Factors Affecting Disclosure of Mental Health Problems

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D. Clin. Psy. Thesis (Volume 1), 2016

University College London

UCL Doctorate in Clinical Psychology

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.

Signature:

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Overview

This thesis set out to develop our current understanding of the factors associated with disclosure and concealment of mental health problems. Part one is a literature review of research published in the past decade looking at the factors associated with disclosure of mental health problems outside the workplace. Part two is an empirical paper based on a study examining disclosure of mental health problems by trainee clinical psychologists. This study used an online survey to better understand what factors may be associated with likelihood of disclosure, for trainees both with and without lived experience of mental health problems. Part three is a critical appraisal of the empirical paper. The critical appraisal presents reflections on the research process, discusses further the value of this research, and expands on the limitations and implications of the findings.

Acknowledgements

Firstly, I would like to thank my supervisors, Dr Katrina Scior and Dr Kat Alcock. It's remarkable how consistently available you've been throughout the process, and how generous you've been with your time and insight. Above all, you have been a constant source of encouragement and a calming influence, for which I am hugely grateful.

Secondly, big thanks – and congratulations – to my thesis buddy Stacie Tay, who I know shared many of the same challenges and frustrations as I did, throughout her research on mental health problems in qualified psychologists. Thanks for all your thoughts and help.

Lastly, massive thanks to Ravi Das, who without a doubt saved me from strangulation by the Statistics Octopus of Inescapable Despair…. I can't work out if Ravi is actually in cahoots with this Octopus, or if he's more of a knight in shining armor. Either way, his patience and SPSS wizardry were superhuman.

Of course, this research would have been nothing without the many trainees who volunteered their time and reflections. Thank you all so much.

Part 1: Literature Review

Factors Affecting Disclosure of a Mental Health Problem: A Systematic Review of the Literature

Abstract

Introduction People with mental health problems sometimes have the choice whether or not to disclose this to others. The decision to disclose or conceal is likely to have a number of consequences, both positive and negative, and is likely to depend on a variety of factors, which may differ between individuals. We aimed to review the literature relating to these factors.

Method A systematic review of three databases (PsycINFO, Scopus and Web of Science) was carried out to identify articles looking at factors affecting disclosure of a mental health problem outside the workplace, published between January 2005 and August 2015.

Results 19 articles, including qualitative and quantitative methodologies, were identified. Common factors affecting the decision to disclose or conceal included stigma, characteristics of the target, relationship with the target, mental health of the discloser, rules and beliefs about mental health problems, and fears about control and sense of identity.

Discussion Limitations of the current literature, and implications for future research and policy are discussed.

Introduction

Individuals who have experienced or are experiencing a mental health problem sometimes have the choice of whether or not to disclose this information to others. Disclosure enables access to professional support, and research has demonstrated that the process of disclosing distress may in itself bring about an improvement in mood and physical health (Frattaroli, 2006). Despite this, research indicates that people with mental health problems often disclose selectively, and that around 10% have not disclosed their mental health problem to even one family member (Bos, Kanner, Muris, Janssen & Mayer, 2009). The factors involved in this decision-making process are at present unclear.

The Disclosure Dilemma

Negative consequences of disclosure. Notwithstanding campaigns to change public perceptions of mental health problems, some members of society continue to view people with mental health problems as unpredictable, dangerous, and responsible for their difficulties (Angermeyer & Dietrich, 2006; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). These stigmatised views frequently have a detrimental effect on the stigmatised individual, whether this is in the form of discrimination within the family, at work and school; the loss of friends; or shame and loss of self-esteem (Ilic et al., 2012; Shrivastava et al., 2011; Suto et al., 2012). Individuals may internalise society's stigmatised beliefs, and this internalised stigma has been shown to impact negatively on relationships and willingness to seek help, particularly for middle-aged people (West, Yanos, Smith, Roe & Lysaker, 2011). Consequently, many people experiencing mental health problems prefer not to disclose these to others.

As Vogel, Wade and Haake (2006) point out, this leaves an 'unsettling paradox' whereby even though psychological treatments have been found to be effective for a range of mental health problems, fewer than 40% of affected people seek help. In addition to the stigma and discrimination that can accompany mental health problems, disclosure of a mental health problem may lead to coercive treatments and medication (Corrigan & Matthews, 2003), and poorer performance in academic environments (Quinn, Kahng & Crocker, 2004).

The benefits of disclosure. Receiving help is not the sole benefit of disclosure. Hiding a concealable stigma can lead to thought intrusions, vigilance and suspiciousness; depression, anxiety and decreased self-esteem; social avoidance and isolation, guilt, anxiety and maladaptive behaviour in close relationships; reduced self-efficacy and identity ambivalence (Pachankis, 2007). Additionally, literature suggests that emotional self-disclosure helps to increase trust and develop social relationships, as well as promoting cognitive processing of emotions (Ignatius & Kokkonen, 2007). The process of disclosure may in itself help to reduce distress, depression, anger, anxiety, and stigma stress, and improve physical health (Frattaroli, 2006; Frisina, Borod, & Lepore, 2004; Pennebaker & O'Heeron, 1984; Rüsch, Brohan, Gabbidon, Thornicroft & Clement, 2014; Smyth, 1998). It may also help the wider community become more accepting of mental health issues (Corrigan & Matthews, 2003).

Factors Affecting Disclosure

Academics working in the field of information disclosure have sought to explain how people make decisions about disclosing or concealing personal information (Greene et al., 2012). Research has largely focused on disclosure of personal or distressing information, and non-visible health conditions, rather than mental health

problems. Factors found to affect disclosure of personal information include the quality of the relationship with the target, the anticipated response of the target, the long-term impact on the relationship, the discloser's confidence that they can accurately anticipate the target's response to their disclosure, aspects of the information itself (such as the stigma perceived to be associated with the information), and the discloser's skills in negotiating disclosure (Greene et al., 2012). Individuals may disclose in order to seek support, out of a duty to inform or wish to educate others, or out of the desire to have a close, trusting relationship with increased intimacy (Greene, Derlega & Mathews, 2006). People may conceal due to fear of rejection and loss of privacy, a belief that the target will not respond helpfully, a desire to protect the target, fear of losing the relationship, or a belief that the information is not relevant (ibid.). The target's availability is a significant factor, as is the extent to which the discloser believes she has the ability to communicate the information effectively (Afifi & Steuber, 2009; Caughlin, Afifi, Carpenter-Theune & Miller, 2005). Further factors contributing to verbal disclosure include features of the target (such as trustworthiness and attractiveness), situational factors (including that disclosure is more likely when communication is not face-to-face), and cultural factors (in non-Western cultures people may disclose less frequently but with greater depth) (Ignatius & Kokkonen, 2007).

Given the complexity of the disclosure decision-making process, and the gravity of this decision, it seems important to better understand the pressures acting on individuals when they make this decision. This area of research requires particular clarity, since much of the pre-existing literature relates to disclosure of personal or distressing information, secrets, and concealable physical health conditions, but not to mental health problems. To what extent do individuals with mental health

problems consider issues of stigma when making disclosure decisions, and to what extent does stigma act as a barrier to disclosure? How much attention is paid to the context of the disclosure situation and to characteristics of the target? What factors ultimately prove the weightiest in persuading individuals to disclose or conceal?

Aims and Objectives

The current review seeks to summarise and critique contemporary research into the factors affecting an individual's decision to disclose to or conceal from others a mental health problem. While reviews exist that focus on disclosure in the workplace (Brohan et al., 2012; Jones, 2011), to the author's knowledge none have examined reasons for disclosure or concealment in other contexts. Therefore, this review will evaluate articles relating to disclosure of mental health problems outside the workplace. At present there are several measures of mental health problem disclosure used by researchers. This review will comment on the tools commonly used to measure disclosure.

The review seeks to address the following question:

What is known about factors that affect the decision to conceal or disclose a mental health problem outside the workplace?

Method

Search Strategy

A systematic search of the literature was conducted by searching PsycINFO, Scopus and Web of Science. Articles published in English between January 2005 and August 2015 were included in the search. The search was restricted to articles published in the previous ten years in order to ensure that findings were most relevant to the state of current research, in relation to both the tools used to measure disclosure and the factors associated with disclosure. This was particularly important because there may have been recent changes in the way that members of the public

view mental health problems. Search terms focused on two areas: disclosure and mental health problems (see Table 1). It was beyond the scope of this review to include as search terms all labels currently used to describe the range of mental health problems experienced by individuals. Schizophrenia, depression and anxiety were included in the literature review search terms, since these were three of the four terms used by Brohan et al. (2012), and are most commonly found in the mental health disclosure background literature. However, it was acknowledged that this may have resulted in the search overlooking eligible articles. Terms were combined using the Boolean terms 'OR' and 'AND' to search for titles that included both disclosure-related terms and mental health problem related terms. The inclusion and exclusion criteria outlined below were applied to the 376 articles identified in the initial search. Article titles were read to determine which met inclusion criteria. Where there remained ambiguity abstracts and where necessary, entire papers, were read.

Table 1

Literature Review Search Terms

Disclosure	Mental health problem
Disclos*	"Mental health problem"
Conceal*	"Mental illness"
Self-disclos*	"Mental disorder*"
Self-conceal*	"Psych* illness"
Non-disclos*	"Psych* disorder*"
Secrecy	"Psych* diagnosis"
	"Psych* problem*"
	Distress
	Schizophrenia
	Depression
	Anxiety

*Truncated terms to allow for multiple endings of words

Inclusion and Exclusion Criteria

Inclusion criteria.

- Studies relating to the disclosure or concealment of a mental health problem and the variables that may affect whether someone chooses to disclose or conceal;
- Articles relating to the impact or consequences of disclosure were included only if they also included analysis of factors affecting disclosure, or affecting decisions relating to disclosure;
- Studies had to be empirically based, using either qualitative or quantitative methodologies;
- Articles written in English.

Exclusion criteria.

- Articles relating to distress about disclosure of physical health conditions;
- Articles relating to disclosure of trauma or traumatic events;
- Articles relating to disclosure by children and adolescents;
- Articles relating to distress disclosure, where distress was not defined as a specific mental health problem (including emotional disclosure in bereavement) (see section 'distress disclosure' below);
- Articles that focused on help-seeking rather than disclosure (see section 'disclosure vs. help-seeking' below);
- Studies that used a general population sample and did not distinguish between participants who did and did not have a personal history of a mental health problem (see section 'target population' below);
- Review articles, conference presentations and unpublished dissertations.

Distress disclosure. The review excluded articles that focused on the disclosure of emotional or 'mental' distress, where this was not described or understood as a mental health problem, diagnosis or illness. We distinguished between emotional distress and mental health problems because distress is ubiquitous to human experience and does not carry the same level of stigma, shame and implications for interpersonal relationships. For the purposes of consistency studies that conflated 'mental distress' with 'mental health problem', were excluded from this review.

Disclosure versus help-seeking. It was important that this review distinguished between disclosure and help-seeking, since disclosure is not always intended as a means to gain help. A small number of articles used the two terms interchangeably. In these instances articles were read in full and included if it was clear that the researchers and participants understood the focus of the study to be disclosure rather than help-seeking.

Target population. Research with participants who neither self-identified nor were identified by others as experiencing a mental health problem was excluded from the review. While studies existed that examined reasons for disclosure in the general population, these studies asked participants about hypothetical situations (Rüsch, Evans-Lacko, Henderson, Clare & Thornicroft, 2011; Rüsch, Evans-Lacko & Thornicroft, 2012). These studies were excluded because it is not clear that individuals asked to imagine having a mental health problem think about disclosure in the same way as those who do have mental health problems (Bell et al., 2011).

Quality Assessment

Articles were compared to the criteria specified in the critical appraisal tool developed by Hawker, Payne, Kerr, Hardey and Powell (2002) (see Appendix A) and used consequently in papers that synthesise quantitative and qualitative research

(for example, Flemming, 2010; Markoulakis & Kirsh, 2013). The tool is used to rate studies on a scale of 1 (very poor) to 4 (good) on nine aspects of their methodology. The tool is particularly useful because it provides clear guidelines for scoring of methodologies. A summed total score of 9 (very poor) to 36 (very good) is obtained.

Results

The database searches combining at least one term from the 'disclosure' domain and one term from the 'mental health problem' domain identified 376 articles. Of these, 16 met the inclusion criteria. Searching the reference lists of included articles identified three further articles. A flowchart of study selection is presented in Figure 1.

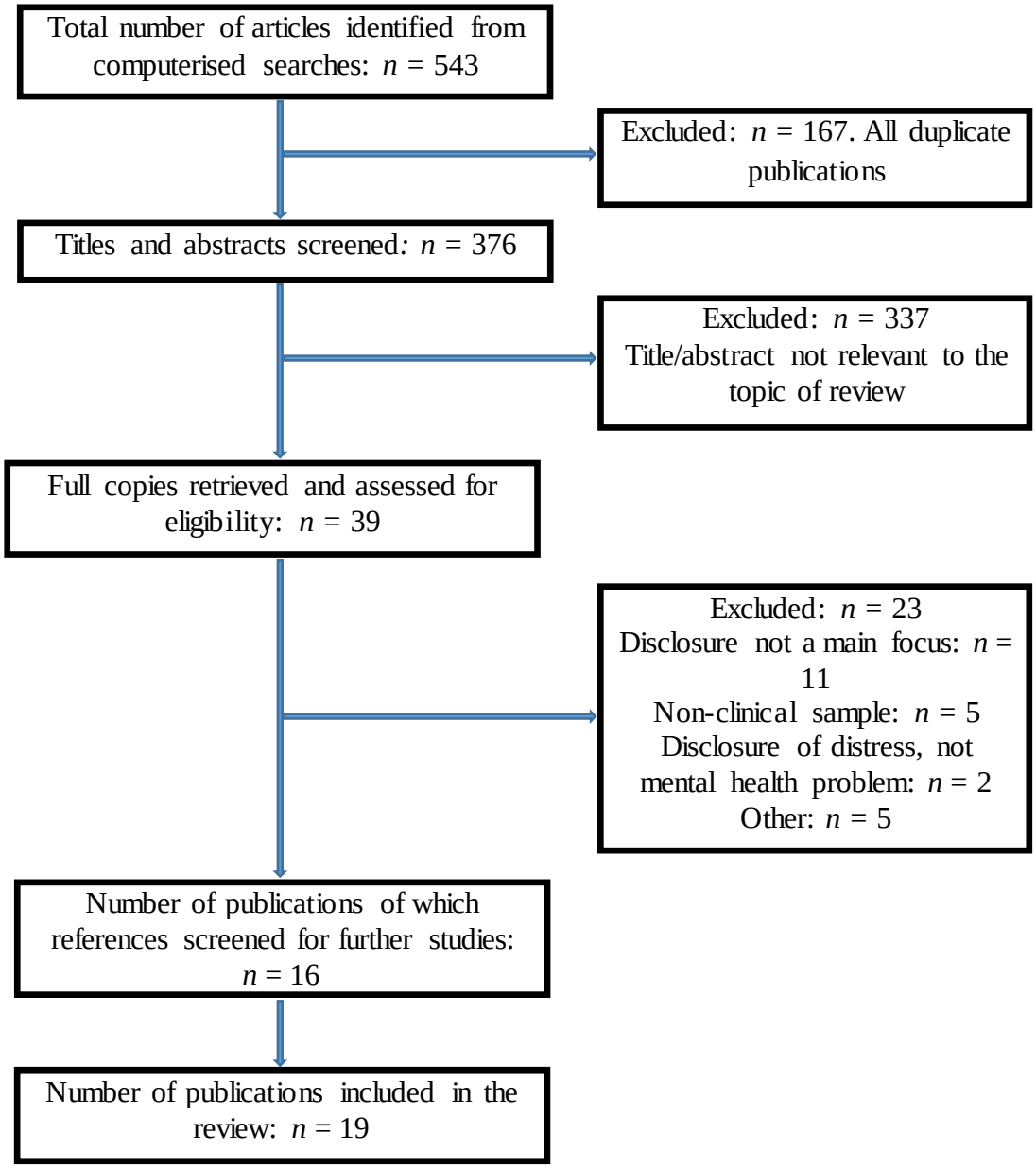

Figure 1. Flowchart showing process of study selection.

Table 2 presents the articles identified in the search. There were 19 publications in total, 11 of which were quantitative and eight qualitative in methodology. The studies were conducted in a total of six countries and investigated disclosure to a variety of targets, including family, friends, primary health provider/GP, acquaintances, neighbours and in educational settings. Six studies asked about disclosure more generally, not specifying the target of disclosure.

