avoid the experience of shame and embarrassment (Corrigan, 2004; Sirey et al., 2001). Ironically, research suggests that attempts to avoid disclosure may bring about an increased sense of shame, stress and isolation (Dinos, Stevens, Serfaty, Weich, & King, 2004). Furthermore, it was shown that stigmatising attitudes towards those who had sought help for their mental health problem(s) were higher than

towards those who had not sought help for the same type of mental health problem(s) (Ben-Porath, 2002).

1.3.2. Additional Factors that Influence Disclosure and Help-seeking

Despite the above, it is noteworthy that there are factors that influence disclosure and help-seeking. Aside from the type of mental health problem experienced, as previously mentioned, disclosure target has an impact, with people practicing selective disclosure (Corrigan & Rao, 2012). Studies have shown that members of the general population (Time to Change, 2015), people with mental health problems (Bos, Kanner, Muris, Janssen, & Mayer, 2009; Pandya, Bresee, Duckworth, Gay, & Fitzpatrick, 2011), doctors (Hassan et al., 2009) and clinical psychologists (Aina, 2015) were more comfortable disclosing their mental health problem(s) to family and friends than to colleagues, employers and the police.

1.4. Rationale for this Study

Despite growing research into stigma among mental health professionals, little is known about the presence of stigma or the willingness to disclose and seek help for mental health problems among clinical psychologists, specifically those in the UK. When stress is inappropriately and ineffectively managed, it can lead to professional impairment and affect a clinical psychologist's ability to treat his/her clients (Guy et al., 1989; Pope et al., 1987). However, similar to that seen in medicine, clinical psychologists might hold the belief that they should be mentally resilient and able to cope independently. It is this culture that may ultimately prevent disclosure and help-seeking. Consequently, it is essential to be aware of the implications of barriers, specifically that of stigma on clinical psychologists' willingness to disclose and seek help, and if necessary, to find means to reduce these barriers.

Furthermore, as frontrunners of destigmatisation and promoters of more favourable views of mental health problems, it is *sine qua non* that clinical psychologists first cultivate a positive perception of mental health, before campaigning against stigma and endeavouring to inspire others to adopt similarly positive views. The first steps towards doing this are to explore lived experience of mental health problems in clinical psychologists and to gain an understanding of the impact of stigma (Schulze, 2007) and other factors on their willingness to disclose and seek help.

1.4.1. Aims and Hypotheses

This study aimed to measure the beliefs and general perceptions of qualified clinical psychologists about mental health problems, in order to establish the extent to which stigma (external, perceived and self) was of concern among clinical psychologists in the UK. It also sought to build a picture of clinical psychologists' experiences of disclosing and help-seeking for their mental health problems, and whether willingness to disclose and seek help was influenced by disclosure target, and type of mental health problem experienced. Lastly, this study examined whether certain factors predicted willingness to disclose and seek help for both actual and hypothetical mental health problems. The factors examined included external stigma (stereotypical and discriminatory behaviour towards people with mental health problems), perceived stigma (one's belief that society/others hold negative stereotypes about mental health problems), self-stigma (when the person with mental health problem(s) internalises negative stereotypes held within society), fear of consequences (being judged negatively, impact on career, impact on self-image), and shame and embarrassment (hereafter referred together as shame).

The following hypotheses were put forward:

Stigma:

1. Perceived stigma among clinical psychologists would be high, while external stigma and self-stigma or for those who have not experienced a mental health problem, anticipated self-stigma (hereafter referred together as (anticipated self-stigma)) would be low.

Disclosure:

- 2a. Clinical psychologists would be more willing to disclose mental health problems to people in their social circles (family and friends) than to people in their work settings (work colleagues and employers).
- 2b. Clinical psychologists would be less willing to disclose heavily stigmatised mental health problems (bipolar disorder, psychosis and addiction) than less stigmatised mental health problems (depression, anxiety and eating disorders).

Help-seeking:

3. Clinical psychologists would be more willing to seek help for less stigmatised than for heavily stigmatised mental health problems.
4. All aspects of stigma (external, perceived and self) would be positively correlated with reluctance to disclose (concealment) hypothetical mental health problems and negatively correlated with willingness to seek help for hypothetical mental health problems.
5. Fear of consequences (being judged negatively, impact on career, impact on self-image), and shame would be associated with reluctance to disclose actual and hypothetical mental health problems and seek help.

2. Method

2.1. Participants

Clinical psychologists were invited to participate in the study via the Division of Clinical Psychology's (DCP) mailing list. According to the DCP senior administrator, the DCP list has around 3,600 members and includes pre-qualified DCP members, whose proportion of the 3,600 list members could unfortunately not be confirmed by the DCP. Prior to dissemination, the survey was piloted on eight qualified clinical psychologists drawn from the UCL course staff team and the author's work place. The written feedback from all pilot respondents was considered and the survey adjusted accordingly. Following dissemination, 892 DCP members responded to the invitation, resulting in a response rate of 24.8%. 64 respondents were screened out at an early stage as they were still in training and a further 150 respondents accessed but did not complete the survey. The final sample comprised 678 qualified clinical psychologists who were UK residents and predominantly female white British. Socio-demographic characteristics of the sample are presented in Table 1.

Table 1

Socio-demographic Characteristics of the Sample (N=678)

	<i>n</i>	%
<i>Gender</i>		
Male	121	17.8
Female	557	82.2
<i>Ethnicity</i>		
White	621	91.6
Black	6	0.9
Asian	13	1.9
Mixed	24	3.5
Other	7	1.0
Do not wish to identify	7	1.0
<i>Age</i>		
20-29	31	4.6
30-39	245	36.1
40-49	195	28.8
50-59	131	19.3
60+	75	11.1
<i>Years since qualifying</i>		
<2 years	64	9.4
2-5 years	110	16.2
6-10 years	135	19.9
11-20 years	189	27.9
>20 years	179	26.4

Note. Total *n* and % might not equate to 678 and 100% respectively due to missing responses.

2.2. Procedure

Emails invitations were sent to participants providing them with details of the study (see Appendix B) and an electronic link which directed them to the data collection website. The survey was run using Qualtrics. The initial invitation was sent in June 2015, following which the DCP sent out three identical follow-up emails in July, September and November 2015. The study was also advertised in the Clinical Psychology Forum, the DCP publication sent to all DCP members. As the study was completely anonymous and voluntary, no monetary incentives or prizes were offered.

2.3. Design

This study utilised a non-experimental, correlational questionnaire design. The survey consisted of a demographic questionnaire that gathered information about participants' gender, ethnicity, age group and years since qualifying as a clinical psychologist. Questions that explored external, perceived and self-stigma as well as attitudes towards disclosure and help seeking were taken from five published scales. The questions on stigma were posed to all respondents regardless of whether they had ever experienced a mental health problem(s). Questions that explored participants' personal experiences of mental health problems as well as their experiences of disclosure and help-seeking relating to current, past, and hypothetical future mental health problems were also included in the survey. A copy of the full survey can be found in Appendix C. Acquiescence and social desirability were controlled for through reverse-keyed items and anonymity of the participants.

2.4. Measures (Scales)

All measures described below were rated on a four-point Likert scale (1=*strongly disagree* to 4=*strongly agree*).

2.4.1. External Stigma

The *Social Distance Scale (SDS)* (Link, Cullen, Frank, & Wozniak, 1987) was used to assess participants' external stigma. This scale is a modified version of an earlier social distance measure (Borgardus, 1925) and consists of seven items specifying social contact in increasing levels of intimacy with a person presented in a vignette. The scale had an excellent internal consistency ($\alpha = .92$) (Link et al., 1987). For the purposes of this study, Link et al.'s (1987) scale was modified. The vignette was omitted as it only portrayed selective aspects of a person with mental health problems and therefore inadequately reflected reality (Lampe, et al., 2013;

McNicholas, O'Connor, O'Hara, & McNamara, 2015). Furthermore, it was assumed that this study's sample of clinical psychologists would have sufficient knowledge of their presentation. Two of this scale's items were omitted as they were assessed to be irrelevant and/or less applicable to this population (i.e., "How would you feel about renting a room in your home to someone like Jim Johnson" and "How would you feel about having someone like Jim Johnson as the caretaker of your children?"), while others were reworded to personalise and enhance their relevance to this population. "How would you feel having someone like Jim Johnson as a neighbour?" was replaced with "I would feel upset/disturbed if someone who has a mental health problem lived next door to me", "How would you feel about introducing Jim Johnson to a young woman you are friendly with?" was replaced with "I would not spend the evening socialising with someone who has a mental health problem", "How would you feel about recommending someone like Jim Johnson for a job working for a friend of yours?" was replaced with "I would not maintain a friendship with someone who has a mental health problem.", "How about as a worker on the same job as someone like Jim Johnson?" was replaced with "I would feel upset/disturbed if I had to work closely with someone who has a mental health problem.", and "How about having your children marry someone like Jim Johnson?" was replaced with "I would not marry/enter into a committed intimate relationship with someone with a mental health problem.". The adapted scale (see Appendix C) used in this study consisted of five items. Possible scores range from 5 to 20 with higher scores indicating greater desire to distance oneself from persons with mental health problems.

2.4.2. *Perceived Stigma*

The *Stig-9* was used to assess participants' perceived stigma. This scale consists of nine items and was claimed by the authors to have good internal consistency (Gierk, Murray, Kohlmann, & Löwe, 2013). It was not possible to confirm its reliability, as the article that described the psychometric evaluation of the *Stig-9* was under review for publication in a scientific journal. Possible scores range from 9 to 36, with higher scores indicating higher expected negative societal attitudes towards people with mental health problems.

2.4.3. *Self-Stigma*

The self-stigma subscale of the *Military Stigma Scale (MSS)* was used to measure self-stigma among clinical psychologists. This scale consists of 10 items and had good internal consistency ($\alpha = .87$) (Skopp et al., 2012). Possible scores range from 10 to 40, with higher scores reflecting greater self-stigma for seeking psychological help. As the MSS was standardised on military personnel, it was piloted as part of the questionnaire and a reliability analysis was conducted to ensure its transferability to clinical psychologists.

2.4.4. *Help-seeking*

The *Attitudes towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF)* (Fischer & Farina, 1995) was used to assess participants' attitudes towards seeking professional psychological help. This scale consists of 10 items and had good internal consistency ($\alpha = .77$ to $.78$) (Elhai, Schweinle, & Anderson, 2008). Possible scores range from 10 to 40, with higher scores indicating more positive attitudes towards seeking professional help.

2.4.5. Disclosure

The *Secrecy Scale* was used to assess participants' attitudes towards disclosure. This scale consists of nine items and had good internal consistency ($\alpha = .84$) (Link, Struening, Neese-todd, Asmussen, & Phelan, 2002). Possible scores range from 9 to 36, with higher scores indicating a lower willingness to disclose a mental health problem.

2.5. 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 UK sample of qualified clinical psychologists. The *Stig-9* ($\alpha = .89$), *MSS* ($\alpha = .88$) and *Secrecy Scale* ($\alpha = .8$) had good internal consistency, while the *SDS* had acceptable internal consistency ($\alpha = .72$). The *ATSPPH-SF*, on the other hand, raised some concerns with less than optimal internal consistency ($\alpha = .69$). The corrected item-total correlations of the *ATSPPH-SF* showed that five items had values of $r < .3$, indicating that these items did not correlate well with the scale overall and might assess interrelated yet distinct concepts. However, there was little improvement in the values for Cronbach's Alpha with the deletion of any of these five items.

To further understand the structure of the scale, an exploratory principle factor analysis (principal axis factoring) with Direct Oblimin rotation was conducted on the 10 items. The Kaiser-Meyer-Olkin (KMO) indicated that the data were suitable for a factor analysis, $KMO = .78$ (Kaiser, 1974). All KMO values for individual items were $> .64$, which is above the acceptable limit of $.5$ (Field, 2009). Bartlett's test of sphericity $\chi^2(45) = 872.85$, $p < .001$, indicated that correlations between items were sufficiently large for this analysis. From the analysis, three factors (with Eigenvalues exceeding one) were identified as underlying the 10 scale

items and accounted for 50.9% of the variance of the scale. As factor one, which accounted for 28% of the variance, was most directly related to the concept of help-seeking that was being measured in this study, a further reliability analysis was conducted on six items that loaded on this factor. These items were chosen for inclusion in the analysis as they had loadings $> .21$, the recommended loading size for studies with 600 or more participants (Stevens, 2002). The analysis showed a decrease in the internal consistency ($\alpha = .67$). As a result, the original scale of 10 items was retained and caution was exercised when interpreting results from this scale. Table 2 shows the rotated pattern matrix for all ten items.

Table 2

Rotated Pattern Matrix for ATSPPH-SF Items

Item	Factor One	Factor Two	Factor Three
If I believed I was having a psychiatric breakdown, my first inclination would be to get professional attention.	.29		
Talking about problems with a fellow psychologist would not be helpful in getting rid of my emotional conflicts.	.29		-.23
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychological therapy.	.79		
There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.		.37	
I would want to get psychological therapy if I were worried or upset for a long period of time.	.64		
I might want to have psychological therapy in the future.	.45		
A person with an emotional problem will likely only solve it with professional help.			.54
Considering the time and expense involved in psychological therapy, it would have doubtful value for a person like me.	.34	.36	
A person should work out his or her own problems; getting psychological therapy would be a last resort.		.57	
Personal and emotional troubles, like many things, tend to work out by themselves.		.54	

Note. Eigenvalues for Factor One = 2.80, Factor Two = 1.22, Factor Three = 1.08. Factor loadings < .21 are suppressed.

2.6. Power Analysis

The power analysis for this study was informed by Hassan et al.'s (2009) study, which examined the attitudes of medical doctors to becoming mentally unwell and the influence of stigma on their willingness to disclose and seek treatment. In their study, stigma and career implications were cited as the main influence on their willingness to disclose or conceal their mental health problems ($\phi = .19$, equivalent to r). Having considered this effect size and the planned statistical analyses for this study (i.e., multiple regression analyses with four predictor variables), a power calculation was carried out using the G*Power 3.1 computer programme (Faul, Erdfelder, Lang, & Buchner, 2007), specifying alpha at 5% and desired power at 80%. The analysis revealed the required sample size to be 68 participants.

2.7. Ethical Considerations

This study was approved by the ethics committee of University College London (Project ID number: CEHP/0241/002, see Appendix D). The first page of the survey consisted of an information sheet, which provided participants with an overview of the study, informed them of the sensitive nature of the study, and served as the study's consent form (Appendix C). There was clear indication that participation was on a voluntary basis and that participants had the right to withdraw from the study at any time. Information on confidentiality, anonymity and data protection was also included. If the participant, having read the information sheet, proceeded to complete the survey, it was assumed that they had given their consent to participate. Once participants completed the survey, they were presented with a debriefing sheet and were once again provided with details of how to contact the researchers to further discuss issues related to the study.

2.8. Statistical Analysis

Data were analysed using SPSS version 22. To avoid the impact of extreme values, z-scores were computed for all five scales to identify any outliers (scores with absolute z-scores $> \pm 3.29$). This revealed the presence of outliers on the SDS, ATSPPH-SF and Secrecy scale. Exploration of the data revealed the SDS and MSS to be positively skewed, the ATSPPH-SF to be slightly negatively skewed and the Stig-9 and Secrecy scale to be normally distributed. Transforming the SDS, MSS and ATSPPH-SF did not improve the normality of these distributions. Statistical analyses involving the SDS, ATSPPH-SF and Secrecy scale were run twice (including and excluding the outliers) and a comparison of the results also revealed no difference in significance levels. Outliers were therefore included in the analyses.

As this study had a sufficiently large sample and was well powered, non-parametric tests were used. Non-parametric bivariate correlations were used to analyse the relationship between stigma (i.e., external stigma, perceived stigma, self-stigma), disclosure and help-seeking, in which stigmas were the predictor variables and disclosure and help-seeking the dependent variables. Chi-square and Fisher's exact tests were used to analyse the effect that types of mental health problems and different types of disclosure targets (i.e., family and friends versus colleagues and employers) had on the willingness to disclose and seek help for a mental health problem. The assumptions of independence of data and expected frequencies of above five when using Chi-square were met. Lastly, multiple regression analyses were conducted to determine the influence of fear of consequences (being judged negatively, impact on career, impact on self-image) and shame on willingness to disclose and seek help, both for actual and hypothesised mental health problems. For actual disclosure and help-seeking, results analysed were taken from respondents

who reported lived experience of mental health problems, while results analysed for hypothesised mental health problems were taken from all respondents regardless of whether they had lived experiences of mental health problems. Fear of consequences and shame in disclosing and seeking help were the predictor variables and the total participant scores for the Secrecy Scale and ATSPPH-SF the dependent variables. The assumptions for conducting a multiple regression analysis to determine the influence of fear of consequences and shame on willingness to disclose were met. To meet the assumption of normal distributions when conducting a multiple regression analysis on willingness to seek help, outliers were removed and the ATSPPH-SF was transformed using log₁₀ transformation. Although transforming the raw data did not improve the normality of the ATSPPH-SF distribution, it was believed that the multiple regression model was still appropriate and useful for drawing conclusions about this sample of qualified clinical psychologists (Field, 2009).

Not all participants responded to all questions. Respondents with missing data were excluded from specific analyses using pairwise exclusion. Consequently, there were fluctuations in the numbers of participants and degrees of freedom throughout the analyses.

3. Results

3.1. Mental Health Problems in Clinical Psychologists

Of the 678 clinical psychologists who completed the survey, 62.7% ($n = 425$) had experienced a mental health problem(s) at some point in their lives. Almost half ($n = 195$) of these 425 psychologists had experienced more than one mental health problem, with 12.2% having experienced three or more types of mental health problems. Depression and anxiety were the most common problems experienced. Of

note, a small number had experienced bipolar disorder, psychosis and addiction; see Table 3.

Table 3

Clinical Psychologists' Current/ Past Experiences of Mental Health Problems

(*n* = 425)

	<i>n</i>	%
<i>Type of Mental Health Problem experienced</i>		
Mild to Moderate Depression	297	69.9
Anxiety	179	42.1
Severe Depression	55	12.9
Eating Disorders	47	11.1
Bipolar Disorder	5	1.2
Psychosis	14	3.3
Addiction	18	4.2
Other	72	16.9
<i>Number of Mental Health Problems experienced (comorbidities)</i>		
1	230	54.1
2	143	33.6
3	40	9.4
4	9	2.1
5	3	0.7

Note. Total % of type of mental health problems experienced exceeded 100% owing to comorbidities.

3.2. Stigma among Clinical Psychologists

High levels of stigma were defined as having an average score above the midpoint of the possible range of scores (Ritsher & Phelan, 2004). In this study, the midpoints for external stigma, perceived stigma and self-stigma were 12.5, 22.5 and 25 respectively, with higher scores indicating higher levels of stigma. The stigma measures were presented to all participants regardless of whether they had experienced, were currently experiencing or had never experienced a mental health problem(s). Participants' mean total score for external stigma was 6.96 (*SD* = 2.12), with scores ranging from 5 to 17. For perceived stigma, their scores ranged from 9 to 35 with a mean score of 22.7 (*SD* = 4.9). Lastly, for self-stigma, their scores ranged

from 10 to 36, with a mean score of 18.4 ($SD = 5.64$). These scores support hypothesis one given that perceived stigma was high while external and (anticipated) self-stigma were low.

3.3. Disclosure of Mental Health Problems

This section reports the lived experience of the 425 participants who had mental health problems. It also reports the responses of all 678 participants to hypothetical questions regarding disclosure of future mental health problems, regardless of whether they had lived experiences.

3.3.1. Disclosure by Disclosure Target

3.3.1.1. Actual Disclosure of Mental Health Problems to Social Circles and Work Settings

Table 4 presents the number of participants who did not disclose their actual mental health problem(s), as well as those who disclosed to specific groups of people including people in their social circles (family and friends), work settings (colleagues/peers and employers) and others. Of the 46 participants who did not disclose their mental health problem(s) to anyone, 58.7% ($n = 27$) experienced one mental health problem, while the rest experienced two to five mental health problems. Those who had disclosed their mental health problems were more likely to do so in their social circles than in their work settings, with most participants having disclosed to their family (68.2%) compared to 25.6% disclosing to their employers.

Table 4

Actual Disclosure of Mental Health Problems (n = 425)

	<i>n</i>	%
<i>Disclosed to</i>		
No one	46*	10.8
Family	290	68.2
Friends	277	65.2
Colleagues/Peers	161	37.9
Employers	109	25.6
Other	119	28

Note. *n* and % exceeded 425 and 100% respectively owing to multiple disclosures. **n* = 27 experienced one mental health problem and *n* = 19 experienced two to five mental health problems.

The perceived quality of their experiences of disclosure was measured on a scale of 0 (very negative) to 10 (very positive). Participants had the most positive experience of disclosing to friends ($M = 7.49$, $SD = 1.93$), followed by family ($M = 6.74$, $SD = 2.53$) and colleagues/peers ($M = 6.65$, $SD = 2.55$). Their most negative experience of disclosure was to their employers ($M = 4.95$, $SD = 3.21$).

A total of 263 clinical psychologists who had experienced mental health problems had disclosed to either people in their social circles and/or in their work settings (this excludes all participants who had also disclosed to ‘others’). Of these 263 clinical psychologists, 45.2% ($n = 119$) disclosed in their social circles only, while 2.7% ($n = 7$) disclosed in their work settings only.

A chi-square test comparing the actual disclosure in social circles and in work settings revealed that significantly more participants who had experienced mental health problems had disclosed to people in their social circles than to people in their work settings, $\chi^2(1) = 26.22$, $p < .001$. This is in line with hypothesis 2a, which proposed that clinical psychologists would be more willing to disclose to people in their social circles than in their work settings.

3.3.1.2. *Hypothetical Willingness to Disclose Future Mental Health Problems to Social Circles and Work Settings*

Participants were then asked hypothetically to whom they would disclose to if they were to experience distress or symptoms in line with a given mental health problem in the future. When presented with this question relating to seven different mental health problems, participants' responses varied markedly depending on the type of mental health problem. They rated themselves as least likely to disclose addiction or an eating disorder to anyone, while only a small minority believed that they would not disclose depression, anxiety, bipolar disorder or psychosis. Additionally, less than a fifth of the participants believed that they would disclose mild to moderate depression, anxiety, eating disorders or addiction to their employer. Based on the multiple responses per mental health problem and disclosure target, 45.2% ($n = 307$)¹ of clinical psychologists said they would disclose to people in their social circles compared to 2.7% ($n = 18$)² who said they would disclose in their work settings. See Table 5 for a detailed breakdown of their willingness to disclose a possible future mental health problem by disclosure target.

Similar to actual disclosure, a chi-square test comparing the hypothetical willingness to disclose in social circles and in work settings revealed that this study's sample of clinical psychologists were significantly more likely to disclose future mental health problems to people in their social circles than in their work settings, $\chi^2(30) = 479.41, p < .001$. This gives further support to hypothesis 2a.

¹ n refers to the number of responses given by participants

² n refers to the number of responses given by participants

3.3.2. Disclosure by Type of Mental Health Problem

The following analyses focused on actual and hypothetical disclosure based on level of stigma associated with the type of mental health problem(s). Heavily stigmatised mental health problems included bipolar disorder, psychosis and addiction, while depression, anxiety and eating disorders were categorised as less stigmatised mental health problems.