Table 2

Summary of Articles Included in Review

Author(s) and date	Country	Sample, recruitment and method	Target of disclosure	Key findings	Overall quality appraisal score (0-36)
Quantitative studies					
Bell et al. (2011)	USA	• N = 1054 (475 with history of depression) • Random sampling followed by stratified sampling • Cross-sectional	Primary care physician	*Most frequently chosen reasons for not disclosing:* • Concern about medical records being seen by others and about being put on medication *Significant predictors of non-disclosure:* • Being female (+ve) • Being Hispanic (+ve) • Beliefs that depression is stigmatised (+ve) • Depression symptoms (+ve) • Higher income (-ve)	30
Bos et al. (2009)	Netherlands	• N = 500 • Random sampling from a mental health institute • Cross-sectional	Family Friends Acquaintances Colleagues	• Highest percentage of disclosure to partner (96.8%), followed by mother (88.8%) and father (84.2%) • Disclosure negatively correlated with perceived stigma • Disclosure positively correlated with perceived social support	28

Table 2 (continued)

Authors	Country	Sample & Method	Target of disc.	Key findings	Overall appraisal (/36)
Chronister, Cho & Liao (2013)	USA	• N = 101 • Flyers posted targeting people attending psychosocial rehab programme • Cross-sectional	General	*Correlations with secrecy:* • Quality of life (-ve) • Societal stigma (+ve) • Internalised stigma (+ve) • Emotional support (-ve) • Tangible support (-ve)	33
Corrigan et al. (2010)	USA	• N = 85 • Flyers targeting people in community rehab programmes • Cross-sectional	General	• No differences in secrecy according to demographics or other variables • Stronger agreement with past reasons for not disclosing were not significantly correlated with secrecy	25
Garcia & Crocker (2008)	USA	• N = 45 • Advertisements in campus newspaper • Longitudinal	Family Friends Co-workers Strangers	• Highest level of disc. when individuals had both ego and eco-system goals • Lowest level of disc. when individuals had high ego and low eco-system goals	29
Kleim et al. (2008)	UK	• N = 127 • Service users from local psychiatrists and hospital outpatient service • Cross-sectional	General	*Correlates of secrecy:* • Perceived stigma (+ve) • Age (-ve); Self-efficacy (-ve) *Regression analysis showed:* • Perceived stigma positively predicts secrecy • Age and gender are not significant predictors of secrecy	29

Table 2 (continued)

Authors	Country	Sample & Method	Target of disc.	Key findings	Overall appraisal (/36)
O'Mahen, Henshaw, Jones & Flynn (2011)	USA	• N = 532 (women only) • 56% with current or past depression • Opportunity sampling • Cross-sectional	General	• For white women, secrecy and depression stigma positively correlated. • For black women, non-significant correlation of secrecy and depression stigma.	33
Pandya, Bresee, Duckworth, Gay & Fitzpatrick (2011)	USA	• N = 258 • Opportunity sampling via National Alliance on Mental Illness • Cross-sectional	Friends Family Colleagues Police Place of worship Doctor Partner	• People most open with doctor, followed by spouse/significant other, parents, and then friends. • Least open with neighbours • Females most open with friends and significant other • Males most open with parents *Predictors of openness:* • Self-reported current mental health status (+ve) • Number of types of relationships (-ve)	28
Rüsch et al. (2014)	UK	• N = 202 • Recruitment via clinicians working in mental health teams • Cross-sectional	Friend Family member	*Predictors of comfort disclosing:* • Anticipated discrimination (-ve) • Stigma stress (-ve) • Psychiatric inpatient treatment in past year (-ve)	29

Table 2 (continued)

Authors	Country	Sample & Method	Target of disc.	Key findings	Overall appraisal (/36)
Weich, Morgan, King & Nazareth (2007)	UK	• N = 866 • Opportunity sampling – people approached in GP waiting room • Cross-sectional	Family/friends	• A person is more likely to disclose to family and friends if she considers depression to be a medical condition that responds to support, and less likely if she considers it a permanent, disabling and stigmatizing condition	33
Yow & Mehta (2010)	Singapore	• N = 84 • Opportunity sampling from attendees of the Institute of Mental Health • Cross-sectional	General	• Secrecy positively correlated with perceived stigma • Higher level of secrecy than in comparative US sample	29
<u>Qualitative studies</u>					
Bushnell et al. (2005)	New Zealand	• N = 775 (481 had mental health problem) • Volunteer sampling followed by stratified sampling • Cross-sectional • Thematic analysis	Doctor	*Reasons for not disclosing:* • GP not the appropriate person to speak to • Mental health problems should not be discussed at all • One's own GP is not the right person to speak with (on account of relationship and GP's attitude) • Concerns about stigma • System factors, including time, cost & confidentiality	32

Table 2 (continued)

Authors	Country	Sample & Method	Target of disc.	Key findings	Overall appraisal (/36)
Chen, Lai & Yang (2013)	USA	• N = 53 • Opportunity sampling on the basis of psychiatric inpatient admissions • Cross-sectional • Content analysis	General	*Reasons for disclosing:* • Disclosure within a circle of confidence • Obligation to inform family (except those living far away) • Disclosure based on affection and trust ('ganqing') • Willingness to disclose outside social network if recipient has similar problems or is understanding/trustworthy/kind • Moral obligation to show kindness in social interactions ('renqing') • Involuntary disclosure (gossip, others trying to help, clues in behaviour) *Reasons for concealing:* • Concerns about shame/losing face • Anticipated negative consequences of disclosure, including alienation, effect on marriage, rejection, loss of friends, others will misunderstand • Avoiding gossip, awkwardness & burdening others • Anticipating low likelihood of help	33
Chew-Graham, Sharp, Chamberlain, Folkes & Turner (2009)	UK	• N = 28 (women only). • Purposeful sampling • Cross-sectional • Thematic analysis	GPs and health visitors	Disclosure facilitated by good relationship with GP *Reasons for concealing:* • Difficulty getting an appointment • Fear of being prescribed medication • Relationship with and attitude of GP (being treated as if wasting GP's time; GP unsympathetic) • Belief that GPs cannot do much to help	26

Table 2 (continued)

Authors	Country	Sample & Method	Target of disc.	Key findings	Overall appraisal (/36)
Dew et al. (2007)	New Zealand	• N = 33 • Opportunity sampling, purposeful sampling • Cross-sectional • Thematic analysis	GP	*Barriers to disclosing:* • Fear of confronting oneself and dealing with a difficult sense of self; loss of control; fear of the unknown; fear of judgement; fear of failure as a mother and losing children; fear of being institutionalised	26
Martin (2010)	Australia	• N = 54 • Opportunity sampling - online survey sent to university students suffering with mental health problems • Cross-sectional • Method of analysis not clear	University staff	*Reasons for not disclosing:* • Fear of judgement/stigmatization • Risk of being seen as telling lies and/or wanting privileges • Embarrassment • No need to • Previous negative experience • Belief that mental health status is no-one else's business *Reasons for disclosing:* • To receive special consideration • To explain difficulty completing work	24
Venville (2010)	Australia	• N = 5 • Non-probability purposive sampling • Poster displays and information sessions in classes • Cross-sectional • Thematic analysis	Educational staff	*Reasons for concealing:* • Desire to be able to do things oneself and to have control over one's identity. • Non-disclosure as a strategy that can aid learning • 'Controlled disclosure' can be helpful but participants did not trust that they will be treated the same as others if they were to disclose	29

Table 2 (continued)

Authors	Country	Sample & Method	Target of disc.	Key findings	Overall appraisal (/36)
Venville, Street & Fossey (2014)	Australia	• N = 20 • Opportunity sampling via posters, emails and presentations • Longitudinal • Thematic analysis	Educational staff	*Reasons for disclosing:* • Advised to disclose by a professional • Necessary due to one's role as a mental health advocate • Fear of failing/need to explain absences/performance • To gain support • Desire to break historical pattern of repeated failures and educational costs *Reasons for concealment:* • Fear of stigma and discrimination • Risks to identity, integrity and personal reputation • Unhelpful experiences following previous disclosures • Fear of being perceived as stupid/weird, untrustworthy, unreliable and irresponsible • Absence of mental health problems indicates self-reliance and dependability	29
Withers, Moran, Nicassio, Weisman, & Karpouzas (2015)	USA	• N = 46 • 65% of sample had personal experience of depression • Opportunity sampling from rheumatology clinic • Cross-sectional • Grounded theory	Doctor	*Barriers to disclosing:* • Stigma • Fear of gossip and being judged 'crazy' • Belief that mental health is not related to physical health, which is the primary reason for seeing doctor • Absence of trusting relationship with health care professional • Practical barriers – time constraints and language difficulties	31

Issues Relating to the Literature

A handful of articles did not distinguish clearly between help-seeking and disclosure. For example, Kravitz et al. (2011), who ostensibly sought to understand barriers to both help-seeking and disclosure, asked participants exclusively about help-seeking. Hence the study was not included in the review. Contrastingly, one article that used the term 'help-seeking' was included in the review because its stated aims related to disclosure and because participants were asked about disclosure rather than help-seeking (Bell et al, 2011). Further articles (including Oakley, Kanter, Taylor & Duguid (2012), and Rusch, Kanter, Manos & Weeks (2008)) that did not clearly distinguish between help-seeking and disclosure were excluded on the grounds that it was not possible to determine what factors were related to one or the other.

Articles that made only passing reference to concealment or disclosure in their results sections were excluded. For example, Üçok et al. (2012) and Üçok, Karadayi, Emiroğlu and Sartorius (2013) used the Discrimination and Stigma Scale-10 (DISC-10), which includes one item relating to concealment ('how much have you felt the need to conceal your diagnosis?'). While this particular item related to the aims of the review, the studies as a whole did not aim to understand concealment. Similarly, qualitative studies that, despite identifying relevant themes, did not initially aim to explore disclosure, were excluded (for example Danielsson & Johansson, 2005; Ezeobele, Malecha, Landrum & Symes, 2010; Oliffe, Robertson, Kelly, Roy & Ogrodniczuk, 2010; Ramirez & Badger, 2014; Rosso & Baarnhielm, 2012).

Two articles in particular did not distinguish clearly between the terms 'distress' and ‘mental health problems’. These articles used the terms 'stress and worry' as 'euphemisms for psychological problems’ (Dew et al., 2007), and 'emotions, nerves,

alcohol or drugs' in place of 'psychological problems' (Bushnell et al., 2005). Although exclusion criteria specified exclusion of studies that used terms such as 'distress', these two articles were included, since in both cases participants underwent an in-depth clinical diagnostic interview to determine mental health status. Contrastingly, one article was excluded because it used the term 'mental distress', but did not determine the mental health status of participants (Han et al., 2015).

Quality Assessment

The quality appraisal ratings for the studies included in this review are presented in Appendix A. A second researcher co-rated nine articles, for which there was high inter-rater reliability (intra-class correlation = .78, $p < .01$). Consequently, the remainder of the articles were only rated by the first author. Overall the studies were of a fair to good quality. No study scored below 24 out of 36 possible points, and none were excluded on the basis of methodology. Despite this, all studies but one fell short on item six, ethics and bias. The strength of the literature reviewed lay in the clarity and thoroughness of the presentation of results. Most studies presented data in a logical and coherent fashion, accompanied by tables and graphs that complemented this.

Measurement of Concealment and Disclosure

Measurement in quantitative studies. One study used a single question, with a seven-point Likert scale, to assess comfort disclosing (Rüsch et al., 2014, see Table 4). A second study used a single 'yes/no' response option to determine the presence of disclosure or concealment (Corrigan et al., 2010), and Weich et al. (2007) asked a single question to determine disclosure to family and friends. In contrast, Pandya et al. (2011) asked participants about openness across a range of relationships, including family, friends, partners and colleagues. Five studies used Link's (1987)

Perceived Devaluation and Discrimination scale (PDD), albeit that they used different versions of the secrecy coping sub-scale of the Link coping orientations. The 5-item secrecy scale included in Link (1987) was used in two studies (Kleim et al., 2008; O'Mahen et al., 2011). Chronister et al. (2013) used the 9-item secrecy scale included in Link, Cullen, Struening, Shrout and Dohrenwend (1989). Corrigan et al. (2010) and Yow and Mehta (2010) used the coping orientations revised in Link, Struening, Neese-Todd, Asmussen and Phelan (2002), which includes a 9-item secrecy sub-scale. Three studies used self-developed measures to understand disclosure (Bell et al., 2011; Bos et al., 2009; Garcia & Crocker, 2008). Although two of these articles presented the items from their measures, they did not include descriptive statistics for these items (Bell et al., 2011; Garcia and Crocker, 2008). The third article reported the internal reliability (Cronbach's $\alpha = .9$) of their measure but did not present its items (Bos et al., 2009). Table 3 displays the measures relating to disclosure and concealment used by the quantitative studies included in this review.

Measurement in qualitative studies. All studies except one used semi-structured interviews to collect data. The exception was Martin (2010), who used an online survey. Articles varied in the level of detail provided about the questions of participants. Two articles did not make it clear that the questions asked during interviews related specifically to disclosure (Chew-Graham et al., 2009; Venville, 2010). However, in both articles the interview responses indicated that disclosure featured significantly in the questions asked. Questions used by researchers to understand participants' disclosure of mental health problems are presented in Table 4.

Table 3

Measures of Concealment and Disclosure Used in Quantitative Studies

Study	Measures used
Bell et al. (2011)	*Barriers to care-seeking/disclosure:* Self-developed – 11 statements. No descriptive statistics
Bos et al. (2009)	*Level of current disclosure:* Self-developed. 12 items. Alpha = .90
Chronister et al. (2013)	*Secrecy:* 9-item scale. Link et al. (1989)
Corrigan et al. (2010)	*Disclosure:* Single 'yes/no' question: 'Are you out about your mental illness? In other words, have you decided to tell most of your family, friends, and acquaintances that you have a mental illness? Have you decided not to hide it?' *Coming out with mental illness:* COMIS – self-developed. 21 items *Secrecy:* Secrecy subscale of the stigma coping orientation scales (Link et al., 2002)
Garcia & Crocker (2008)	*Disclosure:* Self-developed. 4 questions. No descriptive statistics *Eco & ego-system motivations:* Modified scale. No information on how many items
Kleim et al. (2008)	*Secrecy:* Secrecy subscale of PDD (5 items) (Link, 1987)
O'Mahen et al. (2011)	*Secrecy:* Secrecy subscale of PDD (5 items) (Link, 1987) 2 items removed
Pandya et al. (2011)	*Disclosure:* Individual questions about to whom participants had been 'at least somewhat open'. Eleven types of relationship listed 4 point scale – 'not at all open' to 'completely open', for each type of relationship
Rüsch et al. (2014)	*Disclosure:* Single question: 'In general, how comfortable would you feel talking to a friend or family member about your mental health, for example, telling them you have a mental health diagnosis and how it affects you?'
Weich et al. (2007)	*Disclosure:* Single item for family and friends: 'Since [month when index episode began], have you told any of your family or friends that you [are feeling sad, empty or depressed, have lost interest in most things/lacked energy]?'
Yow & Mehta (2010)	*Secrecy:* Secrecy subscale of Link coping orientations (Link et al., 2002). 9 items

Table 4

Questions Used in Qualitative Studies to Explore Disclosure

Study	Question(s)
Bushnell et al. (2005)	• Some people don't talk to doctors about problems with emotions, nerves, alcohol or drugs. Was there ever a time when you did not talk to your doctor, despite having problems like these? • What were the main reasons you did not talk to your doctor?
Chen et al. (2013)	• Regarding your most recent hospitalization, do people know that you have been hospitalized? Do people know you have this condition? • Did you tell other people or did the person find out by accident? • Do you feel that you are better off not telling people about this and why? • Are there certain people who you might tell and certain people who you might not tell?
Chew-Graham et al. (2009)	Questions were related to views on post-natal depression, but these were not included in the article.
Dew et al. (2007)	The area of enquiry was related to discussion of stress and worry with GP. No example of questions included in the article.
Martin (2010)	• Have you told to staff at the university about your mental health condition/s? • What are the reason/s for not telling staff about your mental health condition/s?
Venville (2010)	Participants were asked to describe their experience of learning, their experience of mental illness and the intersection of learning and mental illness. Additional questions were used to probe and expand the narratives. No example was provided of the questions asked.
Venville et al. (2014)	• Have you told staff at (technical and further education) about your mental illness? Can you tell me how and when you did this? • Can you tell me how you decided who and how much to tell? • The next time you enrolled in a course, what factors would influence your decision to tell or not to tell?
Withers et al. (2015)	Questions related to barriers to disclosure and health-seeking behaviour. The questions posed were not included in the article.

Factors Associated with Disclosing or Concealing Mental Health Problems

For the articles reviewed, factors identified as relating to disclosure or concealment of mental health problems are presented below. For clarity, results are differentiated by quantitative and qualitative methodologies.

Factors identified in quantitative studies.

Stigma. Perceived stigma was negatively correlated with disclosure in one study (Bos et al., 2009) and positively with secrecy in four studies (Chronister et al., 2013; Kleim et al., 2008; O'Mahen et al., 2011; Yow & Mehta, 2010). Anticipated discrimination was negatively correlated with comfort about disclosing in one study (Rüsch et al., 2014). One study found that perceived stigma acted as a barrier to disclosure only in individuals who were not motivated by 'ecosystem' goals (Garcia & Crocker, 2008)[1]. Findings showed that internalised stigma was positively correlated with secrecy (Chronister et al., 2013). Researchers also identified a negative correlation between stigma stress (which occurs when people believe that stigma-related harm exceeds their coping resources) and comfort disclosing **(**Rüsch et al., 2014).

Mental health status and psychological wellbeing. Three studies found an association between disclosure and mental health status. One study found that psychiatric inpatient treatment in the most recent year negatively predicted comfort about disclosing (Rüsch et al., 2014). Another study found that openness about a mental health problem was positively predicted by better self-reported current mental health (Pandya et al., 2011). The third study found that concealment was significantly higher in people who were currently or had been recently symptomatic than in people who had not experienced symptoms in the past 12 months (Bushnell et al., 2005). Findings indicated that secrecy is positively associated with symptom distress (Chronister et al., 2013), and negatively associated with self-efficacy (Kleim et al., 2008). Results from Corrigan et al. (2010) demonstrated that people agreeing

[1] 'Ecosystem' motivation describes a 'motivational framework in which peoples' actions are motivated by prioritising both the needs and wellbeing of others, as well as the self.' (Garcia & Crocker, 2008, p. 454)

more strongly with statements about benefits of disclosure had significantly higher ratings of quality of life and empowerment. As this study did not report statistics for people who have not disclosed mental health problems, it was not possible to determine whether concealment was related to lower ratings of quality of life and empowerment. Finally, Bos et al., (2009) found that self-esteem was positively associated with disclosure.

Relationships. Three studies looked at the impact of interpersonal dynamics on disclosure. One study found that disclosure was positively associated with perceived social support (Bos et al., 2009) and another found that openness was negatively correlated with the number of types of relationships of participants (Pandya et al., 2014). Chronister et al. (2013) found secrecy to be negatively associated with both emotional and tangible support.

Demographic variables. Two studies identified that secrecy was higher in younger participants (Bushnell et al., 2005; Kleim et al., 2008). Otherwise, few studies found significant correlations between disclosure/concealment and demographic variables, including gender, level of education, employment and ethnicity. An exception was O'Mahen et al. (2011), who found that perceived stigma was positively associated with secrecy in white, but not black, women. The findings of Corrigan et al. (2010) suggested that there may be some demographic differences in patterns of concealment and disclosure. Their research identified that, of people who have disclosed a mental health problem to family and friends, African-Americans reported significantly stronger agreement with reasons for doing so than did European Americans ($F = 12.36$, $p < .005$). Although Yow and Mehta (2010) described differences in levels of secrecy between people with schizophrenia in

Singapore and the USA, their article did not comment on the statistical significance of these findings.