3.3.2.1. Actual Disclosure of Heavily versus Less Stigmatised Mental Health Problems

First, looking at actual experiences of mental health problems, 8% ($n = 34$) of clinical psychologists experienced at least one heavily stigmatised mental health problem (including three respondents who had experienced two heavily stigmatised problems and excluding six who had also experienced less stigmatised problems), while 84.9% ($n = 361$) experienced at least one less stigmatised mental health problem (including 162 respondents who had experienced two to four less stigmatised problems and excluding 24 who had also experienced heavily stigmatised problems). Fisher's exact test was performed owing to the small sample size ($< \text{five}$) of clinical psychologists who did not disclose their heavily stigmatised mental health problem to anyone. There was no difference between the actual disclosures of heavily and less stigmatised mental health problems, with 11.8% ($n = 4$) of clinical psychologists who had experienced heavily stigmatised mental health problems disclosing these to no one, compared to 11.1% ($n = 40$) who had not disclosed less stigmatised mental health problems ($p = .540$). This finding does not support hypothesis 2b, which proposed that clinical psychologists would be less willing to disclose heavily stigmatised (bipolar disorder, psychosis and addiction)

than less stigmatised mental health problems (depression, anxiety and eating disorders).

3.3.2.2. Hypothetical Disclosure of Future Heavily versus Less Stigmatised Mental Health Problems

The responses to hypothetical disclosure of clinical psychologists were similar to those concerning actual disclosure. 9.5% ($n = 193$)³ said that they would be reluctant to disclose hypothetical heavily stigmatised mental health problem(s) compared to 8.2% ($n = 223$)⁴ for hypothetical less stigmatised mental health problem(s); see Table 5. A chi-square test comparing hypothetical willingness to disclose based on type of mental health problem revealed that similar to actual disclosure, there was no difference between the disclosures of heavily and less stigmatised mental health problem(s), $\chi^2(1) = 2.33, p = .127$. Similar to actual disclosure, this finding regarding hypothetical disclosure does not support hypothesis 2b.

³ n refers to the number of responses given by participants

⁴ n refers to the number of responses given by participants

Table 5

Hypothetical Willingness to Disclose by Type of Mental Health Problem and Disclosure Target (N=678)

	Less stigmatised mental health problems				Heavily stigmatised mental health problems		
	Mild to moderate depression	Anxiety	Severe depression	Eating disorders	Bipolar disorder	Psychosis	Addiction
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
No one	46 (6.8)	43 (6.4)	28 (4.2)	106 (16.3)	36 (5.5)	41 (6.3)	116 (17.8)
Family	536 (79.6)	536 (80)	538 (81.5)	422 (64.7)	514 (78.8)	506 (77.3)	397 (60.8)
Friends	513 (76.2)	511 (76.3)	456 (69.1)	352 (54)	427 (65.5)	404 (61.7)	348 (53.3)
Colleagues/Peers	236 (35.1)	249 (37.2)	234 (35.5)	101 (15.5)	204 (31.3)	189 (28.9)	90 (13.8)
Employer	129 (19.2)	131 (19.6)	333 (50.5)	104 (16)	325 (49.8)	318 (48.5)	127 (19.4)
Other	130 (19.3)	131 (19.6)	198 (30)	180 (27.6)	204 (31.3)	209 (31.9)	179 (27.4)

Note. *n* and % exceeded 678 and 100% respectively as multiple responses were allowed.

3.4. Help-seeking for Mental Health Problems

This section reports the lived experience of the 425 participants who had mental health problems. It also reports the responses of all 678 participants regarding help-seeking of future mental health problems, regardless of whether they had lived experiences.

3.4.1. Clinical Psychologists' Experiences of Seeking Help for Mental Health Problems

Table 6 presents the number of participants who did not seek help for their actual mental health problem(s), as well as those who sought help from various health professionals. Of the 425 participants who experienced a mental health problem(s), 84% ($n = 357$) sought help. More than half of the participants sought help from their GP (63.5%) or a private psychotherapist (54.5%) and a minority sought help from a private psychiatrist (4.5%).

Table 6

Help Sought for Current/ Past Mental Health Problems (n = 425)

	<i>n</i>	%
<i>Sought help from</i>		
No one	68	16
GP	226	63.5
NHS Clinical Psychologist	52	14.6
NHS Psychotherapist	48	13.5
NHS Psychiatrist	43	12.1
Private Clinical Psychologist	56	15.7
Private Psychotherapist	194	54.5
Private Psychiatrist	16	4.5
Other	66	18.5

Note. *n* and % exceeded 425 and 100% respectively owing to help-seeking from multiple health professionals.

The perceived quality of their experiences of seeking help was measured on a scale from 0 (very negative) to 10 (very positive). Participants had the most positive

experience of seeking help from private psychotherapists ($M = 7.86, SD = 2.06$), followed by private clinical psychologists ($M = 7.61, SD = 2.57$), NHS clinical psychologists ($M = 6.44, SD = 3.23$), GPs ($M = 6.35, SD = 2.72$), NHS psychotherapists ($M = 5.8, SD = 3.15$) and NHS psychiatrists ($M = 5.29, SD = 2.66$). Their most negative experience of seeking help was from private psychiatrists ($M = 4.38, SD = 3.72$).

3.4.2. Help-seeking and Type of Mental Health Problem

Descriptive statistics for actual and hypothetical help-seeking based on stigma levels associated with the type of mental health problem(s) are presented in Table 7 and 8 respectively. A detailed breakdown of their perceived willingness to seek help for mental health problems they might experience in the future by type of 'helper' is given in Table 9.

3.4.2.1. Actual Help-seeking of Heavily versus Less Stigmatised Mental Health Problems

A chi-square test was performed to compare the actual help-seeking for heavily and less stigmatised mental health problems. There was no significant difference between current/ past experiences of help-seeking for heavily and less stigmatised mental health problems ($\chi^2(1) = .435, p = .510$). This finding does not support hypothesis three, which predicted that clinical psychologists would be more willing to seek help for less stigmatised than for heavily stigmatised mental health problems.

3.4.2.2. *Hypothetical Help-seeking of Future Heavily versus Less Stigmatised Mental Health Problems*

For hypothetical help-seeking, contrary to hypothesis three, participants said they would be more willing to seek help for a heavily stigmatised mental health problem(s) than for a less stigmatised mental health problem(s) ($\chi^2(1) = 98.83, p < .001$). Similar to actual help-seeking, this finding does not support hypothesis three.

Table 7

Descriptive Statistics for Actual Help-seeking

Mental Health Problem(s)		Level of Stigma	
		Less stigmatised <i>n</i> (%)	Heavily stigmatised <i>n</i> (%)
Actual (<i>n</i> = 425)	Sought Help	303 (83.9)	30 (88.2)
	Did not seek help from anyone	58 (16.1)	4 (11.8)

Table 8

Descriptive Statistics for Hypothetical Help-seeking of Future Mental Health Problems

Mental Health Problem(s)		Level of Stigma	
		Less stigmatised <i>n</i> (%)	Heavily stigmatised <i>n</i> (%)
Hypothetical (<i>N</i> = 678)	Would seek help	2369 (87.4)	1947 (95.7)
	Would not seek help from anyone	343 (12.6)	87 (4.3)

Note. *n* for hypothetical help-seeking exceeded 678 owing to willingness to seek help from multiple groups of health care professionals.

Table 9

Hypothetical Willingness to Seek Help for Mental Health Problem by Type of Mental Health Problem and 'Helper' (N = 678)

	Less stigmatised mental health problems				Heavily stigmatised mental health problems		
	Mild to moderate depression	Anxiety	Severe depression	Eating disorders	Bipolar disorder	Psychosis	Addiction
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
No One	141 (21.1)	135 (20.3)	13 (2)	54 (8.3)	13 (2)	12 (1.8)	62 (9.5)
GP	329 (49.2)	316 (47.4)	472 (71.3)	391 (60.1)	478 (72.3)	469 (71)	381 (58.1)
NHS Clinical Psychologist	112 (16.7)	135 (20.3)	247 (37.3)	266 (40.9)	281 (42.5)	297 (44.9)	227 (34.6)
NHS Psychotherapist	66 (9.9)	70 (10.5)	81 (12.2)	92 (14.1)	78 (11.8)	75 (11.3)	88 (13.4)
NHS Psychiatrist	27 (4)	33 (5)	174 (26.3)	130 (20)	305 (46.1)	331 (50.1)	116 (17.7)
Private Clinical Psychologist	185 (27.7)	201 (30.2)	249 (37.6)	241 (37)	211 (31.9)	206 (31.2)	224 (34.1)
Private Psychotherapist	292 (43.6)	276 (41.4)	263 (39.7)	220 (33.8)	178 (26.9)	155 (23.4)	231 (35.2)
Private Psychiatrist	27 (4)	26 (3.9)	83 (12.5)	61 (9.4)	128 (19.4)	125 (18.9)	64 (9.8)
Other	60 (9)	51 (7.7)	40 (6)	56 (8.6)	41 (6.2)	45 (6.8)	86 (13.1)

Note. *n* and % exceeded 678 and 100% respectively as multiple responses were allowed.

3.5. Relationship between Stigma, Hypothetical Disclosure and Hypothetical Help-seeking

The fourth hypothesis related to hypothetical mental health problems, and predicted that all aspects of stigma (external, perceived and self) would be positively correlated with reluctance to disclose (concealment) and negatively correlated with the willingness to seek help.

Weak, positive correlations were found between external stigma and concealment ($r_s(643) = .189, p < .001$), between perceived stigma and concealment ($r_s(641) = .258, p < .001$), and between self-stigma and concealment ($r_s(640) = .267, p < .001$). These findings suggest that higher levels of external, perceived and self-stigma are associated with higher levels of concealment of mental health problems, giving support to hypothesis four.

Weak, negative correlations were found between external stigma and help-seeking ($r_s(650) = -.181, p < .001$), and perceived stigma and help-seeking ($r_s(648) = -.084, p = .033$). A moderate, negative correlation was found between self-stigma and help-seeking ($r_s(646) = -.507, p < .001$). Although these findings suggest that higher levels of external, perceived and self-stigma are associated with lower levels of help-seeking for mental health problems among clinical psychologists and give support to hypothesis four, caution should be exercised when interpreting these findings due to the less than optimal internal consistency of the ATSPPH-SF scale.

3.6. Relationship between Fear of Consequences, Shame, and Disclosure and Help-seeking

The final hypothesis was that a fear of consequences (being judged negatively, impact on career, impact on self-image), and shame would be associated with the reluctance to disclose mental health problems and to seek help among

clinical psychologists. Multiple regression analyses were conducted to examine the relationship between the four independent variables, and the reluctance to disclose mental health problems and seek help among participants.

3.6.1. Fear of Consequences, Shame and Disclosure

3.6.1.1. Fear of Consequences, Shame and Actual Disclosure

For actual disclosure, being judged negatively (71.7%) and impact on career (67.4%) were the main reasons that prevented participants from disclosing their current/past mental health problem(s). Similarly, being judged negatively (37%) and impact on career (34.8%), as well as shame (31.1%), were reported as being key reasons that would prevent participants from disclosing a future mental health problem(s); see Table 10.

Table 10

Descriptive Statistics: Fear of Consequences, Shame, and Actual and Hypothetical Disclosure

Reasons	Actual MHP (<i>n</i> = 46)	Hypothetical MHP (<i>n</i> = 679)
	<i>n</i> (%)	<i>n</i> (%)
Being judged negatively	33 (71.7)	180 (37)
Impact on career	31 (67.4)	169 (34.8)
Impact on self-image	19 (41.3)	93 (19.1)
Shame	22 (47.8)	151 (31.1)

Note. MHP refers to mental health problem(s). % exceeded 100% as multiple responses were allowed. Hypothetical *n* refers to the number of responses given by participants.

A regression analysis of participants' disclosure of current/past mental health problems indicated that the model combining all four variables was statistically significant and accounted for approximately 3% of the variance ($R^2 = .03$, $F(4,642) = 4.901$, $p = .001$). Independently, none of the variables significantly predicted clinical psychologists' actual disclosure; see Table 11.