Beliefs about mental health problems and treatment. One study found that disclosure of depression to family and/or friends was positively correlated with endorsement of three items: 'people with depression deserve a lot of support from their friends and family', 'depression is a medical condition, just like any other illness', and 'anybody can suffer from depression' ($p < .001$) (Weich et al., 2007). This study showed that people who saw depression as stigmatising, disabling and who had negative beliefs about anti-depressants, were significantly less likely to disclose depression to family and friends. A study comparing people with a history of treatment for depression with people presenting with depressive symptoms, found that the former group was most concerned by medical records privacy (17.9%), being put on medication (15.6%) and being considered a 'psychiatric patient' (13.7%). The latter group was most concerned about being put on medication (27.8%), medical records privacy (25.5%), losing emotional control during disclosure (20.9%) and being considered a 'psychiatric patient' (20.3%) (Bell et al., 2011).

Type of mental health problem. Only one study investigated the disclosure patterns of individuals with a range of mental health problems, including psychotic disorder, anxiety disorder, depressive disorder, bipolar disorder and personality disorder (Bos et al., 2009). The authors claimed that they found a significant difference in disclosure according to mental health problem. However, it is not clear from the table of results where these differences lie. The literature demonstrated that of people who have disclosed their mental health problems to others, those who did not have psychosis, and those who were not taking antipsychotic medication, showed

significantly stronger agreement with reasons for concealing their mental health problems in the past, compared with people who had psychosis and who were taking antipsychotic medication ($p<.05$ and $p<.005$ respectively) (Corrigan et al., 2010).

Characteristics of the targets of disclosure. Two studies looked in more detail at levels of disclosure according to target. Bos et al. (2009) found that disclosure was highest to a partner (96.8% of participants), mother (88.8%) and father (84.2%). Over one third (36.3%) of participants had not disclosed to any colleagues and 11.6% had not disclosed to any friends. In the study by Pandya et al. (2011), participants reported being most open with doctors, followed by spouse/significant other, parents, and then friends (Pandya et al., 2011). Participants were least open with neighbours. While 98% of individuals had been at least somewhat open about their diagnosis with a health care professional, 40% had been with co-workers and 33% with children. The same study found that males were most open with parents and extended family, whereas females were most open with friends and significant others. However, the article did not provide data on the statistical significance of these sex differences.

Additional factors. The only study to measure attitudes towards disclosure at more than one time-point found that disclosure behaviour at time one was positively associated with disclosure behaviour at time two (Garcia & Crocker, 2008). This study found that people motivated by ecosystem goals were significantly more likely to disclose their mental health problem to others than people motivated solely by egosystem goals.[2] A separate study noted various correlations that have been

[2] When people are motivated by egosystem goals, they prioritise their own needs and desires (for example maintaining a desired self-image) over the needs and desires of others (Garcia & Crocker, 2008, p.454)

excluded from the results of this review because the article did not distinguish between people with and without a mental health problem for the purposes of these analyses (Bell et al., 2011). Table 5 displays relationships between variables relevant to this review.

Table 5

Variables Related to Disclosure and Concealment of a Mental Health Problem

Outcome variable	Associated variable	Study	Strength of correlation
Stigma			
Perceived societal stigma	Disclosure	Bos et al. (2009)	-.40***
	Disclosure	Garcia & Crocker (2008)[A]	β = -.27*
	Secrecy	Kleim et al. (2008)	.50**
	Secrecy	O'Mahen et al. (2011)[B]	.36**
	Secrecy	Yow & Mehta (2010)	.24*
	Secrecy	Chronister et al. (2013)	.61**
Anticipated discrimination	Comfort disclosing	Rüsch et al. (2014)	β = -.27**
Stigma stress	Comfort disclosing	Rüsch et al. (2014)	β = -.26**
Internalised stigma	Secrecy	Chronister et al. (2013)	.39**
Mental health status and psychological wellbeing			
Recent inpatient status	Disclosure	Rüsch et al. (2014)	β = -.17* (inpatient status = less likely to disclose)
Mental health status (current mental health)	Openness	Pandya et al. (2011)	β = .72*** (more open when mental health rated 'very good')
Currently/recently symptomatic	Concealment	Bushnell et al. (2005)[C]	"Significant positive" (α level not specified)
Self-efficacy	Secrecy	Kleim et al. (2008)	-.27*
Self-esteem	Disclosure	Bos et al. (2009)	.22***
Symptom distress	Secrecy	Chronister et al. (2013)	.36**

Table 5 (continued)

Outcome variable	Associated variable	Study	Strength of correlation
Quality of life	Positive attitudes towards disclosing[D]	Corrigan et al. (2010)	.32*
Empowerment	Positive attitudes towards disclosing[D]	Corrigan et al. (2010)	.29*
Interpersonal factors			
Perceived social support	Disclosure	Bos et al. (2009)	.24***
No. of types of relationships	Openness	Pandya et al. (2011)	β = -.17***
Emotional support	Secrecy	Chronister et al. (2013)	-.38**
Tangible support	Secrecy	Chronister et al. (2013)	-.48**
Demographic factors			
Age	Secrecy	Bushnell et al. (2005)[C]	t=12.37** (younger people were twice as likely to report non-disclosure)
		Kleim et al. (2008)	-.20*
Beliefs about mental health problems and treatment			
Positive beliefs about depression	Disclosure	Weich et al. (2007)	.29***
Additional factors			
Disclosure time 1	Disclosure time 2	Garcia & Crocker (2008)	.87**
Ecosystem goals	Disclosure	Garcia & Crocker (2008)	β = .37***
Egosystem goals	Disclosure	Garcia & Crocker (2008)	β = -.21**

*Significant at $p < .05$. ** Significant at $p < .01$. *** Significant at $p < .001$. [A] Only when ecosystem goals were low. [B] Significant results restricted to white women only. [C] Qualitative study which included quantitative element to analysis. [D] Only for people who have already disclosed.

Factors identified in qualitative studies. The eight qualitative studies reviewed identified multiple factors contributing to individuals' decision-making processes. These have been summarised as the following themes:

The practical value of disclosure. Findings showed that people took into account the practical value of disclosure when making disclosure decisions. In two studies disclosure of mental health status was seen as a necessary step towards gaining additional support and special consideration in education (Martin, 2010; Venville et al., 2014). Thus, some individuals considered disclosure to be unnecessary if it did not promise to add anything of value to their lives or if mental health status was deemed not to be the business of others (Martin, 2010). For some people, the practical value of disclosure was unclear. Two studies highlighted ambivalence about how much medical professionals could do to help in response to disclosure (Bushnell et al., 2005; Chew-Graham et al., 2009). One study highlighted individuals' concerns about being prescribed medication if they were to disclose (Chew-Graham et al., 2009). Another study underscored participants' fears about being institutionalised should they disclose to a doctor (Dew et al., 2007). Some individuals described a belief that there was no alternative and that they were forced to disclose as a way to either explain their poor academic performance and attendance or to avoid situations deteriorating further (Martin, 2010; Venville et al., 2014). The practical value of disclosure was also highlighted by Chinese immigrants in the USA, who saw disclosure as a way of gaining help with monitoring symptoms, and concealment as appropriate where there seemed to be little likelihood that disclosure would lead to help (Chen et al., 2013). Practical obstacles to disclosure in healthcare settings included difficulty getting an appointment, time constraints during appointments, language barriers, difficulty expressing oneself, and concerns about how confidentiality was managed by the service (Bushnell et al., 2005; Chew-Graham et al., 2009; Withers et al., 2015).

Rules and beliefs about mental health problems. Findings showed that individuals subscribed to sets of beliefs regarding disclosure of mental health problems. This was particularly so in one study of Chinese immigrants to the USA, which highlighted how individuals felt a sense of obligation to inform family members of their mental health status, and viewed disclosure as a necessary part of building a relationship with someone (Chen et al., 2013). In contrast, Bushnell et al. (2005) discovered that some individuals believed that mental health problems should not be talked about at all.

Relationship with target. Willingness to disclose was affected by the relationship that people had with the potential target of this disclosure. People felt that the absence of a trusting relationship with their healthcare professional acted as a barrier to disclosure (Withers et al., 2015). Where people felt that doctors were not empathic or sympathetic, disclosure was more difficult, and disclosure to a general practitioner (GP) was facilitated by a positive relationship between individual and GP (Chew-Graham et al., 2009). Students described the attitude and approach of staff as being central to their decision about whether or not to disclose (Martin, 2010). Chen et al. (2013) found that disclosure to friends and family was facilitated by affection and trust, and that disclosure to those outside the social network was more likely where the recipient was considered to be understanding, trustworthy and kind.

Fear and control. Fear acted as a significant barrier to disclosure. People with mental health problems were afraid that disclosure would involve a process of confronting oneself and coming to terms with aspects of one's own personality that felt threatening (Dew et al., 2007). Participants feared the 'unknown' and the loss of control that might accompany disclosure (ibid.). Research in an educational setting underlined how students believed that disclosure would compromise the control they

had over their identity. Students talked about how control over disclosure represented a victory over the illness and acted as an important source of wellbeing and self-efficacy (Venville, 2010). The issues of identity and control were also highlighted by Venville et al. (2014), who found that individuals may have to disclose because of particular roles they hold within the community, and by Chen et al. (2013), whose work demonstrated how gossip and one's mental health-related behaviours may betray one's health status to others, whether one wishes to disclose or not.

Stigma and discrimination. The most frequently mentioned reason for concealment was concern about the response of others. Many participants described stigma as a barrier to disclosure (Bushnell et al., 2005; Venville et al., 2014). People felt ashamed, embarrassed, were concerned about 'losing face', and were worried about being seen as 'stupid', 'weird' or crazy, and being judged negatively (Chen et al., 2013; Chew-Graham et al., 2009; Dew et al., 2007; Martin, 2010; Venville et al., 2014; Withers et al., 2015). People anticipated negative consequences for them of this stigma, including gossip, awkward questions, costs to personal reputation, receiving special treatment, and others' beliefs that they were unreliable, untrustworthy and irresponsible (Chen et al., 2013; Venville, 2010; Venville et al., 2014; Withers et al., 2015). People identified examples of discrimination they imagined might materialise following disclosure, including social alienation and loss of friends, breakdown of marriage, and the removal of children (Chen et al., 2013, Dew et al., 2007; Martin, 2010; Venville et al., 2014). In two studies, negative experience of previous disclosure was identified as a barrier to future disclosure (Martin, 2010; Venville et al., 2014).

Discussion

This review has summarised and critiqued studies published over the past ten years that look at factors affecting an individual's decision to disclose or conceal a mental health problem. The review identified shortcomings of the existing literature. Foremost amongst these is the simplistic manner in which disclosure and concealment are measured, which is a concern because this may obscure the complexity of the disclosure process. Moreover, authors who had developed their own measures did not include items or descriptive statistics in their articles, and authors did not always include data relating to the statistical significance of their findings. There also is an evident dearth of longitudinal studies of disclosure, which acts as an obstacle to further understanding causal factors in the decision-making process. Additionally, there was a lack of attention paid to ethics and bias in all but one study, which is regrettable given that disclosure of mental health problems is so closely associated with shame, embarrassment and concerns about privacy. Recurrent themes identified in our review, as well as implications and areas for future research, are discussed in the sections below.

Features of Discloser and Target

Taken as a whole, findings indicate that whether or not an individual decides to disclose a mental health problem depends on features of both the potential target of disclosure and the discloser themself. These findings are consistent with the literature on disclosure of secrets and personal information (Afifi & Steuber, 2009; Greene et al., 2006; Ignatius & Kokkonen, 2009). People are most open with their doctors. However, this seems to depend on the empathy and approach of the doctor, and some people are unsure whether disclosure to a doctor is appropriate at all (Bushnell et al., 2005; Chew-Graham et al., 2009; Withers et al., 2015). It is apparent

that doctors must do more to educate patients about the appropriateness of disclosing to them, and to create an environment in which disclosure is empathically handled. People worry that disclosure will lead to a prescription for psychiatric medication (Bell et al., 2011; Chew-Graham et al., 2009; Weich et al., 2007). Healthcare professionals should emphasize that disclosure of a mental health problem need not necessarily lead to treatment or institutionalisation but can facilitate a discussion that allows the patient an active role in deciding the next step(s). It is also the responsibility of healthcare professionals and health services to explore with people their fears about issues of medical record privacy and confidentiality. While in some instances these fears may be reasonable, it seems crucial that services educate service users about these issues, so that they are able to make informed decisions about if and how to share their difficulties with clinicians.

Most studies found no demographic differences between people who disclosed and people who concealed mental health problems. These findings conflict with literature suggesting that patterns of personal disclosure differ according to cultural background (Ignatius & Kokkonen, 2007) and that attitudes towards mental health problems vary across culture (Rüsch et al., 2012). In this review, some studies touched upon how disclosure patterns may differ according to ethnicity (Chen et al., 2013; Corrigan et al., 2010; O'Mahen et al., 2011; Yow & Mehta, 2010). However, the studies reviewed here did not adequately explore the role played by cultural factors in peoples' decision-making. Future research that compares communities according to both levels of and reasons for disclosure would help to shed light on the roles that culture and ethnicity play in this process.

Evidence that younger people are less open than older people may reflect concerns about the implications of disclosure for one's future. It is possible that older

individuals have more established relationships and careers, which they consider more robust to the consequences of disclosure. For younger people, who are already navigating a number of uncertainties in their lives – including identity and independence from parents (e.g., see Erikson (1980) stages of development) – making a disclosure may feel like an unnecessary additional complication. Research on the way that young people with mental health problems think about disclosure may help academic institutions and health services best support this demographic.

It appears that support from others is positively related to disclosure (Bos et al., 2009; Chronister et al., 2013), although the direction of causality is unclear. People may begin to reach out for support by testing the water through making smaller disclosures to a select few people they believe may be sympathetic (Chen et al., 2013). One avenue of public policy and health service development would be to invest in campaigns that ask members of the public to actively demonstrate their support for people with mental health problems. This might reduce the pressure on people with mental health problems and signal to them the extent of support available. This review therefore indicates that studies using measures of disclosure that do not discriminate between the targets of disclosure or that do not explore the nature of the discloser's relationship with these targets, fail to capture the complexity of the process. Future researchers should be encouraged to differentiate between targets of disclosure, and to measure attitudes towards these targets.

Stigma and Symptom Severity

We found that stigma and anticipated stigma act as barriers to disclosure. Since many people with mental health problems still experience detrimental effects of disclosure, concealment may serve a protective function. Where societal attitudes continue to discriminate against people with mental health problems, we must seek

to better educate members of the public about the nature of mental health problems. There is a large amount of information about mental health problems available to the public, for example online. However, in many instances this information continues to be inaccurate and as Stephen Hinshaw (2007) underscores, responsible quality control is often restricted only to advocacy groups and responsible media outlets. This review also found that people are more likely to disclose when they are motivated by ecosystem goals (Garcia & Crocker, 2008). Educating the public about the positive impact of disclosure on the wider community (see Corrigan & Matthews, 2003) may have the effect of increasing ecosystem motivations. This, in turn, may create a snowball effect, with increasing numbers of people disclosing, and the prevalence of stigma decreasing.

Studies found that positive feelings towards oneself, empowerment and quality of life are correlated with disclosure of a mental health problem (Bos et al., 2009; Corrigan et al., 2010; Kleim et al., 2008). Due to the cross-sectional design of the studies it was not possible to ascertain cause and effect. Future longitudinal research tracing changes in self-esteem, self-efficacy and wellbeing in relation to disclosure or concealment would shed more light on these findings. Similarly, studies that found a link between severity of symptoms, or symptom-related distress, and concealment would be illuminated by future research. Taken together these studies suggest that individuals who are experiencing the most distress from a mental health problem are least likely to tell others about their problems. Further research should focus on what may help these people to take steps towards telling someone else about their difficulties.

It must also be acknowledged that concealment is not always a viable course of action. Some people feel that the ways they behave can act as clues to others that

they are suffering with a mental health problem. Disclosure may be a social obligation or may be required to explain poor academic performance. Researchers and policymakers should not assume that people have complete control and freedom over disclosure. It can be misleading to label mental health problems as 'concealable' stigmas.

Identity and Control

In view of the fact that disclosure of a mental health problem does not always bring benefits (Quinn et al., 2004; Suto et al., 2012), particularly where the discloser and/or the target hold stigmatising attitudes, we would do well to respect the value of non-disclosure. Where concealment represents a measure of control over one's mental health problems, then attempting to cajole people into talking about their problems could be detrimental. In this review concealment was considered by some as a way of both avoiding discrimination and of retaining control over one's identity. For some people, having the ability to conceal a mental health problem can make an important contribution to a sense of self-empowerment. At the same time, we must be aware that for others, particularly those who anticipate being stigmatized by society, concealing a mental health problem may create an incongruence between their inner and outer selves. Having to present oneself as something other than one is can have significant implications for one's identity, and can create 'identity ambivalence'. Identity ambivalence has been associated with feelings of guilt, fraudulence and negative self-evaluations (Pachankis, 2007). We should therefore strive to create environments in which people feel safe to disclose mental health problems, while at the same time remaining careful not to assume that disclosure is always the most helpful path forward.

Limitations

The selection criteria of this review prevented inclusion of research on disclosure of emotional distress. Thus, people who were experiencing emotional distress but were not aware that this constituted a mental health problem, or who had never received a diagnosis or label of mental health problem, were unlikely to have featured in the articles reviewed here. It could be argued that a valuable demographic was therefore overlooked. The review also excluded studies about help-seeking. As disclosure is a necessary component of help-seeking (Pederson & Vogel, 2007), one might expect there to be consideration of disclosure in some articles about help-seeking. One justification for the strict selection criteria is that it enabled a clear distinction to be made between the disclosure of emotional experiences common to all humans, and the disclosure of mental health conditions, which continue to attract negative judgement and discrimination. What is more, the distinction between disclosure and help-seeking is an important one, because disclosure is not always intended as a step towards help-seeking. Nonetheless, it is possible that the selection criteria of this review prevented inclusion of articles that would have contributed to an overall understanding of this topic.