Table 11

Predictors of Actual Disclosure: Results of Multiple Regression Analysis

	B	SE B	β
Constant	20.176	0.169***	
Being judged negatively	2.643	1.696	.135
Impact on career	1.955	1.438	.097
Impact on self-image	-1.587	1.463	-.062
Shame	-0.538	1.336	-.023

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

3.6.1.2. Fear of Consequences, Shame and Hypothetical Disclosure of Future Mental Health Problems

Looking at hypothetical disclosure, when asked what might prevent them from disclosing a mental health problem, regression analysis showed that the model was statistically significant and accounted for approximately 5.6% of the variance ($R^2 = .056$, $F(4, 642) = 9.569$, $p < .001$). Hypothetical disclosure was significantly predicted by being judged negatively ($\beta = .176$, $p < .05$). None of the other predictor

variables were significant, although impact on career approached significance; see Table 12.

Nevertheless, it is noteworthy that the percentage of participants who said that they would not disclose a mental health problem as a result of the four predictor variables, was much smaller than the percentage of participants who did not disclose a mental health problem because of the same predictor variables; see Table 10.

Table 12

Predictors of Hypothetical Disclosure of Future Mental Health Problems: Results of Multiple Regression Analysis

	B	SE B	β
Constant	19.753	0.192***	
Being judged negatively	1.683	0.792*	.176
Impact on career	1.159	0.642	.119
Impact on self-image	0.195	0.622	-.016
Shame	-0.823	0.627	-.081

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

3.6.2. Fear of Consequences, Shame and Help-seeking

As the internal consistency of the ATSPPH-SF scale was assessed to be less than optimal, caution should be exercised when interpreting the following findings in this section.

3.6.2.1. Fear of Consequences, Shame and Actual Help-seeking

For actual help-seeking, all four predictor variables were similarly reported by a third of participants as reasons that prevented them from seeking help for their current/past mental health problem(s), see Table 13.

Table 13

Descriptive Statistics: Fear of Consequences, Shame, and Actual and Hypothetical Help-seeking

Reasons	Help-seeking	
	Actual MHP (n = 68)	Hypothetical MHP (n = 401)
	n (%)	n (%)
Being judged negatively	24 (35.3)	90 (19.2)
Impact on career	25 (36.8)	96 (20.5)
Impact on self-image	22 (32.4)	39 (8.3)
Shame	23 (33.8)	79 (16.8)

Note. MHP refers to mental health problem(s). % exceeded 100% as multiple responses were allowed. Hypothetical *n* refers to the number of responses given by participants

A regression analysis of participants' actual help-seeking indicated that the model was statistically significant and accounted for approximately 6.4% of the variance ($R^2 = .064$, $F(4,648) = 11.007$, $p < .001$). Actual help-seeking was predicted by impact on self-image ($\beta = -.165$, $p < .01$), and shame ($\beta = -.136$, $p < .05$). The other two predictor variables were not significant; see Table 14.

Table 14

Predictors of Actual Help-seeking: Results of Multiple Regression Analysis

	B	SE B	β
Constant	30.777	0.146***	
Being judged negatively	2.193	1.324	.108
Impact on career	-1.627	1.259	-.082
Impact on self-image	-3.484	1.109**	-.165
Shame	-2.816	1.343*	-.136

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

3.6.2.2. Fear of Consequences, Shame and Hypothetical Help-seeking for Future Mental Health Problems

For hypothetical help-seeking, impact on career (20.5%) and being judged negatively (19.2%) were reported as being key reasons that would prevent participants from seeking help for a future mental health problem(s), see Table 13.

When asked what might prevent them from seeking help for a mental health problem(s), similar to actual help-seeking, the regression analysis showed that the model for hypothetical help-seeking was statistically significant and accounted for

approximately 10.6% of the variance ($R^2 = .106$, $F(4, 648) = 19.155$, $p < .001$).

Hypothetical help-seeking was significantly predicted by shame ($\beta = -.151$, $p < .01$).

None of the other variables were significant, although impact on career approached significance; see Table 15).

Similar to disclosure, the percentage of participants who said that they would not seek help for a mental health problem as a result of any of the four predictor variables was much smaller than the percentage of those who did not seek help for a mental health problem because of the same predictor variables; see Table 13.

Table 15

Predictors of Hypothetical Help-seeking for Future Mental Health Problems: Results of Multiple Regression Analysis

	B	SE B	β
Constant	31.106	0.151***	
Being judged negatively	-0.944	0.751	-.086
Impact on career	-1.102	0.645	-.103
Impact on self-image	-.589	0.764	-.037
Shame	-1.756	0.651**	-.151

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

4. Discussion

To our knowledge, this is the largest study to date of mental health problems, stigma and views on disclosure and help-seeking among clinical psychologists in the UK. The study set out to uncover the extent to which clinical psychologists have lived experience of mental health problems and to ascertain the extent of stigma that exists among them. It also sought to understand whether their willingness to disclose and seek help when experiencing mental health problems themselves may be influenced by stigma and stigma-related factors.

Approximately two-thirds of the participating clinical psychologists had experienced mental health problems at some point of their lives. This high percentage appears to be in keeping with previous research that suggests that mental health professions attract people who have suffered and that people enter the field of psychology to better understand themselves and manage their mental health problems (Bowlby, 1977; Huynh & Rhodes, 2011; Murphy & Halgin, 1995; Sussman, 2007; Tillet, 2003).

4.1. Clinical Psychologists' Attitudes towards Mental Health Problems

The high level of perceived stigma and low levels of external and self-stigma found in this study suggests that clinical psychologists are mindful of the stigma attached to mental health problems but are typically unlikely to internalise such stigma or to stigmatise others who experience mental health problems. When participants were asked what prevented or might prevent them from seeking help for mental health problems, shame and a potential negative effect on their self-image, both constructs of self-stigma (Chang & Johnson, 2013; Corrigan, 2004), were flagged as significant predictors, albeit accounting for very small parts of the variances. This provides further support for the existence of low levels of self-stigma

among clinical psychologists. However, caution needs to be exercised when interpreting these findings due to the less than optimal internal consistency of the ATSPPH-SF scale.

Differences in the levels of external, self and perceived stigma found in this sample of clinical psychologists may be explained by previous research that has shown that contact with and increased and accurate knowledge of people with mental health problems are associated with lower external and self-stigma and higher perceived stigma (Gilchrist et al, 2011; Hoy & Holden, 2014; Hsiao et al., 2015; Linden & Kavanagh, 2011; Loch et al., 2013a, 2013b; Sun et al., 2014; Teh, King, Watson & Liu, 2014). These findings of low levels of external stigma are supported by findings from previous studies that revealed more positive attitudes towards people with depression (Jorm et al., 1999), but inconsistent with findings that revealed negative attitudes among clinical psychologists towards people with psychosis and personality disorders (Jorm et al., 1999; Servais & Saunders, 2007). The different levels of stigma attached to different mental health problems might explain the differing attitudes towards people with depression, and those with psychosis and personality disorders (Angermeyer & Matschinger, 2003; Crisp et al., 2000; Griffiths et al., 2006; Marie & Miles, 2008).

4.2. Disclosure among Clinical Psychologists

A significant majority of clinical psychologists in this study who had experienced mental health problems had chosen to disclose to people in their social circles (friends/family) rather than to people in their work settings (colleagues/peers/employer), and reported more positive experiences of disclosing to the former. Similarly, when asked to imagine what they would do if they were to experience mental health problem in the future, they believed that they would be

significantly more willing to disclose in their social circles. This study's findings are supported by results from a previous qualitative study of eight clinical psychologists (five trainee and three qualified) (Aina, 2015) and are consistent with the disclosure preferences of members of the general population, people with mental health problems and doctors (Bos et al., 2009; Hassan et al., 2009; Pandya et al., 2011; Time to Change, 2015).

Research has also suggested that disclosure might be influenced by the type of mental health problem based on the level of stigma attached to it, with less disclosure for heavily stigmatised mental health problems (psychosis, bipolar disorder, addiction) owing to higher levels of anticipated discrimination (Rüsch, Brohan, Gabbidon, Thornicroft & Clement, 2014), and more disclosure for less stigmatised mental health problems (depression, anxiety, eating disorders). This study, however, revealed that rates of disclosure for both actual and hypothetical heavily stigmatised mental health problems, did not differ from those for less stigmatised mental health problems. These conflicting findings could be due to the degree of concealability (Corrigan & Matthews, 2003), disruptions and perceived unpredictability of the mental health problems, as well as the nature of a clinical psychologist's role, which requires one to function optimally. Those with more concealable mental health problems (e.g., addictions) might be able to hide their problems from the people around them and thus choose to avoid disclosing for fear of negative consequences. On the other hand, those experiencing mental health problems perceived to be unpredictable (e.g., psychosis), and with symptoms that might not be concealable and/or be serious enough to cause disruption to their daily functioning might have no choice but to disclose their problem, in order to continue in their roles as clinical psychologists. Additionally, this lack of significant

difference might be consequent to the sense of duty and responsibility that clinical psychologists have towards their clients. This, resulting in them disclosing their mental health problems based on the impact of these mental health problems on their ability to treat their clients, regardless of the level of stigma attached to them.

Furthermore, it would be difficult to conceal a serious mental health problem when working in a mental health care setting where fellow colleagues have been trained to pick up on symptoms of mental health problems and are similarly bound by duties of care that require them to report concerns about their colleagues' ability to provide adequate care to clients of their service.

4.3. Help-seeking among Clinical Psychologists

Clinical psychologists had more positive experiences when seeking help from a private therapist and the most negative experiences when seeking help from a private psychiatrist. Against the study's hypothesis, the rates of actual help-seeking for heavily stigmatised mental health problems were not significantly higher than those for less stigmatised mental health problems. On the contrary, when asked to imagine what they would do if they were to experience a mental health problem(s) in the future, participants believed they would be more likely to seek help for heavily stigmatised than for less stigmatised mental health problems. As with disclosure, this is contradictory to research that expects lower help-seeking for heavily stigmatised mental health problems as a result of their association with higher levels of anticipated discrimination (Schomerus & Angermeyer, 2008). These conflicting findings may be similarly explained by difficulties in concealing and functioning while experiencing heavily stigmatised mental health problems, a low perceived need for help and a strong desire and belief in one's ability (Mojtabai et al., 2011) to handle less stigmatised problems without help, and the sense of duty and

responsibility that clinical psychologists have towards their clients, hence seeking help for their mental health problems based on the impact of these mental health problems on their ability to treat their clients, regardless of the level of stigma attached to them.

4.4. Relationship between Stigma, Disclosure and Help-seeking

All aspects of stigma showed significant positive relationships with reluctance to disclose and seek help, consistent with previous research (Corrigan, 2004; Sartorius, 2007; Satcher, 2000; Schomerus & Angermeyer, 2008; Vogel et al., 2007). However, the present study also found that the level of stigma attached to specific types of mental health problem may not significantly influence both actual and hypothetical disclosure and actual help-seeking. When asked to imagine experiencing mental health problems in future, participants believed they would be more likely to seek help for heavily stigmatised mental health problems, contrary to findings of increased reluctance to seek help with increased level of stigma (Schomerus & Angermeyer, 2008).

The way that stigma was measured in relation to different types of mental health problems in the survey may have affected participants' responses, thus explaining the discrepancy seen above. The published scales, which found significant positive relationships between stigma, disclosure and help-seeking, examined stigma by evaluating it against 'all types of mental health problems', while the other questions in the survey measured stigma based on their attachment to specific mental health problems. 'All types of mental health problems' gave participants the flexibility to think of any type of mental health problem when answering questions from the published scales. This would have ultimately led to thoughts of different mental health problems not only across but also within participants, hence affecting

their responses. Furthermore, it is important to consider the less than optimal internal consistency of the ATSPPH-SF scale when interpreting the significant positive relationship between all aspects of stigma and the willingness to seek help for mental health problems.

4.5. Relationship between Fear of Consequences, Shame, and Disclosure and Help-seeking

Being judged negatively was significantly associated with hypothetical willingness to disclose, while impact on self-image and shame were associated with actual help-seeking. Only shame was significantly associated with hypothetical help-seeking.

These findings of being judged negatively, impact on self-image and shame are consistent with findings from previous studies (Corrigan, 2004; Guy & Liaboe, 1986), while the lack of association between impact on career and both disclosure and help-seeking is contrary to findings by Garelick (2012) and Hassan et al. (2009). Although associated with disclosure and help-seeking, being judged negatively, impact on self-image and shame accounted for very small parts of the variances. These weak associations as well as the lack of association between impact on career, disclosure and help-seeking may be attributed to several factors. Having in-depth knowledge of mental health problems, as well as being advocates against stigma may have reduced participants' self-stigma and increased their belief that they would not be discriminated against by the people around them. Furthermore, despite the lack of and weak associations, it was noted that the percentage of participants who said they would not disclose or seek help owing to the four predictor variables was much smaller than those who had not disclose or sought help for mental health problems because of the same variables. This could be an indication of participants'

underestimation of the impact of feared consequences and shame on disclosure and help-seeking. Additionally, as with all other analyses that involved the ATSPPH-SF, it is important to consider the less than optimal internal consistency of this scale when interpreting the significant association between impact on self-image and actual help-seeking, shame and actual help-seeking and shame and hypothetical help-seeking.

4.6. Strengths and Limitations

Convenience sampling was used to recruit this study's sample. This method of recruitment was deemed to be the best way to get responses despite potential selection and non-response biases, which may have limited the generalisability and representativeness of this study's findings. It was thought that results might be skewed due to self-selection bias with the study attracting respondents who might have had a greater interest in this area of research and/or experienced mental health problems. However, it was shown upon analysis that not everyone who responded had a history of mental health problems.

A major strength of this study is its sample size. Results present responses by approximately a fifth of all clinical psychologists in the UK, who are members of the DCP and are on the DCP mailing list. This was in spite of the survey being sent out as a DCP circular that could have been lost amongst the many other DCP emails sent, time constraints faced by clinical psychologists, the study's sensitive nature and the number of questions (60 in total) posed in the survey, which could have dissuaded participants from completing the survey. Although the response rate of 18.8% may appear to be low, it is likely to be an underestimation as an unknown number of the members on the mailing list were unqualified clinical psychologists. There was also a possibility that some of the contact details used to distribute the

survey were out of date. Moreover, as the number of responses that were collected is considerably large, it is likely that these findings are indeed representative of clinical psychologists in the UK as a whole.

While it may have increased the response rate and protected against social desirability, anonymising the survey also had an undesirable consequence of inconveniencing respondents who had only partially completed the survey due to time constraints. To ensure complete anonymity, the only way respondents could return to where they had left off was to follow their original email link, using the same computer and web browser. Despite these constraints, 76% of participants who accessed the survey completed it, suggesting that participants felt that this is an important and hitherto neglected topic. The recognition of this study's significance was also evident in some of the emails sent to the research team. Some of the comments included, "I think this is a hugely important area of research", and "...stigma of mental health problems... This is something as a profession I think we are very bad at acknowledging: The possibility that we, as fellow human beings, are as vulnerable as the clients we work with...and possibly the mask of the profession is more difficult to remove when we need help. My observations are that there is an implicit message that we must be more 'normal' than everyone else, and a history of mental health problems a sign of weakness to be kept out of the profession".

In addition to difficulties in recruitment, this study had other limitations. A non-response bias could have resulted from the use of convenience sampling. However, it was not possible to verify reasons as to why people who were invited did not participate due to this study's complete anonymity. Additionally, participants who were invited to participate in this study were members of the DCP. However, not every clinical psychologist in the UK is a member, and this may have introduced

a bias and reduced the study's representativeness of the wider profession. Another limitation was the measurement of stigma and terms used in this study. Stigma is multifaceted and research has shown that levels of stigma vary according to the type of mental health problem (Angermeyer & Matschinger, 2003; Avery et al., 2013; Crisp et al., 2000; Gilchrist et al., 2011; Griffiths et al., 2006; Hsiao et al., 2015). However, not all of stigma's constructs were measured in this study. Furthermore, some of the terms used in the survey might have led to conflicting thoughts and difficulties in responding as evident in the feedback from two participants. These terms included 'mental health problems', which referred to 'wide range of mental health conditions', 'therapist', 'psychologist' and 'psychiatrist'. Participants commented that the classification of mental health problems was "too broad and made responding to the questions difficult...", "I think there is a marked difference in how socially accepted some kinds of mental health problems are...I answered some as how I felt about someone with depression and others thinking about bipolar disorder or psychosis, which I personally view differently in terms of their possible impact on functioning and likely need for external help... I wasn't able to reflect this difference in stigma in my answers", "...used terms such as therapist, psychologist, and psychiatrist interchangeably... my views differ depending upon the term you used...thus, the words used affected my responses". The limitations in the measurements of stigma and terms used raise concerns about the validity of participants' responses and our subsequent understanding of clinical psychologists' attitudes towards each individual mental health problem. Nonetheless, there were some questions designed specifically for this study (e.g., regarding fear of negative consequences) that distinguished mental health problems.

Additionally, there were limitations in analysing the data for some of the study's hypotheses. These hypotheses include the influence of disclosure target and the level of stigma attached to type of mental health problem, on disclosure and help-seeking. Participants who had disclosed to people in both their social circles and work settings (e.g., family and colleagues), and had experienced comorbidities that were classified under both heavily and less stigmatised categories (e.g., psychosis and depression), had to be excluded from the respective analyses. This study followed previous research, which was to the author's knowledge category driven, in choosing to explore the attitudes of clinical psychologists based on diagnostic labels. It is noted that there are limitations with basing attitudes on diagnostic labels and with grouping the mental health problems into heavily and less stigmatised categories. These include factors such as the heterogeneity within mental health problems, shared symptoms among the mental health problems across the two categories and clinical psychologists' more nuanced understanding of mental health problems as their own entities rather than this dichotomy. Although able to accurately answer this study's hypotheses and contribute to the literature on stigma, disclosure and help-seeking among clinical psychologists, further analyses of the data may be required to provide a more comprehensive understanding of these areas of research.

Lastly, research has highlighted a difference in explicit and implicit attitudes (Kopera et al., 2015). The measures used in this survey explored levels of explicit stigma, but not implicit stigma.

4.7. Conclusion and Implications

This study has highlighted high levels of mental health problems among clinical psychologists and revealed that more participants preferred to and were

willing to disclose to people in their social circles than in their work settings. Where help-seeking was concerned, it was shown that the majority of participants sought help and were willing to seek help for more heavily stigmatised than less stigmatised mental health problems, owing to the disruptions that the former caused to their daily functioning and ability to treat their clients. Despite participants' keen awareness of society's discrimination of people with mental health problems, they are typically unlikely to internalise such stigma and similarly stigmatise others who experience mental health problems. Furthermore, factors closely related to stigma, including fear of being judged negatively, fear of negative impact on self-image and shame, were found to be negatively associated with their willingness to disclose and seek help for mental health problems.

The findings from this study, in addition to the current climate of growing privatisation of the NHS and an increasingly target and outcome-driven culture, have critical implications for addressing the difficulties faced by clinical psychologists at both organisational and individual levels. As it stands, clinical psychologists may in fact experience reduced access to mental health services due to real threats to confidentiality should they seek help from NHS providers⁵. Furthermore, even at training level, there is an emphasis on emotional resilience and an unspoken belief that disclosing one's mental health problems may be viewed with mistrust and could result in discrimination. It is therefore proposed for interventions to be put in place at the training level to address this unspoken belief about the negative consequences of disclosing their mental health problems and consequent reluctance to do so. At the workplace, it is believed that although fellow colleagues are bound by duties of care that require them to report concerns about their colleagues' ability to provide

⁵ This was a real concern emerging in participants' comments. One participant noted that she had discovered through the service's database that a colleague was in receipt of mental health services when searching for information of a client with the same name.

adequate care to clients of their service, this might not translate into action. This may be due to the increasingly target and outcome-driven culture of the NHS, which may lead to colleagues being over-worked and stressed and result in infrequent interaction with their colleagues, hence not picking up on others' distress due to their own stresses. Furthermore, even when aware, there might be resistance to being a "whistle blower" due to fear of the implications it might have on themselves and on their colleagues experiencing mental health problems. It is therefore proposed that clear policy guidelines be developed to improve the work conditions, emotional experiences at work, job satisfaction and most importantly, to change the seemingly unsupportive and unhelpful NHS culture by encouraging open conversations about lived experience of mental health problems in the workplace and subsequently reducing the shame associated with having mental health problems. It is also suggested that appropriate avenues are established to protect the confidentiality and rights of clinical psychologists, and ensure that they are able to disclose and seek help for their mental health problems without having to worry about the consequences of doing so. These interventions are aimed at ensuring and maintaining the wellbeing of clinical psychologists, and their ability to provide clients with the quality of care required.

To achieve the aforementioned, Time to Change, and the BPS and New Savoy Partnership have created employer and organizational pledges, and launched a Charter for Psychological Professionals Wellbeing and Resilience (Rao et al., 2016) respectively, to reduce stigma and improve psychological wellbeing in the workplace.

Besides informing the need for interventions, these findings have important implications for future research. Future research should look into assessing the

effectiveness of such interventions in increasing the willingness of clinical psychologists to disclose and seek help, as well as the knock-on effect on their ability to provide quality care to clients. Moreover, as most studies conducted to date have had a negative focus, it would be beneficial to explore the positive aspects of lived experience of mental health problems. This could further serve to destigmatise mental health problems. Finally, it would be useful to explore the extent of implicit stigma and discriminatory behaviours among clinical psychologists.

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Part 3: Critical Appraisal

Introduction

The purpose of this critical appraisal is to highlight key issues and reflections that arose from the implementation of the research project, through to the write-up of the project's findings. These will be detailed and discussed in three sections. The first section documents my personal reflections on the process of conducting a doctoral research project. The second section consists of my reflections on methodological issues, including reflections on the utilisation of a web-based survey, and my critique of the concepts, measures and terminology used in the survey. The third section documents my reflections on the results of the study and its implications for the field of clinical psychology, wellbeing of clinical psychologists and, finally, future research.

1. Personal Reflections on the Research Process

1.1. Establishment of the Study

Little is known about the extent to which clinical psychologists stigmatise mental health problems and people with mental health problems. On the flipside, there have been increasing reports by people with mental health problems of experienced discrimination from their mental health providers (Burti & Mosher, 2003; Schulze & Angermeyer, 2003; Thornicroft, Rose, & Kassam, 2007). The dearth of literature in this area, in a profession that aims to treat this group of people who are being stigmatised, and one that I will be entering into in a matter of months, piqued my interest in conducting this particular research project.

1.2. Development of the Study

The initial discussion with my supervisors comprised delineating specific under-researched areas within the broader topic of stigma and clinical psychologists that would be appropriate for a doctoral level research project. As a Southeast Asian

researcher with an appreciation of the significant influence of culture on stigma, I was keen to conduct a cross-cultural study involving clinical psychologists from both Singapore and the UK. However, after further discussions with my supervisors, and considerations of procedural difficulties that I might encounter, it was decided that I would focus on researching the lived experience of mental health problems, stigma and attitudes towards disclosure and help-seeking among clinical psychologists in the UK.

1.3. Importance of Good Supervision

“Research supervisors are crucial for professional success and are one of a number of elements that affect the responsible conduct of research” (Bird, 2001). “A dynamic trusting supervisory relationship is a prerequisite for excellence in the research supervision process” (Severinsson, 2015). Both these declarations by Bird (2001) and Severinsson (2015) highlight the important contributions of responsible research supervisors, good supervision and a trusting supervisory relationship, towards the successful conduct and completion of a piece of research. Similarly, this was something that I found to be essential and assuring during the process of conducting my study. In addition to my limited research knowledge and experience, the prospect of having to perform statistical analyses contributed to the anxieties and slightly pessimistic view I had of conducting a research project. This was further compounded by my negative experience of inadequate supervision during my undergraduate days. Nevertheless, my contrary view of research and apprehension in approaching my supervisors for help were promptly dispelled through my subsequent positive relationships with my supervisors, who willingly and readily gave of their time and efforts to assist, encourage and support me all the way. My overall experience was further enhanced by their concerns about my personal wellbeing

beyond the research project. This was especially valued, in the wake of personal losses during the period of conducting this research.