While every attempt was made to underscore the nuanced nature of mental health disclosure, it is likely that this review does not do justice to all of the details included in the articles reviewed. For example, results from qualitative research have been combined together into general themes, thereby risking the loss of the complexity inherent in the original data. For practical reasons, and in the interest of clarity, a decision was also made not to present and examine all analyses included in the quantitative studies in the review. It is inevitable that the biases of the author will have affected this process, and it is likely that exceptions exist to the conclusions that

have been drawn. While it is important to acknowledge these limitations, it should be stressed that the common trends and methodological shortcomings highlighted by this review mark a valuable starting point from which to conduct further critical analyses of the disclosure literature.

Conclusions

Whether one chooses to disclose or conceal a mental health problem depends on a variety of factors, including characteristics of the discloser and the target, the nature of relationship between discloser and target, the mental health problem in question, and the discloser's anticipation of stigmatised reactions. Individuals tend to disclose selectively, when they anticipate that there will be a pragmatic benefit to them doing so. While for some people concealment is associated with control over one's identity, for others concealment is not a viable option, with disclosure being either an obligation or beyond one's control. The studies in this review highlighted that there is a lack of sophistication in the way that disclosure, concealment and secrecy are measured by researchers. Future research should distinguish carefully between types of mental health problem, targets of disclosure, and content of disclosure, and should attempt to measure disclosure longitudinally. Recommendations for public and health policy include educating GPs and patients about the appropriateness and consequences of disclosure of a mental health problem, and public campaigns in which people are encouraged to outwardly demonstrate their acceptance of people with mental health problems. Family members, educational establishments and healthcare services should also be urged to respect that, for some individuals, choosing to continue to conceal their mental health problems may be the most helpful way for them to manage their difficulties.

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Part 2: Empirical Paper

Disclosure of Mental Health Problems by Clinical Psychology Trainees

Aims This study aimed to determine incidence of lived experience of mental health problems amongst UK-based trainees, and the factors associated with disclosure for trainees with and without lived experience of mental health problems. It was hypothesized that 1) trainees with lived experience of mental health problems would be less likely to disclose this to course staff and placement supervisors than friends, family and health professionals, and 2) given a hypothetical situation, likelihood of disclosing three different mental health problems would be predicted by maladaptive perfectionism, anticipated stigma, temporal proximity, and recipient type.

Methods An anonymous online survey was distributed to course directors at all UK training institutions. Directors were asked to circulate this survey to all current trainees.

Results A total of 348 trainees completed the survey. 67% had lived experience of a mental health problem. For these trainees, there was no difference in likelihood of disclosing to different recipient types after controlling for maladaptive perfectionism. For all trainees, hypothetical disclosure was associated with maladaptive perfectionism, temporal proximity, anticipated stigma (past), and recipient type. Anticipated stigma (present) was not associated with disclosure. Additionally, disclosure of schizophrenia was associated with adaptive perfectionism.

Conclusions Results support a new approach to communicating about mental health disclosure in training institutions. Elements of this new approach, including interdependency and transparency, as well as limitations and suggestions for further research are discussed.

Introduction

For people with mental health problems, the decision whether or not to disclose this to others can be a difficult one. While disclosure carries the risk of stigmatization, concealing mental health problems may negatively impact on individuals. Self-concealment has been defined as a tendency to keep distressing, negatively evaluated and potentially embarrassing personal information from others (Masuda, Boone & Timko, 2011). Concealing personal information and keeping secrets from others has been associated with physiological distress and the intensification of psychological problems, including depression, anxiety, and negative self-esteem (Ichiyama et al., 1993; Ilic et al., 2012; Kawamura & Frost, 2004; Kelly & Achter, 1995; Larson & Chastain, 1990). It has also been inversely related to psychological flexibility (Masuda et al., 2011).

Additionally, high self-concealers have less positive attitudes towards seeking help and, crucially, less intent to seek psychological help (Kelly & Achter, 1995; Vogel & Wester, 2003). Consequently, self-concealers may decide to engage in destructive coping strategies, such as drug and alcohol misuse, as was found to be the case for undergraduate psychology students who avoid professional help (Thomas, Caputi & Wilson, 2014). For people with mental health problems, using secrecy as a coping strategy may increase isolation and demoralisation, depressive symptoms and feelings of shame and of being different (Link, Struening, Neese-todd, Asmussen & Phelan, 2002). The use of secrecy also negatively correlates with self-esteem (Hinshaw, 2007), while comfort with disclosing a mental health problem has been positively associated with psychological wellbeing (Rüsch, Brohan, Gabbidon, Thornicroft & Clement, 2014).

Although disclosure might appear to represent an adaptive way of coping with a mental health problem, indiscriminate disclosure is unlikely to be helpful for the individual. One study of university students found that disclosure of a history of mental health problems prior to taking an academic test impacts negatively upon test performance (Quinn, Kahng & Crocker, 2004). Moreover, concealing a mental health problem can represent an important step in maintaining control over one's identity (Venville, 2010). Selective disclosure has been described as the process of disclosing to only those who seem like they will understand (Corrigan and Rao, 2012). Research has shown that while selective disclosure may facilitate social support, indiscriminate disclosure may have a negative impact on self-esteem (Bos, Kanner, Muris, Janssen & Mayer, 2009).

Mental Health Problems in Trainee Clinical Psychologists

To date, very little research has looked at disclosure of mental health problems by trainee clinical psychologists (hereafter, 'trainees'). There is reason to believe that mental health problems exist amongst trainees at an equivalent, if not higher, rate than the general population. Brooks, Holttum and Lavender (2002) found that a sample of UK trainees scored higher on measures of self-esteem problems (23% of sample), anxiety (18%) and depression (14%) than normative means, and that around one-third reported significant substance misuse. Acknowledging the dearth of research in this area, Pakenham and Stafford-Brown (2012) presented findings from three surveys of qualified psychologists, which showed that the level of current depression in this group is between 62% and 76%, and that between 29% and 42% of psychologists have at some point experienced suicidal ideation, with 4% having attempted suicide.

It has been observed that medical students experience mental health problems at a higher rate than the general population, as well as having a higher rate of suicide and lower quality of life (Schwenk, Davis & Wimsatt, 2010; Wallace, 2010). A survey of medical students in the USA found that 24% currently met BDI criteria for depression (Givens & Tija, 2002). Clinical training itself can be a highly stressful experience. Using the General Health Questionnaire (GHQ), Cushway (1992) found that 59% of trainees were currently at or above caseness for a mental health problem, which was a higher percentage than both civil servants and medical students. Kuyken, Peters, Power & Lavender (2003) found that trainees reported increased problems with depression and an increase in interpersonal difficulties over the course of training. These findings are consistent with the recent work of El-Ghoroury, Galper, Sawaqdeh and Bufka (2012), who found high levels of stress amongst postgraduate psychology students.

Factors Affecting Willingness to Disclose

A variety of factors may predict an individual's willingness to disclose a mental health problem. Until now, research into these factors has focused on the general population, and no published research has explored factors most pertinent for trainees. Across the Western World a substantial proportion of the public continue to judge people with mental health problems to be unpredictable and dangerous, and thus seek distance from them (Angermeyer & Dietrich, 2006). A UK-wide survey found that over two-thirds of people believed that schizophrenia and substance misuse lead people to be dangerous, over half believed that people who misuse substances and 38% of people with an eating disorder could 'pull themselves together', and over half believed that people with severe depression are unpredictable (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). A recent report by the independent

mental health taskforce to the NHS in England has highlighted that people living with mental health problems continue to experience stigma and discrimination, including from staff within mental health services (Mental Health Taskforce, 2016). While commendable steps have been taken towards reducing public stigma, in the words of one expert, 'even under the most optimistic of scenarios, the stigmatization of mental disorders will not soon recede' (Hinshaw, 2007, p. 229).

Anticipated stigma. Anticipated stigma describes what an individual thinks most people believe about the stigmatised group and themselves for being in this group (Brohan, Slade, Clement & Thornicroft, 2010). Studies show that anticipated stigma and discrimination correlate negatively with disclosure of mental health problems (Bos et al., 2009; Rüsch et al., 2014), and one large-scale survey demonstrated that anticipated stigma acted as a barrier to disclosure for over 50% of the mental health service users surveyed (Time to Change, 2008). It is also known that peoples' use of coping strategies such as withdrawal and secrecy is associated with their level of anticipatory anxiety about future stigmatization (Vauth, Kleim, Wirtz & Corrigan, 2007). There is every reason that trainees with mental health problems share this anticipatory anxiety about disclosure. It is known, for example, that fear of stigma is a central factor preventing medical and non-medical students who meet criteria for a mood disorder from seeking professional support (Demery, Thirlaway & Mercer, 2012; Givens & Tija, 2002).

Type of mental health problem. There is evidence that the nature of an individual's mental health problem affects their likelihood of disclosing this problem (Brohan et al., 2012; Jones, 2011). It may be that one explanation for this is that the risk of rejection associated with disclosure differs depending on mental health problem. For example, at particular risk of public rejection are people who suffer

with drug and alcohol dependence (Angermeyer & Dietrich, 2006; Feldman & Crandall, 2007). One study showed that positive symptoms of mental health problems (such as bizarre behaviour), or the combination of negative symptoms and poor physical appearance, are more stigmatised than negative symptoms or poor physical appearance alone (Schumacher, Corrigan and Dejong, 2003). Similarly, self-stigma, defined as endorsement of and behaviour consistent with negative public beliefs about oneself due to having a stigmatised condition (Corrigan & Watson, 2002), appears to differ according to mental health problem (Suto et al., 2012). Increased self-stigma has also been associated with reduced willingness to disclose a mental health problem (Hinshaw, 2007).

However, the link between mental health problem and disclosure does not appear to be mediated solely by stigma. A review examining public desire for social distance from people with mental health problems reflected that, on the whole, greater social distance is desired from people with substance misuse disorders and schizophrenia compared with depression and anxiety disorders (Jorm & Oh, 2009). Yet, research also shows that people are more likely to disclose bipolar disorder or schizophrenia than anxiety or personality disorders (Bos et al., 2009). A recent review of disclosure in the workplace found that people are less likely to disclose a mood disorder than schizophrenia (Brohan et al., 2012). It therefore appears that while public stigma may affect willingness to disclose, there are likely to be other factors affecting this decision.

Recipient of disclosure. In the process of deciding whether or not to disclose, the level of trust and the level of emotional rapport between the individual disclosing and the recipient are key considerations (Ignatius & Kokkonen, 2007). Research demonstrates that people show different levels of willingness to disclose a mental

health problem depending on the potential recipient. On the whole, people tend to be more open with health professionals and close family members, and more secretive with neighbours and work colleagues (Bos et al., 2009; Pandya, Bresee, Duckworth, Gay & Fitzpatrick, 2011). There is also evidence that students may not favour disclosure of mental health problems because of a concern that this will negatively affect their chances of gaining employment (Venville, Street & Fossey, 2014). On this basis, it is expected that trainees would be more willing to disclose a mental health problem to a health professional, family member or friend, than to a member of their university staff or their placement supervisor.

Temporal proximity to mental health problem. There is some tentative evidence that a person may be less willing to disclose a mental health problem they are experiencing currently than one they experienced in the past (Bushnell et al., 2005). This may be because they anticipate that a current mental health problem carries a greater level of stigma than a past mental health problem. On the other hand, it may not feel as necessary or relevant to disclose an historical mental health problem. While it is therefore likely that temporal proximity affects one's decision to conceal, it is unclear whether people are more or less likely to disclose a current or an historical mental health problem.

Perfectionism. Another factor that may affect willingness to disclose is perfectionism. This has been defined as the setting of excessively high standards for performance accompanied by overly critical self-evaluation (Frost, Marten, Lahart & Rosenblate, 1990). One particular study of undergraduate females demonstrated how 'perfectionist individuals conceal negative personal information to maintain a flawless appearance and to avoid negative evaluation by others' (Kawamura & Frost, 2004, p. 184). This study identified a negative correlation between perfectionism and

willingness to disclose personal information to a family member and friends. Researchers have named this sort of perfectionism 'maladaptive' perfectionism, and distinguish it from 'adaptive' perfectionism, which is associated with positive striving, increased self-esteem, self-efficacy and less dysfunctional coping (Ashby, Rice & Martin, 2006). Evidence suggests that part of what makes perfectionism maladaptive, rather than adaptive, is 'discrepancy', which describes a perfectionist's sense that they are not achieving the high standards they set for themselves (Rice & Ashby, 2007). The extent to which perfectionism amongst trainees is maladaptive has not been investigated. However, Kawamura and Frost's (2004) research suggests that higher scores on measures of maladaptive perfectionism will correlate with a higher tendency to conceal mental health problems.

Rationale for Proposed Study

While institutions teach trainees to provide high quality psychological care to people with a range of mental health problems, there has been little emphasis within the profession on the mental health needs of these very trainees. Moreover, the effect of mental health stigma on trainees has been largely ignored. Reduced self-esteem, self-efficacy and psychological wellbeing are likely to impact on trainees' experiences of training, as well as their hopes and aspirations for careers afterwards. There may be additional negative consequences which affect patients. For example, Myers et al. (2012) suggest that the combined challenge of coping with stressors while developing knowledge and skills relating to clinical work may impact negatively on both clinical practice and training experience. This is echoed by Thomas et al. (2014) and Pakenham and Stafford-Brown (2012), who propose that the stress experienced by trainees may have a negative impact on their personal and professional functioning, and standards of care for their patients. What is more,

research underscores the difficulties that trainees have in accurately assessing their own psychological needs (Johnson, Barnett, Elman, Forrest & Kaslow, 2012). This indicates that course staff and supervisors would do well to understand how to best cater to the needs of trainees who are reluctant to disclose.

Alarmingly, when it comes to supporting the next generation of clinicians, the British Psychological Society (BPS), which oversees UK-based clinical psychology training programmes, appears to lag behind bodies such as the General Medical Council (GMC). The GMC has published detailed guidelines for medical schools in order to help them support medical students who experience mental health problems (General Medical Council, 2013). The most recent BPS guidelines on clinical psychology training and disability, which were published in 2007, offer a useful starting point for thinking about how to support trainees who experience mental health problems. However, the guidelines say little about why trainees may feel reluctant to disclose mental health problems to others. Moreover, whilst the guidelines emphasize the importance of providing 'multiple opportunities for trainees to disclose' (Harper, Rowlands & Youngson, 2007, p. 31), there is little guidance about how to do this.

There may be various explanations for the aforementioned poverty of research into the mental health needs of trainees. It may be that both trainers and trainees believe that trainees should have the skills to cope when problems arise, or that the field of psychology should prioritise research relating to the needs of service users. Regardless, it is likely that by continuing to minimise the significance of the mental health of trainees, training institutions will perpetuate self-concealment and stigma in the profession. The first step towards supporting trainees with mental health problems is to better understand the nature of these problems and the extent to which

trainees are willing to disclose them to others. Moreover, if training courses are to support trainees in the disclosure process, it seems important to understand which factors influence trainees' likelihood of disclosure. This study set out to gain a clear picture of the incidence of mental health problems amongst trainees, and to understand some of the mechanisms that may underlie their decisions about disclosure.

Aims and Hypotheses

This study aimed to determine the proportion of UK trainees who are currently experiencing, and have in the past experienced, mental health problems, and the types of problems they have experienced. It also aimed to investigate the factors affecting trainees' likelihood of disclosing a mental health problem. Based on current research, it was hypothesized that:

1) For all trainees, the anticipated likelihood of disclosing a hypothetical mental health problem would be associated with the trainee's level of anticipated stigma towards the mental health problem, the recipient of the disclosure, temporal proximity to the mental health problem, and the trainee's level of maladaptive perfectionism. Likelihood of disclosing would not be associated with adaptive perfectionism.

2) Trainees with lived experience of mental health problems would be less likely to disclose this to course staff and clinical supervisors than to friends, family and health professionals, after controlling for maladaptive perfectionism.

Method

Participants and Data Collection

Participants were trainees from UK-based training institutions. At the time of the study there were 1768 trainees in the UK (Leeds Clearing House, n.d.). To maximise

the response rate, data was collected via an online survey. The study received approval from the BPS Division of Clinical Psychology (DCP). Prior to dissemination, the survey was piloted on ten current trainees based at University College London (UCL). These trainees provided written feedback on all aspects of the survey and the survey was adjusted accordingly. Information about the study, including details of DCP approval, were sent to the directors of all 30 clinical psychology courses with a request to disseminate the invitation to their trainees (see Appendix B). The invitation contained a link to an online survey (see Appendix C). A follow-up email was sent two months later to course directors who had not responded to the initial communication. A poster promoting the study was sent to two universities, following requests from the course directors at these universities.

Ethical Considerations

Ethical approval for the study was granted by the UCL ethics committee. To protect anonymity, the sole demographic characteristic requested in the survey was the gender of participants.

Measures

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

perfectionism is represented by one subscale (seven items) (Kawamura & Frost, 2004).

Type of mental health problem. To understand whether the factors associated with likelihood of disclosure differed depending on the type of mental health problem, trainees were asked about three mental health problems believed to represent a range of severity and level of stigmatisation. On the basis of research by Feldman and Crandall (2007), specific phobia was chosen to represent a less stigmatised mental health problem. Major depression was chosen to represent a moderately stigmatised mental health problem, and schizophrenia to represent a highly stigmatised mental health problem. To confirm that this view was matched by trainees, the Perceived Devaluation and Discrimination scale (PDD; Link, 1987; see below) was included as a measure of participants' level of anticipated stigma towards each of the aforementioned mental health problems.