1.4. Personal Thoughts and Beliefs about Mental Health Problems, Stigma, Disclosure and Help-seeking

Despite the pervasiveness of stigma, it was not a topic that I had devoted much time and thought to, prior to this research project. Conducting this study and paying heed to my supervisors' comments prompted an evaluation of my own personal beliefs and attitudes towards mental health problems, specifically my views towards the potential experience of mental health problems. While I believed that I had not actively stigmatised people with mental health problems, a comment made by my supervisors suggested otherwise. They had detected some negativity in the tone and language that I had used in the introduction of my literature review.

From the perspective of a mental health professional, I felt embarrassed that my immediate thoughts as someone who had been trained to show empathy and respect for people with mental health problems might be tinged, or seen to be tinged, by negativity surrounding mental health problems. I recognised that I had failed to consider positive aspects such as the enhancement of spirituality, empathy and resilience through the experience of mental health problems (Galvez, Thommi, & Ghaemi, 2011). I also realised the serious implications of stigma and the difficult yet immeasurably important task that lay ahead of us in shifting the attitudes of mental health professionals towards disclosing and help-seeking for mental health problems.

Additionally, I reflected further upon my attitudes towards disclosure and help-seeking if I were to experience a mental health problem. Even after having completed this piece of research and recognising the potential benefits of disclosing and seeking help for one's mental health problems (on one's own mental health,

ability to function and to treat our clients), I admit to still experiencing some sense of discomfort when considering the idea of disclosure to colleagues and employers. This provoked further thoughts about factors that might influence disclosure and help-seeking, and in particular, the culture of mental health professions ('us versus them') and the significant influence of one's cultural background. Similar to a participant in this study, I had viewed personal therapy as a tool to develop professionally as a clinical psychologist rather than for the purposes of managing potential mental health problems. Despite encouraging others to seek help, and affirming the benefits of therapy, I found myself still experiencing mixed feelings about therapy. I reflected on my intrinsic doubts of society and organisations, and in relation, the consequences of disclosure and help-seeking for mental health problems. Despite my belief that the experience of disclosure and help-seeking for mental health problems could promote empathy and empowerment, and thus reduce the divide between 'us' and 'them', I still have some reservations. I believe that disclosure, especially in the context of employment, would result in some amount of discrimination and rejection, and that culture is a key component in promoting these deep-seated beliefs.

The literature on culture and mental health problems suggests that beliefs about the origins and nature of mental health problems shape attitudes towards people with mental health problems, and influence disclosure and willingness to seek help (Nieuwsma, Pepper, Maack, & Birgenheir, 2011). This is inherent in various cultures. Mental health problems are perceived to be the consequence of a lack of emotional control, disruption of harmony ('yin and yang') within the individual, punishment for previous bad deeds, misfortune, being possessed and not a real illness (Gervais & Jovchelovitch, 1998; Lin, 1981; Tien, 1985). They are heavily

stigmatised and generate much shame in the individual and members of their family through associative/courtesy stigma (Angermeyer, Schulze, & Dietrich, 2003; Goffman, 1963; Schulze, 2007; Verhaeghe & Bracke, 2012). This results in the denial of problems and avoidance of disclosure and help-seeking. Even if distress is acknowledged, these cultural perspectives of mental health problems lead to the individual's preference for seeking help from traditional healers over mental health professionals (Ae-Ngibise et al., 2010). In spite of their prominence, these cultural perspectives may be lost in countries with biomedically driven models of mental health problems. It is therefore imperative that mental health professionals bear this in mind and practice cultural sensitivity to facilitate access to and usage of mental health services.

Where clinical psychologists as potential service users are concerned, my beliefs concerning the risks of discrimination and self-stigma associated with disclosure and help-seeking, compelled me to seriously consider the interventions that would be effective in reducing self-stigma. This seemed essential as my knowledge, training and contact with people with mental health problems did not wholly eliminate my negative attitudes. In line with Corrigan, Kosyluk, and Rüsch (2013), I believe that increases in clinical psychologists' public disclosure, and the sharing of their positive experiences and consequences of disclosure and help-seeking would encourage others who struggle to disclose and seek help, thereby reducing self-stigma.

1.5. Media Storm

In February 2016, the BPS and New Savoy Partnership published the findings of their 2015 survey of psychological professionals' wellbeing (Rao et al., 2016). They declared in a press release that 46% of survey respondents reported depression,

49.5% felt they were failures, 70% found their work stressful and that incidents of bullying and harassment had more than doubled. The media, not surprisingly, picked up on this announcement and soon reports about the fragile mental health of psychologists were reported in major newspapers including The Guardian, The Telegraph and The Times. This media frenzy also reached people far afield, including clinical psychologists from as far as Australia who made comments on social media about a need for research on this “important yet under-discussed topic”. Other comments included, “It seems like a lot of this kind of stuff is coming out of the UK. Can you say something about the current context”, “I’d really like to get a handle on that. I hear things through the grapevine but have no way of assessing their reliability or validity. From the sidelines, it looks like not only an economic but also a challenging professional environment, given the power of NICE to set practice guidelines”. Knowledge about my study had returned comments on their keen interest in being kept abreast, “I will be very interested to see what you find. Please keep us posted”.

The media storm and these comments highlighted the prominence of this under-researched area and the value and implications of my study. However, the negative tone used in some of the articles could have blindsided the public into forming distorted perspectives and expectations of psychologists and/or question our ability to provide therapy (e.g., “...using cognitive behavioural therapy which relies on a psychologist being upbeat and positive...their therapist is depressed... its success often depends on the client being able to think or positively, which relies on the psychologist being optimistic”). It is hoped that the public has not been influenced into a misleading view of psychology and clinical psychologists, and that the present study in addition to the BPS and New Savoy Partnership staff wellbeing

survey (2015) will make headway for and encourage further research into clinical psychologists' mental health and stigma.

2. Reflections and Critique on Concepts, Methodology and Terminology

2.1. Data Collection

Initial considerations for recruitment included utilizing the London supervisors' list and/or the DCP's mailing list. An approach to the then, DCP Chair at a UCL DClinPsy conference, allowed me to introduce and share my project's aims and implications. This led to the collaboration between UCL and the DCP's Equality & Diversity Subgroup, under the DCP's new Inclusivity Strategy.

Qualified clinical psychologists were subsequently recruited through the DCP's electronic mailing list, which according to the DCP administrator, had 3,600 members. Despite its wide reach, later conversations with a few clinical psychologists revealed that they were not aware of the study, as they were not members of the DCP. This meant that there was a group of clinical psychologists that I was not able to reach and this could have reduced the representativeness of this study's results.

For this study, participants were given access to the online survey via an electronic link sent to their email. Conducting the survey online had both its advantages and disadvantages. It was time and cost saving, facilitated distribution to a large and geographically dispersed population, ensured respondents' anonymity, reduced social desirability, and in general allowed for easier data collection (Benfield, 2006; Kwak & Radler, 2002; Markovitch, 2009). Moreover, the advanced features of the online survey platform, Qualtrics, allowed me to customise the survey by displaying only relevant questions, based on participants' response. The online survey platform was also linked to the statistical analysis program and eliminated the

need for manual data entry. Nonetheless, these advantages did not compensate for the disadvantages associated with online surveys. Unlike interviews, participants were unable to clarify any queries or confusions they had pertaining to the terms and/or questions used in the survey, thus resulting in different interpretations among participants. Although reliability analyses of the psychometric properties of the published measures for this sample of clinical psychologists showed that the measures had acceptable to good internal consistency, different interpretations of the questions used in online surveys could have reduced the reliability of the study. Despite controlling for social desirability, anonymising the survey meant that respondents who had only partially completed the survey due to time constraints had to return to the same computer and same web browser in order to pick up from where they left off. This could have resulted in a higher number of partial responses and abandonment, thus affecting the quality of responses (Saunders, 2012). Creating unique links for each participant would have counteracted this inconvenience to participants, but this was not done, as I did not have direct access to the DCP's mailing list. For future research, it would be helpful to define broad and confusing terminology.

2.2. Data Analysis

Commonly used statistical methods were used to analyse this study's data. Although the analyses were mostly straightforward, difficulties were still encountered. When designing the survey's questions, I was aware that some participants would have comorbidities. However, I did not consider how this would affect the data analysis of heavily (addictions, psychosis and bipolar disorder) and less stigmatised (depression, anxiety, eating disorder) mental health problems. In order to test the study's hypothesis on the aforementioned, I had to exclude

participants who had experienced mental health problems that were classified under both categories (e.g., depression and psychosis). In the same vein, I had to do the same for the exploration of disclosure target. Participants who had disclosed to people in both their social circles and in their work settings were excluded. Although still accurate and able to contribute to stigma, disclosure and help-seeking research, the results of the statistical analyses might not be thorough reflections of these areas of research. Further analyses of the data may provide a more comprehensive picture.

2.3. Concepts, Measures and Terminology

Two of four main concepts explored in this study included mental health stigma (hereafter known as stigma) and mental health problems. Stigma has been linked to stereotypes, rejection and attributes that are discrediting and devaluing (Goffman, 1963), and defined as human differences with negative attributes, the classification and labelling of differences, distinction of “us” from “them”, status loss, discrimination and an imbalance of power (Link & Phelan, 2001).

2.3.1. Multifaceted Nature of Stigma and its Corresponding Measures

Stigma can be broken down into various dimensions. Some of these include external (Link & Phelan, 2001), perceived (Barney, Griffiths, Jorm, & Christensen, 2006), self (Corrigan & Watson, 2002), experienced (Van Brakel et al., 2006), associative/courtesy (Angermeyer et al., 2003; Goffman, 1963, Verhaeghe & Bracke, 2012), and structural/institutional stigma (Corrigan, Markowitz, & Watson, 2004). Adding to the multifaceted nature of stigma are the various constructs of the distinct stigma dimensions. The multi-dimensionality and constructs of stigma have necessitated the development of multiple measures. For example, research focusing on external stigma has utilised measures of social distance, stereotyping, benevolence, social restrictiveness, perceived controllability of the stigmatising

condition (blame, personal responsibility and changeability of each mental health problem), emotional reactions, behavioural intentions and rejection (Borgardus, 1925; Cohen & Struening, 1962; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Olmsted & Durham, 1976). Perceived stigma, on the other hand, has been assessed through measures of perceived devaluation-discrimination, perceptions of rejection, stereotype awareness and stigma consciousness (Corrigan & Watson, 2002; Link, Mirotznik, & Cullen, 1991; Wahl, 1999). Research exploring self-stigma have done so through measures of secrecy, social withdrawal, alienation, stereotype endorsement and agreement, self-esteem decrement and stigma-related feelings of being different and ashamed (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Link, Struening, Neese-todd, Asmussen, & Phelan, 2002). Lastly, experienced stigma has been assessed through discrimination experiences and fear of discrimination (Wahl, 1999).

Different conceptualisations of stigma by researchers may lead to the subsequent use of different measures, which may then result in different conclusions about the levels of stigma among people. This is supported by Sayce (1998), who stated that different terms could lead to “different understandings of where responsibility lies for the ‘problem’ and as a consequence to different prescriptions for action”, raising concerns about the potential implications of different measurements.

For this study, external, perceived and self-stigma were investigated. The measures used to assess these aspects of stigma were the Social Distance Scale (Link, 1987), Stig-9 (Gierk, Murray, Kohlmann, & Lowe, 2013), a measure of respondents’ perceptions of the behaviours of others towards people with mental health problems, and the self-stigma subscale of the Military Stigma Scale (Skopp et

al., 2012), which measured the self-confidence and self-image of the respondent in relation to mental health problems. Although reliable, these measures only assess certain properties of individual aspects of stigma. Moreover, there were certain limitations within the measures that were highlighted by participants in their feedback. It was highlighted that questions that were reversed to control for social desirability in members of the general population, might not have served this purpose in a profession of people who have been trained in research and may therefore be primed to notice the function of these questions. Moreover, the terms used to define professional ‘helpers’ were used interchangeably across the different published measures (e.g., “... if I talked to a therapist”, “...with a fellow psychologist...”), and might have ultimately affected participants’ responses, as evident in a participant’s feedback, “My views differ depending upon the term you used... thus, the words used affected my response”. Although this study was able to contribute to the literature on stigma among mental health professionals, other studies exploring other constructs of external, self and perceived stigma, and other dimensions of stigma are required for a comprehensive understanding of stigma among this population. Furthermore, the questions posed in the measures used in this study appeared to assume that mental health problems are viewed negatively. It would therefore be beneficial for future research to include measures that reflect an anti-stigma and better-balanced perspective of mental health problems.