Anticipated stigma. Anticipated stigma was measured using an adapted version of the PDD (Link, 1987). The PDD is a 12-item measure that asks respondents to rate statements on a six-point scale from 'strongly agree' to 'strongly disagree'. Higher scores indicate increased anticipation of devaluation and discrimination. The PDD has been used in 82% of studies on perceived stigma and has demonstrated internal consistency of between 0.86 and 0.88, as well as adequate construct validity (Brohan et al., 2010). To account for the distinction between current and historical mental health problems, the survey included one version of the PDD for the three hypothetical current mental health problems, and one version for the three hypothetical past mental health problems. Although in the original version of the PDD respondents are asked to imagine public attitudes towards a 'psychiatric patient', this terminology does not reflect the terminology used by most trainees.

Moreover, it does not make a distinction between types of mental health problems. Trainees were therefore asked to anticipate attitudes towards people with 1) specific phobia; 2) major depression and 3) schizophrenia both currently and in the past. Item 11 of the measure ('Most young women would be reluctant to date a man...') was adjusted to ensure that it was congruent with the experiences of trainees ('Most young women/men would be reluctant to date a man/woman...'). The adapted measure is included in Appendix C.

Likelihood of disclosure. Likelihood of disclosing was measured using a question adapted from previous studies by Rüsch and colleagues (Rüsch et al., 2014; Rüsch, Evans-Lacko & Thornicroft, 2012; Rüsch, Evans-Lacko, Henderson, Flach & Thornicroft, 2011). In these studies, participants were asked to rate on a scale of one (very uncomfortable) to seven (very comfortable) the question, 'In general, how comfortable would you feel talking to a friend or family member about your mental health, for example, telling them you have a mental health diagnosis and how it affects you?'. For the current research this seven-point scale was retained, while the original question was adapted to ask trainees about likelihood of disclosure rather than comfort in disclosing. Trainees were asked to rate their likelihood of disclosing to the following six recipients: 1) friends, 2) family, 3) member of cohort, 4) placement supervisor, 5) course staff and 6) health professional. The question was also adapted to allow for the distinction between the three mental health problems detailed above (schizophrenia, major depression and specific phobia), and whether these were current or historical (see Appendix C).

Lived experience of mental health problems. After participants had responded to the measures relating to hypothetical disclosure, the survey asked about lived experience of mental health problems. To determine lived experience, participants

were presented with a single question: 'Have you ever experienced a mental health problem? This includes but is not limited to mental health problems as defined by DSM and ICD criteria, whether or not you have received a diagnosis. For the purpose of this question mental health problems refer to psychological and behavioural difficulties that have diminished your capacity for coping with the ordinary demands of life'. For those who responded 'no' to the question, the survey ended at this point. Trainees who responded 'yes' to this question were presented with a list of mental health problems and were asked to indicate which problem(s) they had experienced, and whether this was past or current (or both). Trainees were able to indicate more than one mental health problem and space was provided to add a mental health problem not included in the list.

Disclosure by trainees with lived experience of mental health problems. For trainees with lived experience of mental health problems, likelihood of disclosing each mental health problem was measured using the same question about likelihood of disclosure included earlier in the survey (adapted from Rüsch et al., 2014), retaining the six recipient types. However, in this instance the question was adapted to the mental health problem of which the trainee had lived experience. Thus, the question was phrased: 'How likely is it that you would talk to the following people about (mental health problem) that (you experienced in the past/are currently experiencing?)'. Participants were asked separately about each mental health problem of which they had lived experience. Included at the end of each measure in the survey was space for comments relating to the responses given.

Analyses

An exploratory factor analysis was conducted to determine whether responses to the MPS fell into the six factors identified by Frost et al. (1990). This was also used

to distinguish between maladaptive and adaptive perfectionism. To clarify levels of anticipated stigma towards specific phobia, major depression and schizophrenia, a two-way repeated measures ANOVA was conducted, in which type of mental health problem (three levels) and temporal proximity (two levels) were predictor variables and total anticipated stigma the dependent variable. For the hypothetical disclosure scenarios, a multilevel linear model analysis was used to understand, for each of the three mental health problems, the relative contributions to anticipated likelihood of disclosing of i) adaptive and maladaptive perfectionism; ii) anticipated stigma; iii) temporal proximity and; iv) recipient type. For trainees with lived experience of mental health problems, one-way repeated measures ANOVAs were conducted to understand how the likelihood of disclosure differed depending on the recipient type. To better understand the pattern of quantitative results a basic qualitative thematic analysis was conducted on trainees' comments on all measures.

Power analysis. A number of studies have looked at correlations between the measures used in this study, as well as measures of similar constructs in similar population groups (for example, Ichiyama et al., 1993; Kahn & Hessling, 2001; Kawamura &Frost, 2004; Vauth et al., 2007). These studies showed medium effect sizes. Based on this literature and the planned statistical analyses for the proposed study, a power calculation was carried out using the G*Power 3.1 computer programme (Faul, Erdfelder, Lang and Buchner, 2007) specifying alpha = 5% and desired power = 80%. The analysis revealed that the required sample size was estimated at 64 participants.

Results

In total, 17 of 30 courses confirmed that they had distributed the survey link to trainees by email, and a further two courses confirmed that they had displayed

posters advertising the survey to trainees. Two courses declined to participate, stating that university data protection regulations prevented them from doing so. The remaining nine courses did not respond to either the initial or follow-up emails. A total of 564 trainees accessed the survey, of which 348 trainees completed the survey, representing a total response rate of 28% and a drop-out rate of 38%. Figure 1 displays where during the survey participants dropped out.

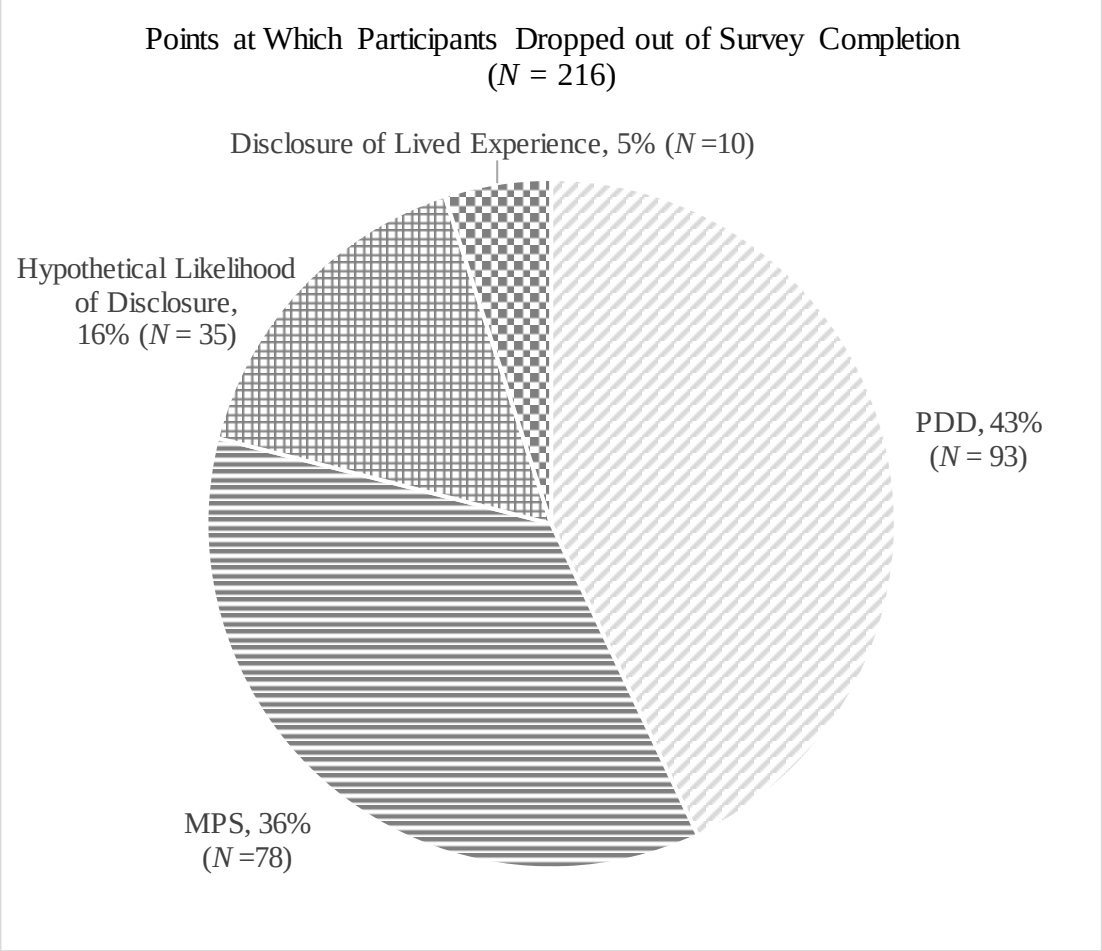

Figure 1. Pie chart displaying when participants dropped out of survey completion

Males made up 14% (n =49) of those who completed the survey. This is comparable to the proportions of males and females on clinical training courses in the UK (for 2014 entry, males made up 17% of trainees, Leeds Clearing House, n.d.). Only complete survey responses were included in the analysis. The number of trainees completing the survey exceeded considerably the required sample size, as determined

by the power calculation. Analysis of the data from the completed surveys is presented below.

Results Pertaining to All Trainees

Perfectionism. Previous research indicated that the MPS is composed of six factors (Frost et al., 1990). Consequently, a principal axis factor analysis was conducted of the 35 items using orthogonal rotation (varimax). The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, KMO = .90, and the KMO values for all individual items were greater than .76, which is above the acceptable limit of .5 (Field, 2013). Six factors had eigenvalues over Kaiser's criterion of 1 and in combination explained 57% of the variance. The scree plot justified retaining six factors. All items except two loaded in the same way as identified by Frost and colleagues (1990). Item four ('If I do not set the highest standards for myself, I am likely to end up a second-rate person') loaded on to the factor 'concern over mistakes', whereas item 18 ('I hate being less than the best at things') loaded on to the factor 'personal standards'. In the original study, these loadings were reversed. For the purposes of this research, the loadings from the current analyses, which appeared to most accurately reflect the trainee population, were retained. Reliabilities were computed for the resulting factor scales. All subscales had high internal reliability, with Cronbach's alphas ranging from .83 to .91. Table 1 shows the factor loadings and reliability statistics for each factor.

Table 1

Factor Loadings for Exploratory Factor Analysis of the Multidimensional Perfectionism Scale

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

Table 1 (continued)

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

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

Factors were separated into 'maladaptive' and 'adaptive' groupings in the same fashion as in previous research (Kawamura & Frost, 2004). The following factors were grouped as maladaptive: 'concern over mistakes', 'parental expectations', 'parental criticism', and 'doubts about actions'. The factor 'personal standards' was used as a proxy for adaptive perfectionism. Adaptive perfectionism scores were significantly non-normal, $D(348) = .100$, $p < .001$, as were maladaptive perfectionism scores, $D(348) = .052$, $p < .05$. Consequently, means for maladaptive and adaptive perfectionism were compared using a paired sample t-test with bias corrected and accelerated confidence interval (BCa) bootstrapping (Field, 2013). This revealed a significant difference in means, with trainees scoring significantly higher on adaptive perfectionism ($M = 3.58$, SD = 0.73) than on maladaptive perfectionism ($M = 2.66$, SD = 0.68), $t(347) = 25.9$, $p < .01$. Cronbach's α for the maladaptive perfectionism items was .92, and for adaptive perfectionism items, .84.

Anticipated stigma. A two-way repeated measures ANOVA was used to ascertain trainees' levels of anticipated stigma associated with the chosen three mental health problems. It also investigated interaction effects of mental health problem and temporal proximity on anticipated stigma. Mauchly's test indicated that the assumption of sphericity had been violated, χ^2 (2) = 52.10, $p < .001$, therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .88$) (Field, 2013). There was a significant main effect of mental health problem on anticipated stigma, $F(1.52, 527.18) = 1340.43$, $p < .001$. Trainees anticipated the most stigma associated with schizophrenia, followed by major depression, and the least with specific phobia. There was also a significant main effect of temporal proximity on anticipated stigma, $F(1, 347) = 830.4$, $p < .001$. Trainees anticipated more stigma associated with current mental health problems than with past mental health problems. Finally, there was a significant interaction between mental health problem and temporal proximity, $F(1.76, 608.88) = 103.66$, $p < .001$. For all three mental health problems, trainees anticipated significantly more stigma when the problem was current compared to past. However, this difference was greater for depression and schizophrenia than it was for specific phobia. Results confirmed that for both past and current mental health problems, trainees anticipated highest levels of stigma associated with schizophrenia, followed by major depression, followed by specific phobia. Mean scores for PDD items are presented in Table 2.

Table 2

Mean Levels of Anticipated Stigma Associated with Current and Past Mental Health Problems

Mental Health Problem	Mean score on PDD items
Comparison group (Link, 1987)†	4.13 (.73)
Schizophrenia (past)	3.73 (.95)
Major depression (past)	2.92 (.85)
Specific phobia (past)	1.88 (.72)
Schizophrenia (current)	4.45 (.77)
Major depression (current)	3.74 (.72)
Specific phobia (current)	2.26 (.79)

Responses were on a scale of 1 to 6. Higher scores indicate higher anticipated stigma. Standard deviations are shown in parentheses. †Statistics based on the comparison group, 'untreated cases', taken from Link (1987) and comprising adults with no previous treatment and not currently in treatment but deemed to meet DSM-III criteria for psychiatric diagnosis by way of Diagnostic Interview Schedule (DIS), $N = 142$.

Likelihood of disclosing. A multilevel linear model analysis was run on the data for hypothetical disclosure situations, to determine the contributions to likelihood of disclosing of 1) anticipated stigma, 2) recipient type, 3) temporal proximity 4) maladaptive perfectionism and 5) adaptive perfectionism. Schwarz's Bayesian Criterion (BIC) was used to assess overall fit of each model, aiming to balance best fit with parsimony. In all three models *subject* was included as a random intercept and *recipient* as a random slope. A compound symmetry covariance structure was used, since it was hypothesised that there would be covariance within levels of the random effect 'recipient' (Kincaid, n.d; Littell, Pendergast & Natarajan, 2000). For all three mental health problems non-significant predictors were removed from the models. Tables 3 to 5 display parameter information for the three final models.

Table 3

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

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

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

Table 4

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

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

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

Table 5

Parameter Information for Significant Predictors of Likelihood Disclosing a Diagnosis of Schizophrenia

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

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

Models for the three hypothetical mental health problems demonstrated that trainees anticipated being more likely to disclose each of the mental health problems if they were current rather than historical. The models also demonstrated that, as maladaptive perfectionism increased, likelihood of disclosure decreased and that, as anticipation of stigma associated with a past diagnosis of the mental health problem in question increased, likelihood of disclosure decreased. Additionally, for schizophrenia, the model demonstrated that as adaptive perfectionism increased, likelihood of disclosure increased. The effect of recipient type on likelihood of disclosure was significant for all three mental health problems. Likelihood of disclosure differed depending on recipient and the pattern for this differed according to mental health problem. To better understand the interaction between recipient type and the other variables, a mixed model analysis was run on each recipient, for each mental health problem individually. To correct for multiple comparisons, the

significance value was adjusted using the Bonferroni correction. Predictors were therefore deemed significant at $p < .0083$. Table 6 displays the predictors that were significant for each recipient type according to mental health problem.

Table 6

Rankings of Disclosure Recipient by Likelihood of Disclosure and Predictors Significant to Disclosure

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

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

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

Anticipated likelihood of disclosing schizophrenia or major depression to course staff or a supervisor was higher if the problem was current as opposed to past.

Likelihood of disclosing a current mental health problem. To better understand trainees' anticipated likelihood of disclosing a hypothetical current mental health problem, a repeated measures ANOVA was used, comparing likelihood of disclosing 1) schizophrenia, 2) major depression and 3) specific phobia, to all six recipient types. Results are shown in Table 7.

Table 7

Mean Likelihood of Disclosure for Hypothetical Current Mental Health Problems

	Type of mental health problem			Rüsch et al. (2012)†
Recipient	Specific phobia	Major Depression	Schizophrenia	(*N* = 348)
Family	5.89[A]	5.40[A]	5.61[A]	5.10
Friends	6.05[A]	5.40[A]	4.96	5.10
HCP	5.25	5.59[A]	5.54[A]	-
Member of cohort	5.33	4.35	3.88[B]	-
Course staff	4.14[B]	4.38	4.37	-
Placement supervisor	4.16[B]	4.03[B]	3.96[B]	-
Prospective or current employer	-	-	-	3.70

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

Table 7 shows that trainees consistently expected that they would be most likely to disclose a mental health problem to a family member, friend or health professional and least likely to disclose to a placement supervisor, and in the case of schizophrenia, a cohort member. In comparison with the results of Rüsch et al. (2012), trainees anticipated being more likely than the general population to disclose to family and friends, except in the case of disclosing schizophrenia to friends, and

more likely to disclose to staff or supervisors than the general population felt likely to disclose to a current or prospective employer.

Qualitative data. A basic thematic analysis was conducted on comments relating to likelihood of hypothetical disclosure. The following five themes were identified: 'need to know', 'relationship with recipient', 'response of others', 'previous experiences' and 'nature of the distress'. Due to practical limitations a small number of comments have been chosen to augment the quantitative findings. Participants repeatedly stated that the likelihood of disclosure depended on the relevance of the information to the situation. For example, one participant said, 'I would disclose about my mental health problem on a need to know and relevant basis'. Similarly, many trainees were clear that they would disclose a mental health problem if there was a risk that it would negatively impact on their academic or clinical performance. As one participant commented, 'Disclosure to a professional would depend upon whether I felt they needed to be aware to monitor my fitness for work.' While trainees acknowledged that specific phobia carried less stigma than major depression or schizophrenia, they observed that it might be more necessary to disclose the latter mental health problems. For example, one trainee remarked, 'it is more likely that I would tell a member of the course team about a diagnosis of schizophrenia than a specific phobia – because I would feel that they needed to know about the schizophrenia.'

Trainees with Lived Experience of Mental Health Problems

Results showed that 67% of respondents had lived experience of at least one type of mental health problem (see Figure 2). Of all participants who completed the survey, 29% (n = 100) were experiencing at least one mental health problem at the time of completion (see Figure 2).

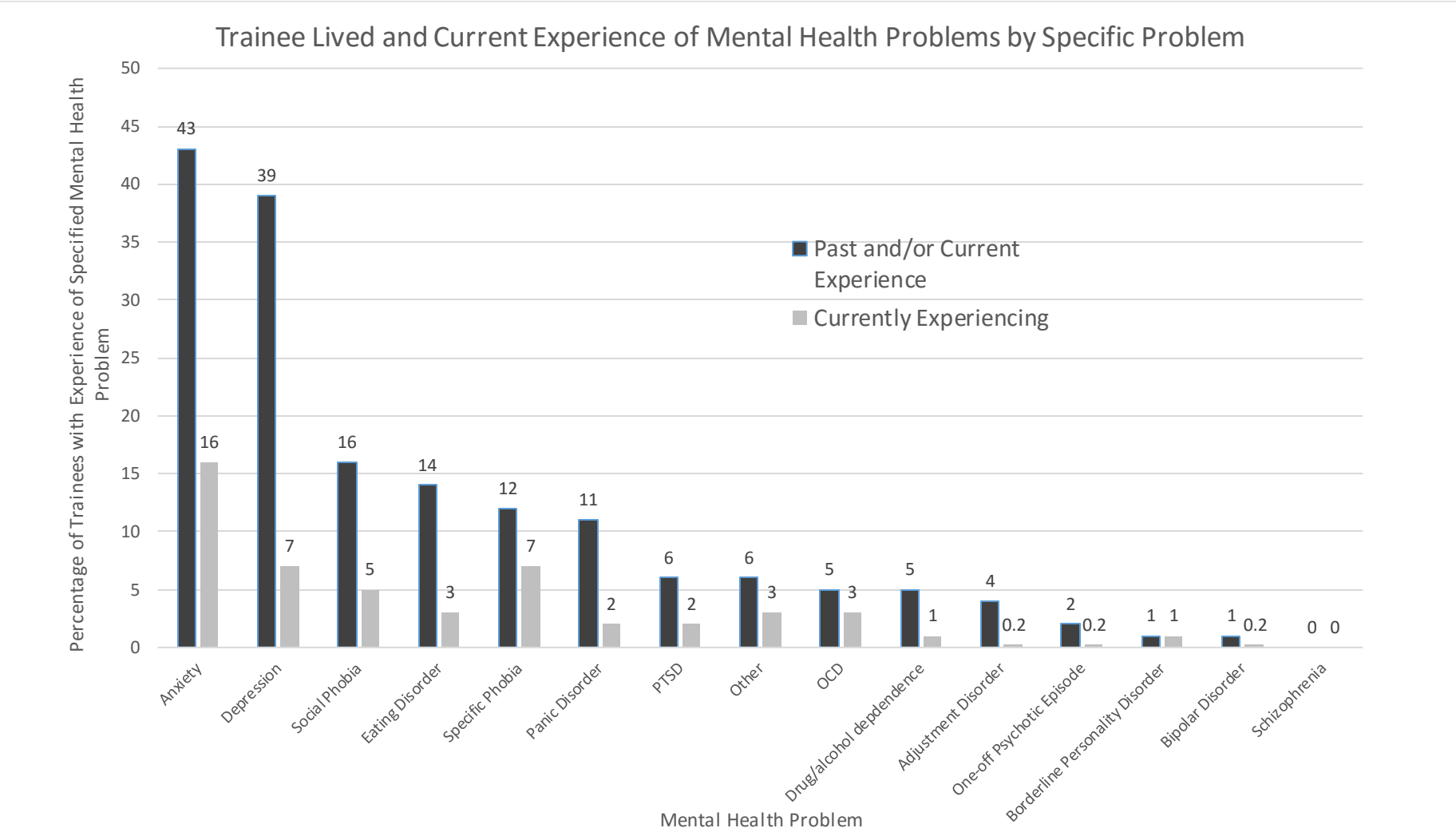

Figure 2. Graph displaying trainee lived experience and current experience of mental health problems

Disclosure by trainees with lived experience. One-way repeated measures ANOVAs were run to compare the likelihood of trainees with lived experience of a) depression and b) anxiety disclosing to the six recipient types. These two mental health problems were chosen because they were most frequently identified by trainees as representing their lived experience of mental health problems. Mauchly's test indicated that the assumption of sphericity had been violated for depression, χ^2 (14) = 100.15, $p < .001$, and anxiety, χ^2 (14) = 133.55, $p < .001$. Degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity (for both, $\varepsilon = .79$). Results showed that there was a main effect of type of recipient on likelihood of disclosing lived experience of depression, $F(3.97, 539.85) = 30.23$, $p < .001$. There was also a main effect of type of recipient on likelihood of disclosing lived experience of depression, $F(3.92, 584.73) = 40.73$, $p < .001$. Table 8 displays means for likelihood of disclosing lived experience of depression and anxiety according to recipient type.

Table 8

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

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

Standard deviations are shown in parentheses. All means are significantly different at $p < .01$ except for those sharing the same letter superscript (within columns only), †Excludes social phobia, specific phobia, OCD and panic disorder.

Since scores of less than four indicated responses somewhere between 'very unlikely' (1) and 'undecided' (4), Table 8 shows that trainees with lived experience

of depression or anxiety felt at most 'somewhat unlikely' to disclose this to a placement supervisor or member of course staff. To control for maladaptive perfectionism, likelihood of disclosing lived experience of a) depression and b) anxiety was compared across types of recipient using repeated measures ANOVAs with 'maladaptive perfectionism' as a covariate. Results showed that, after controlling for maladaptive perfectionism, there was no significant effect of type of recipient on likelihood of disclosing depression, $F(3.99, 539.23) = 1.92$, $p = .11$, or anxiety, $F(3.91, 578.74) = 2.14$, $p = .08$.

Qualitative data. Comments revealed that for trainees currently experiencing anxiety, one of the most prominent factors affecting likelihood of disclosure was how they would be perceived following disclosure. For example, one trainee noted, 'I feel I will be seen negatively by course staff if they are aware I am struggling.' One trainee relayed that following disclosure to a member of staff, they had been told, 'not to inform future supervisors in case they formed a "preconception" of me', and another trainee responded that 'I feel as though the course still sees mental health difficulties as a sign of a lack of resilience and incompetence.' Comments relating to disclosure of depression revealed that participants had concerns about others' reactions. One trainee observed that course staff are 'generally quite cold and can be aggressive', another stated, 'I wouldn't tell my boss because I wouldn't want to be sent on leave or patronised', and another commented, 'I am unlikely to tell my cohort as I feel I might be judged or seen as less capable'. A second notable factor in trainees' likelihood of disclosing lived experience of either depression or anxiety was the perceived necessity of this disclosure. This was underscored by statements such as, 'I am not sure I would disclose to course staff or placement supervisors unless I thought it was impacting on my work'.

Discussion

This study sought to determine the incidence of lived experience of mental health problems within the trainee population. It also examined factors associated with likelihood of disclosing a mental health problem, for trainees with and without lived experience of mental health problems. Results partly supported hypothesis one. Likelihood of disclosing three selected hypothetical mental health problems was predicted by maladaptive perfectionism, anticipated stigma associated with a previous mental health problem, temporal proximity to the mental health problem, and recipient type. Contrary to hypothesis one, anticipated stigma associated with a current mental health problem did not predict likelihood of disclosing a hypothetical mental health problem. Additionally, adaptive perfectionism predicted likelihood of disclosing schizophrenia. Contrary to hypothesis two, after controlling for maladaptive perfectionism, there was no significant difference in likelihood of disclosing lived experience of mental health problems according to recipient type. The results, implications, and suggestions for further research are discussed below.

Hypothetical Disclosure

This study identified that, based on a hypothetical scenario, trainees anticipated being least likely to disclose a current mental health problem to placement supervisors. Trainees also anticipated being less likely to disclose a current mental health problem to course staff than to family members or health professionals. Crucially, however, trainees did demonstrate willingness to disclose mental health problems to someone. Indeed, it was discovered that figures for likelihood of disclosing to family were higher here than in previous research on members of the general public (Rüsch et al., 2012). This suggests that trainees are willing to selectively disclose. According to qualitative data, obstacles to disclosure to course

staff and supervisors included trainees' beliefs that the information is not relevant to individuals within the training environment. Additionally, trainees anticipated being equally unlikely to disclose current depression to a cohort member as to course staff, and equally unlikely to disclose current schizophrenia to a cohort member as a placement supervisor. It therefore seems that trainees consider the training environment as a whole to be unsuitable for disclosure of current diagnoses. It may be that trainees are reluctant to disclose to fellow trainees because they fear that news of this will find its way back to staff, or because they anticipate being viewed by fellow trainees as unreliable or unable to cope. Likelihood of disclosing a specific phobia was higher across recipient types than it was for depression or schizophrenia, although it remained lowest for supervisors and course staff. Qualitative feedback suggested that this may be due to the belief that disclosure of a specific phobia carries a lower risk of negative reaction compared with disclosure of depression or schizophrenia. Further analysis of qualitative data from trainees would shed light on why it is that they anticipate feeling reluctant to disclose to people associated with the training environment.

Different variables for different recipients. The factors that predicted likelihood of disclosure in a hypothetical situation differed depending on recipient type, as well as mental health problem. For example, whereas trainees anticipated being more likely to disclose depression to course staff, supervisors, and health professionals if this was a current as opposed to past problem, the current/past distinction did not make a difference to likelihood of disclosing depression to friends, family members and cohort members. The finding that temporal proximity predicts likelihood of disclosing schizophrenia or depression to health professionals, supervisors and course staff, may reflect trainees' reluctance to disclose, beyond

family and friends, more than what is deemed necessary. Varied patterns also emerged with other predictor variables. For example, none of the variables significantly predicted likelihood of disclosing a specific phobia to friends, whereas anticipated stigma (past), temporal proximity, maladaptive perfectionism and adaptive perfectionism all significantly predicted likelihood of disclosing a specific phobia to a cohort member. These results point to the complexity of the disclosure process, and imply that trainees weigh up multiple competing considerations when making decisions about disclosure. Evidently, different considerations may be more or less influential, depending on the recipient type. Disentangling these differences may help us to tailor our support for trainee disclosure to the specifics of their circumstances. On the basis of this study, it is clear that future research on the factors affecting disclosure should distinguish between type of recipient and type of mental health problem.

The limited impact of anticipated stigma. Perhaps the most surprising discovery was that, given a hypothetical scenario, trainees who perceived there to be high levels of stigma associated with someone currently experiencing a mental health problem anticipated being no more or less likely to disclose this mental health problem than trainees who perceived there to be low levels of stigma associated with someone currently experiencing this mental health problem. This finding was consistent across specific phobia, depression and schizophrenia. Since previous research has linked anticipated stigma with willingness to disclose, these results offer a challenge (Bos et al., 2009; Rüsch et al., 2014). It may be possible to explain the absence of association between anticipated stigma and disclosure by arguing that other factors weighed more heavily in trainees' decision-making. However, this explanation fails to explain why it was that anticipated stigma associated with a *past*

mental health problem was found to be a significant predictor. It could be that a lack of variation between trainees in their anticipation of stigma associated with current mental health problems may account for this being a non-significant predictor. Descriptive statistics provided some limited evidence for this hypothesis in the case of depression and schizophrenia. For both mental health problems, the data on anticipated stigma showed greater variance for past than for current diagnoses. However, there is no evidence for this explanation in the case of specific phobia. Further research looking at anticipated stigma amongst trainees would help to disentangle the findings of this study. For example, a valuable line of enquiry would be to investigate trainees' perceptions of stigma beliefs held by course staff and supervisors, rather than by the general population. These perceptions may correlate more closely with likelihood of disclosing to these recipients.

Maladaptive perfectionism negatively predicts disclosure. The most consistent finding for a hypothetical disclosure situation was that maladaptive perfectionism negatively predicted likelihood of disclosure. Moreover, controlling for maladaptive perfectionism in trainees with lived experience of anxiety and depression resulted in there being no significant differences between likelihood of disclosure depending on recipient type. These findings support existing literature highlighting the tendency of people high in maladaptive perfectionism to conceal from others information that may be evaluated negatively (Kawamura & Frost, 2004). The findings also complement the notion that perfectionism is not always socially desirable. In a recent overview of the destructive elements of perfectionism, Flett, Hewitt and Sherry (2016) reflected on the ways in which perfectionistic individuals may have difficulties both personally and interpersonally. While it is unlikely that most trainees are the type of rigid, narcissistic perfectionists described in their work, Flett

and colleagues draw attention to the ways in which perfectionism more generally can restrict personal development. Moreover, it may be that through intellectualizing their problems perfectionists actually find it more difficult to experience negative emotions, compounding the risk of concealing mental health problems (Flett et al., 2016).

It should be acknowledged that trainees were found to be significantly higher in adaptive compared to maladaptive perfectionism. This is a welcome finding, especially because the current survey revealed positive associations between adaptive perfectionism and likelihood of disclosing schizophrenia to family members, as well as between adaptive perfectionism and disclosing a specific phobia to cohort members. However, the positive impact of adaptive perfectionism on disclosure was far less emphatic than the negative impact of maladaptive perfectionism on disclosure. Although there may be certain situations in which high personal standards act as an incentive to share with others one's mental health problem, this should not obscure the key message of caution communicated by the findings of this survey. For while various external factors may play a role in disclosure decisions, in many instances these can be trumped by one's maladaptive perfectionism. In light of this, research into ways of monitoring maladaptive perfectionism, as well as interventions for maladaptive perfectionism, appears to be essential. Research examining the positive and protective elements of perfectionism would also make a welcome addition to the literature.

Lived Experience of Mental Health Problems

Survey results demonstrated that there are a substantial number of trainees with lived experience of mental health problems, and that many trainees conceptualize their problems as current. Overall, 67% of participants indicated lived experience of

a mental health problem, with the most common problems being anxiety (43% of participants) and depression (39%). A considerable number of trainees indicated lived experience of social phobia (16%) and eating disorder (14%), and 29% said that they were experiencing at least one mental health problem at the time of survey completion. This latter figure is lower than the 59% of trainees that Cushway (1992) identified as meeting caseness for a mental health problem, which may be due to her use of the GHQ as a direct measure of current mental health problems. While the number of trainees currently experiencing anxiety (16%) and depression (7%) were slightly lower than those identified by Brooks et al. (2002) (18% and 14% respectively), the total percentage of trainees with lived experience of a mental health problem is higher than the 26% of UK adults who have at some point in their lives been diagnosed with one or more mental health problems (Health & Social Care Information Centre, 2015). Hitherto, the most up-to-date statistics relating to prevalence of mental health problems amongst trainees showed that in both the 2013 and 2014 training cohorts, only one percent of trainees had a self-declared mental health problem (Leeds Clearing House, n.d.). These statistics grossly underestimate the prevalence of lived experience of mental health problems amongst trainees. The current statistics should motivate training institutions and trainees to focus more closely on the psychological wellbeing of trainees.

Disclosure by trainees with lived experience. Although likelihood of disclosure by trainees with lived experience of mental health problems also differed depending on recipient type, these differences became non-significant after controlling for maladaptive perfectionism. It may be that maladaptive perfectionism affects trainees' decision-making processes to such an extent that the identity of the potential recipient loses its relevance. Nonetheless, comments by trainees suggested that some

felt particularly reluctant to disclose lived experience to course staff and supervisors, for fear of being viewed negatively and judged as incompetent. It therefore seems vital that future research explores further the construct of maladaptive perfectionism. It also seems vital that future quantitative research focusing on trainees with lived experience of mental health problems measures variables additional to those measured in this study, and that qualitative research closely examines the impact of recipient type on disclosure. This will help to provide greater certainty about the extent to which recipient type matters in disclosure decisions made by trainees with lived experience of mental health problems.

Implications

The complexity of the data unearthed by this study should discourage sweeping statements about the disclosure process. At the same time, the survey highlighted that, on the whole, trainees anticipated feeling reluctant to disclose a mental health problem to individuals within the training environment. There may be valid reasons for trainees to conceal mental health problems in this environment. After all, indiscriminate disclosure of mental health problems may negatively affect self-esteem (Bos et al., 2009), and it is clear from this study that some trainees have had unpleasant experiences of disclosure in the past. On the other hand, previous research informs us that concealing psychological distress can place a heavy burden on individuals, increase isolation, and negatively affect wellbeing (Hinshaw, 2007; Link et al., 2002). What is more, although this survey demonstrated that trainees feel a strong sense of professional responsibility and anticipate being able to identify when a mental health problem is impacting negatively on their academic and clinical roles, it is known that even psychologists are not very good at assessing accurately their own competency and needs. Research shows that 59% of psychologists

continued to see clients when too distressed to be effective, while 30% admitted that personal problems decreased the quality of care they provided (Johnson et al., 2012).

There is a will within the BPS and training establishments to support trainees with mental health problems. Yet despite this will, there exists no published trainee-based research to help put into place steps to transform good intentions into concrete policy. BPS guidelines for training courses emphasize the need for courses to provide more opportunities for trainees to disclose (Harper et al., 2007). However, these guidelines are difficult for trainees to access, which serves to perpetuate the perceived gap between trainers and trainees, and the sense that improving the psychological wellbeing of trainees can only be achieved via a top-down approach.

The evidence presented by this study is that the impetus for disclosure is just as much in the hands of trainees as in the hands of trainers. Type of mental health problem and type of recipient may affect likelihood of disclosure. However, trainees make their own decisions about the perceived value of disclosure, and this may be influenced by personality traits, such as maladaptive perfectionism. The challenge for trainees is in understanding just what constitutes 'need', and where their clinical responsibilities lie. It appears that trainees may err on the side of concealment, particularly within the training environment and when they believe that their own experiences of mental health problems are not relevant. It is crucial that trainees do not overlook or diminish their own responsibilities as clinicians working within ethical frameworks established by universities and professional bodies. Fitness to practice should be one of the factors motivating trainees to consider disclosure within the training environment, and this should be a process that is supported by the training system (Forrest et al., 2008).