2.3.2. Mental Health Problems

Similar to stigma, ‘mental health problems’ is a broad term that covers a wide range of problems that affect people’s moods, cognitions and behaviours. This study utilised the broad term ‘mental health problem’ in referring to questions from published measures, while using more prevalent and specific mental health problems

for additional questions pertaining to attitudes towards disclosure and help-seeking. Descriptive analyses indicated that the majority of the participants who reported lived experience had experienced one or more of the represented mental health problems (83.1%). These findings verified the suitability of types of mental health problems chosen. Where the term “mental health problem” was used, feedback from two participants suggested that its classification was too broad and made responding to the questions difficult. “I found it quite difficult to answer as I think there is a marked difference in how socially accepted some kinds of mental health problems are”, “...because the definition of this (mental health problems) could be narrow and broad...I found it difficult that you clumped together a large group of different diagnoses. I answered some as how I felt about someone with depression and others thinking about bipolar disorder or psychosis, which I personally view differently in terms of their possible impact on functioning and likely need for external help... the neurosis/psychosis split might have different types of response which my responses mixed up depending on the question asked. I wasn’t able to reflect this difference in stigma in my answers”. While on one hand, this might add to the literature that mental health problems are stigmatised differently, it raises concerns about the validity of participants’ responses. It would be helpful for future research to have clearer definitions of concepts and terminology used.

3. Reflections on the Study’s Findings and Implications

This study’s sample size surpassed the number required to achieve statistical power by approximately ten-fold. The successful recruitment and responses of a fifth of all the clinical psychologists who were part of the DCP and were on the mailing list might support the representativeness of the sample. However, it was noted that

not every clinical psychologist in the UK is a member of the DCP, thus raising questions about the generalisability of this study's findings.

The present study showed that 62.7% of clinical psychologists experienced mental health problems at some point in their lives. Although the majority of participants were willing to disclose and seek help, this was dependent on disclosure target (i.e., family and friends were preferred over colleagues and employers). It was also shown that clinical psychologists would be more willing to seek help for certain types of mental health problems. These indicate that despite experiencing mental health problems, clinical psychologists still face difficulties disclosing to their colleagues and employers and might only disclose and seek help when they are left without a choice (e.g., when they no longer feel able to conceal the mental health problem and its impact on their performance at work). It was further shown that shame and fears of being judged negatively and of a negative impact on self-image prevented clinical psychologists from disclosing and seeking help for mental health problems.

These findings call attention to the need to implement interventions to cultivate cultures and environments that prioritise psychologists' well-being, foster empathy towards, and promote acceptance and openness of one's vulnerabilities, distress and mental health problems. Furthermore, findings from the New Savoy staff well-being survey (2015) suggests that factors contributing to the stress and pressures faced by psychological professionals include increased work targets, extra administrative demands and an overall stressful working environment. It is, therefore, necessary to involve not only workplace managers but also the wider system of NHS leaders and the government. To this end, Time to Change created employer and organizational pledges to encourage organisations to commit to

challenging stigma and discrimination in the workplace. Additionally and more recently, the BPS and New Savoy Partnership launched a Charter for Psychological Professionals Wellbeing and Resilience in February 2016, with the aim of improving psychological wellbeing in the workplace (Rao et al., 2016). It is further recommended that this culture of acceptance and openness be nurtured during university education, where the culture of clinical psychology fosters in emerging psychologists the need to be mentally resilient, invincible and self-reliant. It is hoped that this and improvements in the workplace environment will work hand-in-hand to facilitate clinical psychologists' willingness rather than necessity to disclose and seek help.

4. Conclusion

This study has provided valuable insight into the mental health of clinical psychologists and the impact of stigma and stigma-related factors on their willingness to disclose and seek help for mental health problems. It has also highlighted the need for targeted interventions to improve the wellbeing of clinical psychologists, and their willingness to disclose and seek help for mental health problems. It is hoped that this critical appraisal of the study will assist future researchers in their exploration of the positive aspects of experiencing mental health problems, and other aspects of stigma, both explicit and implicit.

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APPENDIX A: Quality Assessment Checklist

Author:				
Question	Yes	Can't tell	No	Comments
1. Is the study relevant to the needs of the project?				
2. Does the paper address a clearly focused issue? In terms of: <ul style="list-style-type: none"> • The population studied? • (case-control study only) Is the case definition explicit and confirmed? • The outcomes considered? • Are the aims of the investigation clearly stated? 				
3. Is the choice of study method appropriate?				
4. Is the population studied appropriate? <ul style="list-style-type: none"> • (Cross-sectional) Was the sample representative of its target population? • (Cohort) Was an appropriate control group used – i.e. were groups comparable on important confounding factors? • (Case-control) Were the controls randomly selected from the same population as the cases? 				
5. Is confounding and bias considered? <ul style="list-style-type: none"> • Have all possible explanations of the effects been considered? • (Cohort study) Were the assessors blind to the different groups? • (Cohort study) Could selective drop out explain the effect? • (Cross-sectional) Did the study achieve a good response rate? • (Cross-sectional) Were rigorous process used to develop the questions (e.g. were the questions piloted/validated/reliable) • (Case control study) How comparable are the cases and 				

<p>controls with respect to potential confounding factors?</p> <ul style="list-style-type: none"> • (Case control study) Were interventions and other exposures assessed in the same way for cases and controls? • (Randomised designs) Is assignment of subjects to intervention groups randomised? • (Randomised designs) Are the intervention and control groups similar at the start of the trial? 				
<p>6. (Cohort study) Was the follow up long enough?</p> <ul style="list-style-type: none"> • Could all likely effects have appeared in the time scale? • Could the effect be transitory? • Was follow up sufficiently complete? • Was dose response demonstrated? 				
<p>7. Are the tables/graphs adequately labelled and understandable?</p>				
<p>8. Are you confident with the authors' choice and use of statistical methods, if employed?</p>				

Summary Judgment:	
++	All or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions of the study or review are thought <i>very unlikely</i> to alter.
+	Some of the criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.
–	Few or no criteria fulfilled The conclusions of the study are <i>thought likely or very likely</i> to alter.

APPENDIX B: Study's Email Invitation

Dear colleagues,

We are conducting a study into mental health stigma among clinical psychologists and its impact on willingness to disclose and seek help when experiencing mental health problems. This study is conducted by UCL in collaboration with the DCP's Equality & Diversity Subgroup, under the DCP's new Inclusivity Strategy.

In recent years, mental health stigma has been recognised as an issue of concern in some health professional groups, particularly among doctors. Professional bodies like the GMC are taking an active role to address mental health stigma and support doctors in seeking help when needed. However, to date, we have no evidence on whether this may also be a concern among clinical psychologists, and something that the profession may need to give more thought to. This study is a first attempt to get a sense of clinical psychologists' general perceptions of mental health problems, and also their views on disclosure and help seeking when they themselves do or might experience mental health problems.

Taking part means completing an anonymous web survey that will take approximately 20 minutes. We are seeking the views of qualified clinical psychologists. Whether or not you have personally experienced mental health problems in the past (or at present), we are very keen to hear from you. All information provided will be treated as strictly confidential and only summary data will be shared with the DCP.

Due to the sensitivity of the information sought, we have deliberately made response choices to demographic questions sufficiently broad so as not to make any participant potentially identifiable. The study has received ethical approval from the UCL Research Ethics Committee (Project ID: 0241/002).

To read more about the study and consider taking the survey please follow this link: https://uclpsych.eu.qualtrics.com/SE/?SID=SV_e4jarIT4aaxQXYx

The results will be summarised and shared with the DCP, both through presentations at DCP related events and through dissemination of papers reporting the findings. They will also be reported as a doctoral assignment and submitted for publication in an academic or professional journal.

NB: If you are unable to complete the survey in one sitting, you will be able to return to the survey within seven days (by following the link in the original email) and pick up from where you started, as long as you use the same computer.

Kind Regards,
Katrina, Kat, Stacie & Stephen

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Dr Kat Alcock, Senior Clinical Tutor
Stacie Tay, Trainee Clinical Psychologist
Doctorate in Clinical Psychology
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Cc: Dr Stephen Weatherhead, Inclusivity Lead, Division of Clinical Psychology
Executive

APPENDIX C: Full Survey

Participant Information Sheet

We would like to invite you to participate in an important research project, conducted by University College London in collaboration with the BPS Division of Clinical Psychology (DCP) Equality & Diversity Subgroup, and in line with the DCP's new Inclusivity Strategy. Before you decide whether you want to take part, it is important that you read the following information carefully. It is entirely up to you to decide whether or not to participate; choosing not to will not disadvantage you in any way.

Purpose of this study

Mental health stigma has been recognised as an issue of concern in some health professional groups, particularly among doctors, and bodies like the GMC have taken an active role to address mental health stigma and support doctors in seeking help when needed. However, to date, we have no evidence whether this may also be an issue of concern among clinical psychologists, and something that the profession may need to give more thought to. This study is a first attempt to get a sense of the views of clinical psychologists on the personal experience of mental health problems and reactions to them.

For this study, we are seeking the views of qualified clinical psychologists, who are UK nationals or residents. Whether or not you have personally experienced mental health problems in the past (or at present), we are very keen to hear from you.

Your participation in this study is entirely voluntary and you are free to withdraw from the study at any time and without giving any reason.

Completing this anonymous survey will take you approximately 20 minutes. Should you be unable to complete the survey in one sitting, you will be able to return to the survey (by following the link in the original email) and pick up from where you started, as long as you use the same computer and web browser. If you decide to stop during the survey or are not able to complete it fully, your responses will be automatically deleted when the survey closes.

The personal information you provide will only be used for the purposes of this study and not transferred to any organisations outside of UCL. Qualtrics will not record any personal information such as your IP address. The information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Please ask if there is anything that is unclear or if you require more information. Contact details can be found below.

Principal Investigators: Dr Katrina Scior, Dr Kat Alcock and Stacie Tay; Clinical, Educational & Health Psychology, University College London, London WC1E 6BT;

██████████; Email: ██████████
██████████

This study has been approved by UCL Research Ethics committee.

This study is in two parts. The first part asks for some demographic information which we have purposefully made sufficiently broad so as not to make any participant potentially identifiable. The second part asks about your views on disclosure and help seeking for mental health problems, your personal contact with and general beliefs about individuals with mental health problems and your perceptions of discrimination faced by people with mental health problems. You will have the option to move on and leave questions unanswered if you choose.

Answering questions related to current or past mental health problems you may have experienced might be distressing. You can stop taking part in the survey at any point by closing your web browser. If you wish to talk about your difficulties, you may contact the researchers via the contact details provided above. If you wish to speak to someone other than the researchers, you can find information about confidential mental health support lines on this page: <http://www.nhs.uk/conditions/stress-anxiety-depression/pages/mental-health-helplines.aspx>

By clicking on to the next page, you acknowledge that you have read this information and consent to participate in the study.

Survey

Demographic Questionnaire

Please try to answer the following questions honestly. Your responses will be completely confidential and will remain anonymous. You will have the option to move on and leave questions unanswered if you choose. We realise that every person is unique and that it is hard to generalise about any group. However, based on your experience as a clinical psychologist who comes into frequent contact with individuals with a wide range of mental health problems, we would like you to indicate your general beliefs and perceptions towards them. You will also be asked about your personal experiences and attitudes relating to disclosure of mental health problems and help seeking.

About you

Gender

- Male
- Female

Ethnicity

*These categories are purposefully broad to ensure anonymity of participants.

- White
- Black
- Asian
- Mixed
- Other
- Do not wish to identify

Age

- 20-29
- 30-39
- 40-49
- 50-59
- 60+

Number of years since qualifying

- Not yet qualified
- Under 2 years
- 2-5 years
- 6-10 years
- 11-20 years
- > 20 years

Have you ever experienced a mental health problem?

- Yes
- No

What type of mental health problem(s) have you experienced? *Please tick all that apply

- Mild to moderate depression
- Anxiety disorder
- Severe depression
- Bipolar disorder
- Psychosis
- Addiction
- Eating disorders
- Other _____

To whom did you disclose that you were experiencing a mental health problem? *Please tick all that apply

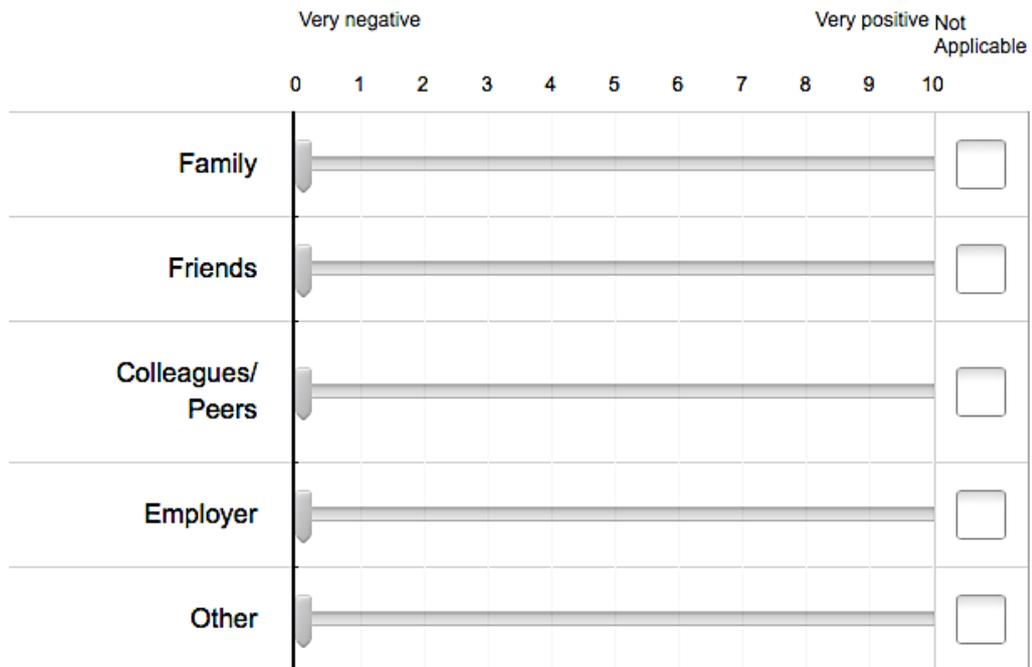
- No one
- Family
- Friends
- Colleagues/ Peers
- Employer
- Other _____

What prevented you from disclosing? *Please tick all that apply

- Fear of being judged negatively
- Fear of negative effect on my career
- Impact on self-image
- Shame and embarrassment
- Other _____

Please rate your experience of disclosing *Please click to drag the indicator to your desired point

Note: If you disclosed mental health problems to this person/source on several occasions, please rate your experience of the most memorable occasion, that is the occasion most likely to influence whether you disclose to this person/source in future.



Have you ever sought help for a mental health problem?

- Yes
- No

From whom did you seek help? *Please tick all that apply

- GP
- NHS Clinical Psychologist
- Private Clinical Psychologist
- NHS Psychiatrist
- Private Psychiatrist
- NHS Therapist
- Private Therapist
- Other _____

As part of your treatment, have you ever *Please tick all that apply

- Taken psychotropic medication
- Received talking therapy
- Received counselling

Please rate your experience of seeking help *Please click to drag the indicator to your desired point

Note: If you sought help from this source on several occasions in relation to mental health problems, please rate your experience of the most memorable occasion, that is the occasion most likely to influence where you might seek help in future.

	Very negative	0	1	2	3	4	5	6	7	8	9	10	Very positive	Not Applicable
GP		<input type="range"/>												<input type="checkbox"/>
NHS Clinical Psychologist		<input type="range"/>												<input type="checkbox"/>
Private Clinical Psychologist		<input type="range"/>												<input type="checkbox"/>
NHS Psychiatrist		<input type="range"/>												<input type="checkbox"/>
Private Psychiatrist		<input type="range"/>												<input type="checkbox"/>
NHS Therapist		<input type="range"/>												<input type="checkbox"/>
Private Therapist		<input type="range"/>												<input type="checkbox"/>
Other		<input type="range"/>												<input type="checkbox"/>

What prevented you from seeking help? *Please tick all that apply

- Fear of being judged negatively
- Fear of negative effect on my career
- Impact on self-image
- Shame and embarrassment
- Other _____

The following questions are all hypothetical. Please imagine you were to experience distress in the future. Please try to answer as honestly as possible.

Views on disclosure

If you were to experience distress or symptoms in line with the following mental health problems in the future, who would you disclose to?

*Please tick all that apply

	No one	Family	Friends	Colleagues/Peers	Employer	Other
Mild to moderate depression	<input type="checkbox"/>					
Anxiety	<input type="checkbox"/>					
Severe depression	<input type="checkbox"/>					
Bipolar disorder	<input type="checkbox"/>					
Psychosis	<input type="checkbox"/>					
Addiction	<input type="checkbox"/>					
Eating disorders	<input type="checkbox"/>					

If you've chosen 'other' for any of the mental health problems, please elaborate

If you ticked 'no one' for any of the mental health problems, what would prevent you from disclosing?

*Please tick all that apply

- Fear of being judged negatively
- Fear of negative effect on my career
- Impact on self-image
- Shame and embarrassment
- N/A
- Other _____

The following questions are all hypothetical. Please imagine you were to experience distress in the future. Please try to answer as honestly as possible.

Views on seeking help

If you were to experience distress or symptoms in line with the following mental health problems in the future, from whom would you seek help?
*Please tick all that apply

	No one	GP	NHS Clinical Psychologist	Private Clinical Psychologist	NHS Psychiatrist	Private Psychiatrist	NHS Therapist	Private Therapist	Other
Mild to moderate depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you've chosen 'other' for any of the mental health problems, please elaborate

If you ticked 'no one' for any mental health problems, what would prevent you from seeking help?

*Please tick all that apply

- Fear of being judged negatively
- Fear of negative effect on my career
- Impact on self-image
- Shame and embarrassment
- N/A
- Other _____

Social Distance Scale

The following questions ask you to rate how you would feel about interacting with someone experiencing mental health problems in your personal life, that is, outside of work. The term 'mental health problems' here refers to a wide range of mental health conditions, including depression, anxiety disorders, bipolar disorder, psychosis, addictions and eating disorders.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
I would feel upset or disturbed if someone who has a mental health problem lived next door to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not spend the evening socialising with someone who has a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not maintain a friendship with someone who has a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel upset or disturbed if I had to work closely with someone who has a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not marry/enter into a committed intimate relationship with someone with a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Stig-9

The following questions ask how you think most people would respond to someone who has been treated for a mental health problem. I think that most people....

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
Take the opinion of someone who has been treated for a mental health problem less seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consider someone who has been treated for a mental health problem to be dangerous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hesitate to do business with someone who has been treated for a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think badly of someone who has been treated for a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consider mental health problems to be a sign of personal weakness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hesitate to entrust their child to someone who has been treated for a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do not even take a look at a job application from someone who has been treated for a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do not enter into a relationship with someone who has been treated for a mental health problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel uneasy when someone who has been treated for a mental health problem moves into the neighbourhood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Military Stigma Scale

The following questions ask you to rate how you would personally feel about seeking help for a mental health problem you might experience. Please rate the following items in relation to seeking help in response to experiencing a mental health problem and not in relation to therapy you may access to support your work as a therapist.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
My self-confidence would be harmed if I got help from a mental health professional.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My view of myself would deteriorate if I made the choice to see a therapist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel okay about myself if I made the choice to seek professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel worse about myself if I could not solve my own problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My self-esteem would increase if I talked to a therapist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel inadequate if I went to a therapist for psychological therapy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeking psychological therapy would make me feel less intelligent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My self-confidence would not be threatened if I sought professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I went to a therapist, I would be less satisfied with myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would make me feel inferior to ask a therapist for help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

The following questions ask how you feel about seeking mental health support more generally.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
If I believed I was having a psychiatric breakdown, my first inclination would be to get professional attention.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talking about problems with a fellow psychologist would not be helpful in getting rid of my emotional conflicts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychological therapy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would want to get psychological therapy if I were worried or upset for a long period of time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I might want to have psychological therapy in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A person with an emotional problem will likely only solve it with professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Considering the time and expense involved in psychological therapy, it would have doubtful value for a person like me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A person should work out his or her own problems; getting psychological therapy would be a last resort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal and emotional troubles, like many things, tend to work out by themselves.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Secrecy Scale

The following questions ask about your views on disclosing a range of severe mental health problems. The term 'severe mental health problems' here refers to mental health problems which significantly impact on a person's basic activities of daily living, interpersonal relationships and occupational functioning (e.g., not being able to get out of bed for a week; having to take a sustained period of time off work).

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
If I had a close relative who had been treated for a severe mental health problem, I would advise him or her not to tell anyone about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I were in treatment for a severe mental health problem, I would worry about certain people finding out about my treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I have ever been treated for a severe mental health problem, the best thing to do is to keep it a secret.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is no reason for a person to hide the fact that he or she was a psychiatric patient at one time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In view of society's negative attitudes toward people with severe mental health problems, I would advise people with severe mental health problems to keep it a secret.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In order to get a job, a former psychiatric patient will have to hide his or her history of hospitalisation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would encourage other members of my family to keep my mental health problem a secret.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that a person who has recovered from a mental health problem experienced earlier in life should not tell other people about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
When one meets people for the first time, one should make a special effort to keep the fact that one has been in mental health treatment to oneself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are you aware of any initiatives to address mental health stigma within the profession, e.g., through discussions, research, meetings etc.? If yes, please provide some details here so that we can follow this up/contact the relevant people.

Would you be interested in being involved in a working group to be convened, once the findings have been reported to consider these issues further, under the banner of the DCP/BPS? If yes, please send a separate email to [REDACTED] or [REDACTED] briefly stating your interest.

Thank you for your participation!

If you have any concerns or queries about this research, you may contact the researchers using the contact details below. If you are affected by any of the issues raised in the survey and wish to speak to someone other than the researchers, you can find information about confidential mental health support lines on this page: <http://www.nhs.uk/conditions/stress-anxiety-depression/pages/mental-health-helplines.aspx>

The results will be summarised and shared with the Division of Clinical Psychology (DCP). They will also be reported as a doctoral assignment and submitted for publication in an academic or professional journal. If you are interested in the results of the study, we are happy to send you a short report on the results and/or a copy of the paper. To be kept informed about the findings of the study, please email [REDACTED] to request this.

Thank you once again for your participation, it is greatly appreciated.

Contact details

Dr Katrina Scior, Dr Kat Alcock and Stacie Tay
Doctorate in Clinical Psychology
UCL Gower Street
London
WC1E 6BT
United Kingdom
[REDACTED]
[REDACTED]

APPENDIX D: Email Confirmation of Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES



Dr Katrina Scior
Research Department of Clinical, Educational and Health Psychology
UCL

11 March 2015

Dear Dr Scior

Notification of Ethical Approval

Project ID: 0241/002: Mental health stigma among clinical psychologists and trainee clinical psychologists: impact on disclosure and help-seeking

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee that I have approved your study for the duration of the project i.e. **until March 2016**.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form':
2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events

For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator [REDACTED], within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely



Professor John Foreman
Chair of the UCL Research Ethics Committee

Cc:
Stacie Tay Keng Min & Tom Grice, Applicants
Dr John King