A further reason for trainees to consider disclosure is to signal to fellow trainees, clinicians, potential trainees and members of the public that mental health problems exist across professions, and need not be sources of shame. This concept is consistent with the work of Corrigan who has argued that 'coming out proud' is an important means by which to reduce self and public stigma towards mental health problems (Corrigan & Matthews, 2003; Corrigan, Kosyluk & Rüsch, 2013).

One approach would be to borrow from the work of Forrest and colleagues, who have argued for a shift in the way that clinical psychologists think about the competency and wellbeing of our colleagues. Their approach places care, communitarianism and interdependency at the centre of psychology training and practice. They have promoted the idea of a 'competence constellation' – a network of fellow professionals that a psychologist establishes at the start of training, which helps to ensure ongoing competence throughout their career. In order to begin embracing this communitarian concept, Forrest argues that trainees must experience trainers who are willing to be transparent and vulnerable (Johnson et al., 2012). If embraced, this paradigm shift has the potential to create a culture of equality and openness between trainees, staff and supervisors, such that all sides would feel both a responsibility and a willingness to disclose and seek help for personal difficulties such as mental health problems.

The concept of a compassionate workplace is not revolutionary. Based on results from an online survey of mental health professionals in the NHS (Rao et al., 2015), the Joint Wellbeing Project Team (comprising the BPS DCP and the New Savoy Partnership) has established a Charter for Psychological Staff Wellbeing and Resilience. This charter calls for a move towards more compassionate workplaces. However, despite this commitment to change, there are few details about how this

might be done. Indeed, the research conducted by Rao and colleagues is neither focused on disclosure, nor on trainees. A model of potential value is the 'This is Me' campaign, which has been backed by over 50 companies in the City of London (Lord Mayor, 2016). 'This is Me' encourages business leaders and employees with lived experience of mental health problems to come forward and talk about their experiences. In conjunction with this, business leaders emphasize that companies must be doing more to provide the right environment and support to allow employees to disclose.

Recommendations

Undoubtedly, a sea-change on this level will bring challenges, particularly in a training environment that often emphasizes self-reliance, and in which there can exist a distance between assessors and those being assessed. A first step would be to ensure that all stakeholders, including trainees themselves, are made aware of the findings of this research. It is hoped that this will lead to discussions about the ideas raised here. Secondly, there is a critical need for more detailed qualitative research, into the experience and attitudes of not only trainees but also course staff and supervisors, some of whom may themselves have lived experience of mental health problems. If we hope to introduce a culture of interdependency, it seems essential that trainers and trainees are exposed to one another's voices. What is more, conversations about the lived experience of mental health problems in trainees and qualified psychologists is likely to enrich our clinical practice.

Thirdly, training institutions may wish to consider providing self-care interventions for all trainees and staff, regardless of mental health status. Hinshaw has argued in favour of offering mental health clinicians group and individual support, to help them cope with job-related stress (2007). Others have stated that

because trainees are particularly vulnerable to experiencing high levels of stress, there is a need for further research into the effectiveness of interventions to reduce this (Pakenham & Stafford-Brown, 2012). There is evidence that short term mindfulness-based interventions can be effective in reducing perceived stress, negative affect, anxiety and rumination, and increasing self-compassion, in trainee counselling psychologists (Shapiro et al., 2007). However, there is no comparable evidence relating to trainee clinical psychologists. A further consideration would be to require trainees to engage in personal therapy, as is the requirement for counselling psychology trainees. Including in training courses compulsory personal therapy or short-term self-care interventions, may have the combined effect of supporting psychological wellbeing and reducing the stigma associated with psychological distress. Finally, because maladaptive perfectionism appears to be so closely associated with concealment, it may be worthwhile thinking further about how this manifests itself in both trainees and trainers. One approach would be to invest in interventions to reduce or manage maladaptive perfectionistic traits. Where this is not viable, it seems valuable to encourage trainees and trainers to think about how perfectionism can be monitored, and the professional scenarios in which it may be helpful or unhelpful.

Limitations

There are a number of potential limitations to the research presented here. In the interest of brevity, three will be highlighted. Firstly, it must be acknowledged that a substantial proportion of the research measured likelihood of disclosure in a hypothetical scenario. Since trainees were asked to imagine experiencing a specific mental health problem, it is not possible to claim for certain that their responses reflected how they would actually behave if that scenario were to arise in the future.

Any trainee might develop a mental health problem during the course of training, so it was not appropriate to focus exclusively on trainees with lived experience. Nonetheless, the distinction between hypothetical and lived experience of a mental health problem does raise important questions about the validity of the results. It is conceivable, for example, that the level of public stigma anticipated by a trainee without lived experience of a mental health problem might change were they to develop a mental health problem. Research restricted to trainees with lived experience of mental health problems would help to overcome this limitation, but it would also fail to gather information about the attitudes of all trainees towards mental health problems. Trainees without lived experience of a mental health problem are also be able to offer useful insights into the existence of mental health stigma and the extent to which the trainee population feels able to be open with course staff and supervisors.

Secondly, the data presented here does not allow causal links to be made between the factors investigated. For example, on the basis of this research it is not possible to conclude that maladaptive perfectionism or temporal proximity cause concealment of a mental health problem. Qualitative data, in the form of trainees' comments, helped to give a clearer sense of causal associations. However, one must be open to the possibility that trainees themselves are not aware of all of the underlying factors that affect their likelihood of disclosing. Future researchers should be encouraged to use longitudinal, as well as qualitative, methodologies to help identify causal factors relating to disclosure decisions.

A third limitation is that there is likely to have been a self-selection bias present in the sample of trainees, such that those who participated in the research may not have accurately represented the trainee population. One might conclude that the

sample over-represented trainees who had either personal experience of a mental health problem, a close friend or family member with a mental health problem, or a particularly strong opinion about disclosure of mental health problems. One might therefore argue that the actual proportion of trainees with mental health problems is lower than identified in the study. Moreover, qualitative responses are likely to have represented the opinions of trainees most moved to comment, and one should be cautious not to assume that all trainees feel so strongly about disclosure. To overcome this limitation in future studies, course directors should be more engaged in disseminating and promoting research associated with trainee mental health. Course directors can play a central role in communicating to their trainees the importance of participating in this research, and while this will not guarantee the participation of all trainees, it is likely to increase the representativeness of the sample population.

Conclusions

This research helps to address a glaring omission in the mental health literature. Results highlighted the substantial incidence and variety of lived experience of mental health problems in trainees. Furthermore, by demonstrating that trainees as a whole anticipated being less likely to disclose a mental health problem to individuals in the training environment, this study indicated that there is something about the training environment that discourages disclosure. Findings suggest, however, that trainees have considerable control over disclosure. Given the strong associations between likelihood of disclosure and personal factors, such as maladaptive perfectionism, it seems essential that trainees acknowledge their own responsibility for disclosing. I have argued that rather than continuing to try to change the training environment through top-down attempts at demonstrating openness and tolerance,

the BPS and training institutions should champion a training environment that encourages the interdependency of all stakeholders. A paradigm shift on this level would require a significant sea-change, with trainees, course staff and supervisors communicating transparently about their psychological wellbeing. It is hoped that this will help cultivate a system of training that produces psychologists able to take the lead in demonstrating the value of mental health disclosure.

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Part 3: Critical Appraisal

Overview

This critical appraisal is divided into three sections, each of which offers reflections on particular aspects of the research process. The appraisal begins by exploring the background to the research, including how and why disclosure came to play a central role, as well as describing how the final measures were decided upon. It then presents some of the challenges that arose during the data analysis phase of the study, and expands on limitations of the research. Finally, personal learning points and implications are discussed, and ideas for dissemination of the findings are outlined.

Developing The Idea

Birth and teething problems. When I first started thinking about how trainees share their own experiences of mental health, I assumed that stigma would play a central role – particularly for trainees with personal experience of a mental health problem. I therefore spent time understanding stigma as a construct, which took me to Goffman's (1986) seminal work on stigma, as well as more recent social and cultural psychology theory on stigma (including Major & O'Brien, 2005 and Neuberg, Smith & Asher, 2003). From here I focused more specifically on the stigma of mental 'illness' (as it is referred to in the majority of the literature), reading Stephen Hinshaw's (2007) 'The Mark of Shame' and directing my attention to journal articles, such as Byrne (2000) and the Lancet series on the stigma of mental health problems (The Lancet, 1998). I was also very mindful of national campaigns to reduce the stigma of mental health problems, such as Time to Change, which was set up in 2007 by leading mental health charities, funded in part by the UK Department of Health. It was evident that stigmatization of mental health problems was still prevalent, that mental health problems were associated with terms such as

'burden' and 'fear' (James, 1998, p. 1047) – propagated at least partly by the press (Heginbotham, 1998) – and that service users continued to find it difficult to speak out about their problems (Shaw, 1998). Attempting to immerse myself in literature about the experience of people with mental health problems, I read not only qualitative research that described the personal experiences of service users (i.e., Dinos et al., 2004), but also literature written by service users (for example 'Beyond Bedlam: Poems Written Out of Mental Distress', Smith & Sweeney, 1997).

Although the aforementioned literature did not feature heavily in the final research project, the breadth of my focus at this early stage perhaps reflected my lack of certainty about how to begin what seemed such a substantial undertaking. Whilst it felt relevant to understand the extent to which trainee psychologists have experienced or may experience mental health stigma, scouring published material for related research proved largely fruitless. It therefore became necessary to widen my initial readings to include research on mental health problems and stigma in medical students, a group at least somewhat comparable to trainees. There were a number of studies focusing on psychological distress, suicidal ideation and burnout in medical students (Dyrbye et al., 2008; Dyrbye, Thomas & Shanafelt, 2006); barriers to use of mental health services by medical students (Givens and Tija, 2002); and stigma perceptions held by medical students with mental health problems (Lawn et al., 2012; Schwenk, Davis & Wimsatt, 2010). It was also possible to find an unpublished dissertation relating to help-seeking attitudes in counselling trainees (Pfohl, 2010).

Looking back over research journal reflections, it is clear that during these initial stages my ideas were unwieldy and scattered, making the task of producing the research proposal feel anxiety-provoking and overwhelming. Attempting to narrow a focus and create parameters for the research demanded that certain constructs and

variables be excluded, which raised concerns about whether this process would render the research uninteresting and uninformative. Due to the abundance of research into the experience of people with mental health problems, it was a challenge to make meaningful and confident distinctions between literature that was essential and literature that was interesting but superfluous. I also felt a duty to my fellow trainees, and to training institutions, to conduct research that did justice to the complexity of the subject. I was therefore aware of the need to provide a clear rationale for the research, and this seemed bound up in ensuring that it made a contribution of practical value to both trainers and trainees.

Value and importance of the research

As I came to better understand the experience of people with mental health problems it was increasingly apparent that, in order for my research to be meaningful, it needed to go beyond trainees' experiences of stigma and investigate how this affected behaviours such as disclosure. Literature highlighted the complexity of the disclosure process, as it applied to mental health problems and to distress more generally (see Kahn, Hucke, Bradley, Glinski & Malak, 2012; Kahn & Hessling, 2001). For example, researchers underscored how disclosure of distress does not solely facilitate access to support but can also impact upon constructs such as self-esteem, empowerment and psychological wellbeing. Investigating disclosure patterns amongst trainees therefore offered the potential to discover something associated in more than one way with their mental health. This seemed valuable to not only trainees but to course staff and supervisors, since it is they who are best situated to provide practical support and guidance in the context of the trainee's workplace.

Research into mental health disclosure patterns amongst trainees was not only intended as a means to understanding how training courses might increase disclosure of mental health problems. At a very basic level, the research was intended as sketch of the current state of play in trainee mental health. There existed no published up-to-date research on the rates of mental health problems or likelihood of disclosing these to others. The BPS Clinical Psychology Training and Disability guidelines (Harper, Rowlands, Youngson, 2007), which relied on voluntary disclosure in the context of applying for training, suggested that no-one with a mental health problem was accepted onto a training programme in 2003. I recognised that disclosure would not always be the most beneficial course of action for all trainees. For example, research noted the benefit of concealment to one's sense of personal control (Dew et al., 2007). Yet I was also keen to acknowledge that, although disclosure may not always feel comfortable, it may be in some cases beneficial to service users, the wider public, and trainees themselves. Firstly, we know that individuals, including trainees, are inaccurate judges of their own competence, especially where psychological distress is a factor (Forrest, Shen Miller & Elman, 2008; Johnson, Barnett, Elman, Forrest & Kaslow, 2012). Disclosure therefore brings others into the process of assessing one's own needs. This is likely to help trainees be in the best possible position to provide the best possible care for service users. Secondly, mental health disclosure can help to destigmatise mental health problems amongst the wider public (Corrigan & Matthews, 2003). Thirdly, disclosure by trainees not only allows them access to academic and placement support, it can also send a hopeful message about disclosure to other trainees who have mental health problems, helping them to feel less alienated.

Variables and measures. If disclosure was to be an essential component of my research, it was essential that the study reflected its multifaceted nature. It was evident that I needed to measure certain factors already shown to be associated with disclosure. These included the type of mental health problem being disclosed, whether the mental health problem being disclosed was a current or past problem, the recipient of the disclosure, and the anticipated stigma associated with the mental health problem being disclosed. I was aware that many more factors might be associated with trainees' disclosure decisions, but it was simply not possible to include all of these in my research. As I came to better understand the related literature I found myself drawn to the construct of perfectionism, and its association with self-concealment. "Maladaptive" perfectionism has been distinguished from positive aspects of perfectionism, and defined as maladaptive because of its association with psychological distress (Kawamura & Frost, 2004). It has been associated not only with the tendency to withhold negatively evaluated personal information, but also with decreased self-esteem and increased internalized shame (Ashby, Rice & Martin, 2006). One study of qualified clinical psychologists had found perfectionism to predict work-related burnout through the mediating variable 'stress', and suggested that training programmes should educate psychology trainees about the potentially negative consequences of elevated levels of perfectionism (D'Souza, Egan & Rees, 2011). I found the construct of perfectionism interesting in part because it seemed especially relevant to the trainee population. Trainees are likely to display perfectionistic traits, such as high personal standards, organisation and positive striving. Training courses emphasize how important are these qualities in the process of applying for and completing clinical training. Additionally, unlike my other variables, perfectionism represented an aspect of the personality rather than

a situational factor or a feature of the mental health problem itself. In an environment where the features of a mental health problem and its associated level of stigma might be beyond a trainee's control, the notion that someone's level of "maladaptive" perfectionism might affect their likelihood of disclosure offered the potential to empower trainees to make changes themselves.

Once I had decided upon a set of potentially related variables (perfectionism, temporal proximity, anticipated stigma and recipient type), the challenge was in identifying the most valid measures of these variables. For certain variables, such as perfectionism, this was more straightforward, since there existed fewer published measures and a clearer picture of which were most commonly used. Measures of stigma and mental health disclosure were numerous and varied. I decided to exclude measures of self-stigma, such as the Self-Stigma of Depression Scale (Barney, Griffiths, Christensen & Jorm, 2010), the Stigma Scale (King et al., 2007), the Discrimination and Stigma Scale (DISC-12: INDIGO, 2008) and the Internalised Stigma of Mental Illness Scale (Ritsher, Otilingam & Grajales, 2003), on the basis that these measures assumed that the respondent was experiencing a mental health problem. Measures that asked about respondents' own views of mental health problems, such as the Stigmatising Attitudes-Believability Questionnaire (Masuda, Price, Anderson, Schmertz & Calamaras, 2009), and the Mental Illness: Clinicians' Attitudes Scale (MICA-4: Kassam, Glozier, Leese, Henderson & Thornicroft, 2010) seemed inappropriate for use with trainees. It was felt that statements such as 'I would use the terms 'crazy', 'nutter', 'mad' etc. to describe to colleagues people with a mental illness who I have seen in my work' (MICA-4, item 15), were likely to cause trainees to cease completion of the survey. I also decided to exclude measures of stigma related to help-seeking, such as the Perceptions of Stigmatization by

Others for Seeking Help Scale (Vogel, Wade & Ascheman, 2009) and the Attitudes Towards Seeking Professional Counselling Help Questionnaire (Fischer & Turner, 1970), since my research was not focused on help-seeking. The Perceived Discrimination and Devaluation Scale (PDD, Link, 1987) appeared to best measure the respondent's perception of stigma as it existed in the general population. However, as described in the empirical paper, it was necessary to adapt this measure slightly so as to make it more consistent with trainees' ways of thinking about people with mental health problems. To best determine likelihood of disclosure it was important to find a measure that allowed the inclusion of multiple potential recipients. Measures such as the Coming Out with Mental Illness Scale (Corrigan et al., 2010) assume that disclosure is an all or nothing process, whereas I wished to understand whether there were contrasting levels of disclosure depending on the type of recipient. The simple question, 'In general, how comfortable would you feel talking to a friend or family member about your mental health, for example, telling them you have a mental health diagnosis and how it affects you?' (Rüsch, Brohan, Gabbidon, Thornicroft & Clement, 2014; Rüsch, Evans-Lacko & Thornicroft, 2012) seemed best suited to measuring trainees' likelihood of disclosing to a variety of recipients.

Challenges and Limitations

Statistical analysis. I had hoped that the statistical analysis of my data would be straightforward. However, the design of my survey meant that levels of variables merged together, which demanded that I disentangle these using SPSS and reconsider the process of analysis. This took a great deal of time and led to frustration – and at times nothing short of despair. The outcome variable 'likelihood of disclosure' produced no single score, since the survey had asked for likelihood of

disclosure according to type of recipient, and dependent on whether the mental health problem was past or present. Thus, I was forced to restructure the data and use a form of analysis called 'multilevel linear model analysis', which is sometimes known as 'mixed model analysis'. Multilevel linear model analysis 'provides a general, flexible approach…because it allows a wide variety of correlation patterns' (Seltman, 2015, p.357). There is not an abundance of available and clear information relating to multilevel linear model analysis, which made the process of learning and understanding how to use it particularly challenging. Fortunately, I received invaluable support from a member of the department, Ravi Das, who was able to give me an outline of the analysis and point me in the direction of Andy Field's most recent edition of 'Discovering Statistics using IBM SPSS Statistics' (Field, 2013). Nonetheless, I struggled with the complexity of the approach. In the words of Field, 'multilevel modelling is very complicated…multilevel models often fail to converge, with no apology, or explanation, and trying to fathom out what's happening can feel like hammering nails into your head' (Field, 2013, p.863). I was eventually able to reach an understanding of the imperfect nature of finding a model fit for the data, based on including and excluding variables, random effects and using Schwartz's Bayesian Criterion (BIC), which is recommended by researchers (i.e., Seltman, 2015). The BIC rewards models for their fit of the data, but penalizes models for a higher number of parameters. Thus, parsimony played an important role in my choosing the final models included in the empirical paper. Due to the number of factors included in my models it was not possible to include further interaction effects, as SPSS was unable to run models with this number of parameters. Consequently, I chose to run further multilevel linear model analyses for individual recipients, in order to understand the interaction effects of recipient with anticipated

stigma, temporal proximity, "maladaptive" and "adaptive" perfectionism (see Field, 2013). In summary, the analysis process was far more complex than I had anticipated, and helped me to understand why it is that researchers on the whole have tended to avoid looking at disclosure in such a nuanced fashion. For example, one previous study looking at mental health disclosure in the general public asked participants, 'Are you out about your mental illness? In other words, have you decided to tell most of your family, friends, and acquaintances that you have a mental illness? Have you decided not to hide it?' (Corrigan et al., 2010). A single measure of disclosure such as this may make statistical analysis more straightforward, but it fails to distinguish between types of recipient and is therefore, it could be argued, less valid.

Qualitative data. While the study had been intended first and foremost as a piece of quantitative research, it had always felt important that participants were given the opportunity to provide their personal reflections throughout the survey. It seemed likely that trainees would hold strong opinions about mental health disclosure and the stigma associated with mental health problems. It was also felt that these additional comments could help augment the quantitative data collected. When it came to data analysis I was struck by the number of comments that had been provided. Given that previous studies on mental health stigma and disclosure tended to focus specifically on either quantitative methodologies (i.e., Bell et al., 2011; O'Mahen, Henshaw, Jones & Flynn, 2011) or qualitative methodologies (i.e., Chen, Lai & Yang, 2013; Martin, 2010), but not both, it was clear that my empirical paper could not do justice to the richness of the feedback from participants. Whilst I gave myself the freedom to read and classify into themes the qualitative responses, it was both necessary and unfortunate that the final paper provides an impoverished

reflection of this. There is little doubt that the study would have benefitted from a more thorough thematic analysis, had there been the scope, and it is consequently my intention to prepare a second paper focusing solely on this. Overall, the qualitative data presented in the empirical paper do help to go beyond the correlational patterns identified by the analyses and lay strong foundations on which to conduct future research. It seems essential that in order to better understand the experience of trainees with mental health problems, and the attitudes of all trainees towards disclosing a mental health problem, future research should focus on collecting qualitative data. There will undoubtedly be challenges in doing so, most obviously the challenge of recruiting trainees who are willing to speak openly with a researcher about their personal experiences of mental health. Nonetheless, qualitative research offers the opportunity to better understand multiple aspects of disclosure, and go beyond the correlational associations identified in this study to begin to more clearly identify causal relationships.

Limitations. The empirical paper highlighted three limitations that seemed most relevant to the discussion. These included that: a) a significant component to the research was based on hypothetical disclosure situations, b) I was unable to draw causal links between variables, and, c) there was a possibility of a biased sample. However, there were two further limitations that are of note. Firstly, it is important to acknowledge that the factors measured are very unlikely to represent the entire range of factors that predict likelihood of disclosure. It would not have been possible to perform a manageable analysis including every potential associated factor. Based on the status of current literature the factors chosen were those that it seemed most sensible to hypothesize would be associated with disclosure. However, factors that may have been equally important were omitted, for example disclosure setting,

cultural beliefs about mental health or previous experiences of disclosure. Future qualitative research doing justice to the wider range of factors associated with disclosure would be valuable.

The second limitation to highlight is that researchers may object to the definition of 'mental health problem' used in the study. It would not have been appropriate to have narrowed the definition to include only official diagnoses, as this would have immediately excluded all participants who had not disclosed to a health professional. Even so, one might argue that the definition of a mental health problem used in the survey was too wide, thereby inflating the proportion of trainees identified as having mental health problems. Whilst this is a valid observation, it is important to recognise that many trainees experiencing psychological distress would have not received a diagnosis of any sort, on account of not having sought professional help. Thus, it was necessary to provide a definition that not only encompassed DSM and ICD criteria, but also significant impairment of one's day-to-day life, which seemed most relevant to the overarching aim of moving towards better support for trainees experiencing psychological distress. In some previous studies, researchers have included screening measures to determine whether participants meet the threshold for a mental health problem. For example, the General Health Questionnaire (GHQ) was used as a screening tool by Bushnell et al. (2005) and the Patient Health Questionnaire (PHQ-9) was used by Schwenk, Davis & Wimsatt (2010) to determine levels of depression in medical students. It was decided that a screening measure would not enable identification of such a wide range of mental health problems and would not allow the survey to identify trainees with past but not current experience of a mental health problem. Furthermore, it was strongly felt that trainees would have a better understanding of mental health problems than the general public, or

medical students, and that it would therefore be appropriate to ask them to choose whether or not they felt this term described their own experiences.

Looking Forward

Learning points. Over the course of this research I came to see the issue of trainee disclosure of mental health problems in a more sophisticated fashion. This was both in terms of my understanding of the shared nature of the disclosure process, and in relation to the ways in which data unearthed by theory-driven quantitative research must be analysed in order to do justice to its complexities. With reference to the first point, prior to undertaking this project, I had imagined that trainee disclosure could be most effectively facilitated by firstly educating training institutions and supervisors about the prevalence of mental health problems in trainees, and secondly intervening to reduce stigmatising attitudes held towards these trainees by training institutions and supervisors. By the end of the study I understood that this approach would serve only to perpetuate an attitude of 'us and them', with trainers handed sole responsibility for managing levels of disclosure. The strength of the association between perfectionism and likelihood of disclosure in this study suggested that there are aspects of the disclosure process that lie very much in the hands of trainees, and that we must think more carefully about the roles that both trainers and trainees play in this. In relation to the second point, this study has convinced me that future research of mental health disclosure must be driven by theory, even where this requires challenging statistical methodologies, which may sometimes preclude straightforward conclusions. By not taking into account the complex theoretical underpinnings of mental health disclosure, we risk drawing misleading conclusions about this important area of investigation.

Implications and future directions. The empirical study highlighted a variety of avenues for future research, as well as ways in which future research may be better designed. With the benefit of hindsight it may have been more valuable to have included, instead of schizophrenia as a hypothetical mental health problem, alternative mental health problems comparable in levels of stigma to schizophrenia, such as an eating disorder or substance misuse. The survey findings demonstrated that not a single trainee had lived experience of schizophrenia, whereas 14% had lived experience of an eating disorder and 5% had lived experience of substance misuse. Moreover, on the basis that the symptoms of schizophrenia are often difficult to conceal, it is unlikely trainees would have as much control over whether or not it is disclosed to others. I would therefore argue that future research with trainees should use the findings of this research to better tailor measures to the mental health problems most relevant to this population.

A second implication of this study is that the phraseology and format of the questions used in future research should be sensitively adapted, so as to be more consistent with the attitudes of trainees towards mental health. In this survey, the original wordings of measures were adapted where it was felt that they might not resonate with trainees (for example changing 'mental patient' to 'person experiencing a mental health problem' in the PDD). Despite this, the comments of a minority of trainees indicated that there was some discomfort with the measure items. For example, one trainee stated about the PDD, 'this doesn't feel comfortable to answer and because of this I don't think these questions tap into my views and opinions at all', and another stated of the disclosure questions, 'I think I would answer differently to all of these questions if they weren't so diagnosis led'. Furthermore, the inclusion of three mental health problems and the past/current

distinction meant that participants were required to answer a large number of questions that were very similar to one another. It is likely that this led some trainees to cease completion of the survey. As one participant wrote, 'This seems like too many questions'. One adaptation for future research would be to include only two mental health problems – one highly stigmatised mental health problem and one less stigmatised mental health problem – when asking about hypothetical likelihood of disclosure and anticipated stigma. A further adaptation would be to state clearly at the beginning of each measure that, although items might not connect with the participant's own view of mental health problems, they form part of validated and established measures that are a necessary part of the research. Alternatively, I would encourage future researchers to consider developing original and validated measures tailored specifically to trainees. Ideally, these measures would not only include appropriately worded statements, they would also take into account the fact that not all trainees think about mental health problems in terms of diagnoses.

The third implication for future research is that studies collect more extensive demographic information on participants. This information may provide a valuable insight into whether there are significant differences between trainees with contrasting demographic characteristics in the way that they think about mental health stigma and disclosure of mental health problems. The sensitive nature of the research made it necessary to prioritise anonymity in the current study. There are, for example, very few men from minority ethnic backgrounds in the trainee population, and revealing these characteristics would therefore have compromised anonymity. However, perhaps I was too cautious in excluding any demographic information except for gender. It would perhaps have been acceptable and valuable to have collected data on each participant's year of training. This would have allowed for a

discussion about whether there is a difference in likelihood of disclosing at different stages over the three years of training. It might be, for example, that trainees begin their training reluctant to disclose to course staff, but that this changes as they become more trusting of staff and more confident in themselves. Indeed, the current findings show that one particular personal characteristic – maladaptive perfectionism – appears to be associated with disclosure. It is therefore possible that other personal characteristics, such as cultural background, might impact upon disclosure decisions. Consequently, I would encourage researchers to consider carefully how future studies might best collect and use demographic information.

Dissemination. The findings of this study will be presented at the Group of Trainers in Clinical Psychology (GTiCP) annual conference, to be held in November 2016. It is hoped that this will help to bring to the fore the issue of trainee mental health, and act as a catalyst for conversations about how best to support trainees with mental health problems. If there is to be a change in the way that trainees and trainers think about trainee mental health it is vital that not only course directors, but course tutors, placement supervisors, and trainees themselves, are encouraged to think about this research. Rather regrettably, the BPS Clinical Psychology Training and Disability publication (Harper et al., 2007) seems to have been disseminated only to trainers, and there appears to be no way for trainees to easily access it online. It is crucial that the data from this study do not follow a similar path. In light of this, the aim is to submit for journal publication the quantitative and qualitative outcomes of this survey. To ensure that justice is done to the richness of the qualitative data, it may be necessary to submit a second manuscript, focused solely on trainees' comments. In addition to the aforementioned plans for dissemination, it is promising to see that UCL has already begun work on a follow-on project, funded by the BPS

division of clinical psychology (DCP), which seeks to develop an intervention supporting mental health disclosure-related decision making for trainees and qualified clinical psychologists. The intervention will build in part on the findings of this study, and will help to translate theory into practical steps that it is hoped will impact positively on the wellbeing of clinicians and, by extension, service users.

Conclusions

Whilst it was clear from the outset that there existed a dearth of research relating to trainees' experiences of mental health problems, the process of developing and refining parameters for such research represented a considerable challenge. The decision to focus on factors relating to mental health disclosure evolved over some time, and out of a desire to provide research that would benefit both trainees and trainers. As part of this research it was necessary to make sense of, and present in a coherent fashion, large amounts of relevant and complex data, which demanded a sophisticated understanding of statistical analysis and a succinct summary of substantial amounts of qualitative information. Although there were several limitations to the study design, it is perhaps worthwhile holding on to these as learning points that may help guide future research into trainee disclosure. Indeed, it is hoped that this future research, some of which has already begun, will be able to build on the findings of this study to produce further evidence supporting the need for a sea-change in the way that trainees and training institutions communicate about trainee mental health.

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Appendices

Appendix A: Literature Review Quality Appraisal

Quality Appraisal Checklist (Hawker et al., 2002)

1. Abstract and title: Did they provide a clear description of the study?
   - Good (4): Structured abstract with full information and clear title.
   - Fair (3): Abstract with most of the information.
   - Poor (2): Inadequate abstract.
   - Very poor (1): No abstract.
2. Introduction and aims: Was there a good background and clear statement of the aims of the research?
   - Good: Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions.
   - Fair: Some background and literature review. Research questions outlined.
   - Poor: Some background but no aim/objectives/questions, OR aims/objectives but inadequate background.
   - Very poor: No mention of aims/objectives. No background or literature review.
3. Method and data: Is the method appropriate and clearly explained?
   - Good: Method is appropriate and described clearly (e.g., questionnaires included). Clear details of the data collection and recording.
   - Fair: Method appropriate, description could be better. Data described.
   - Poor: Questionable whether method is appropriate. Method described inadequately. Little description of data.
   - Very poor: No mention of method, AND/OR method inappropriate, AND/OR no details of data.
4. Sampling: Was the sampling strategy appropriate to address the aims?
   - Good: Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates shown and explained.
   - Fair: Sample size justified. Most information given, but some missing.
   - Poor: Sampling mentioned but few descriptive details.
   - Very poor: No details of sample.
5. Data analysis: Was the description of the data analysis sufficiently rigorous?
   - Good: Clear description of how analysis was done. Qualitative studies: Description of how themes derived/respondent validation or triangulation. Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.
   - Fair: Descriptive discussion of analysis.
   - Poor: Minimal details about analysis.
   - Very poor: No discussion of analysis.
6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?

Good	Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed. Bias: Researcher was reflexive and/or aware of own bias.
Fair	Lip service was paid to above (i.e., these issues were acknowledged).
Poor	Brief mention of issues.
Very poor	No mention of issues.

7. Results: Is there a clear statement of the findings?

Good	Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.
Fair	Findings mentioned but more explanation could be given. Data presented relate directly to results.
Poor	Findings presented haphazardly, not explained, and do not progress logically from results.
Very poor	Findings not mentioned or do not relate to aims.

8. Transferability or generalizability: Are the findings of this study transferable (generalizable) to a wider population?

Good	Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).
Fair	Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.
Poor	Minimal description of context/setting.
Very poor	No description of context/setting.

9. Implications and usefulness: How important are these findings to policy and practice?

Good	Contributes something new and/or different in terms of understanding/insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice.
Fair	Two of the above (state what is missing in comments).
Poor	Only one of the above.
Very poor	None of the above

Quality Appraisal of Studies Included in Review

Author(s) & date	Methodological items (0-4)									Overall score (0-36)
	Abstract & title (Q1)	Intro & aims (Q2)	Method & data (Q3)	Sampling (Q4)	Data analysis (Q5)	Ethics & bias (Q6)	Findings & results (Q7)	Transferability/ generalizability (Q8)	Implications & usefulness (Q9)	
Bell et al. (2011)	4	4	2	3	4	2	4	4	3	30
Bos et al. (2009)	2	3	3	3	4	3	3	3	4	28
Bushnell et al. (2005)	4	4	3	4	4	2	4	4	3	32
Chen et al. (2013)	4	4	4	3	4	3	4	3	4	33
Chew-Graham et al. (2009)	4	4	2	2	4	1	4	2	3	26
Chronister et al. (2013)	3	4	4	4	4	2	4	4	4	33
Corrigan et al. (2010)	3	3	2	2	3	2	3	3	4	25
Dew et al. (2007)	3	4	3	2	3	1	4	2	4	26
Garcia & Crocker (2008)	3	4	3	4	4	1	4	4	2	29
Kleim et al. (2008)	4	4	3	2	4	2	4	2	4	29
Martin (2010)	2	4	4	2	2	1	4	2	3	24
O'Mahen et al. (2011)	4	4	3	4	3	3	4	4	4	33
Pandya et al. (2011)	4	3	2	3	3	3	3	3	4	28
Rüsch et al. (2014)	4	4	2	3	4	3	4	3	2	29

Quality Appraisal of Studies (Continued)

Author(s) & date	Methodological items (0-4)									Overall score (0-36)
	Abstract & title (Q1)	Intro & aims (Q2)	Method & data (Q3)	Sampling (Q4)	Data analysis (Q5)	Ethics & bias (Q6)	Findings & results (Q7)	Transferability/ generalizability (Q8)	Implications & usefulness (Q9)	
Venville (2010)	3	4	3	2	4	4	4	2	3	29
Venville et al. (2014)	4	3	4	3	3	2	3	3	4	29
Weich et al. (2007)	4	4	4	4	4	1	4	4	4	33
Withers et al. (2015)	4	4	3	4	3	2	4	4	3	31
Yow & Mehta (2010)	2	3	3	4	4	2	3	4	4	29

Appendix B: Email Invitation to Course Directors

Dear Colleagues,

We know very little about the extent to which trainee clinical psychologists experience mental health problems (pre- and during training) and what their views are on disclosure and help-seeking. We are writing to ask for your help with a study to aims to close this gap.

In collaboration with the DCP and in line with its inclusivity work, we are gathering evidence whether mental health problems, reluctance to disclose and seek help may be of concern among the trainee body.

We are hoping that you will support us and distribute an invitation to participate in this study to your trainee body. Data is being collected via a completely anonymous web survey: https://uclpsych.eu.qualtrics.com/SE/?SID=SV_6AxO6ZzzhAZoMC1

While we expect that training courses would welcome findings specific to their training body, in order to protect trainees' anonymity we are not asking them to declare where they are training and are only seeking minimal demographic data. The study has received ethical approval from the UCL Research Ethics Committee (Project ID: 0241/002).

The results of this study will be shared with the training community, both through presentations at GTiCP meetings and dissemination in journals. We very much hope that the results will inform discussion regarding how course staff, trainees and supervisors talk about stresses during training, and how trainees who experience significant mental health problems are supported.

We thank you very much in advance for your support. Should your course be unable to distribute the survey to trainees, e.g. due to institutional data protection rules, we would be grateful if you could let us know. We'd also be enormously grateful if you, or the person who forwards this invitation to your trainee body, could send us a quick line confirming that it has been circulated.

We'd of course be more than happy to address any queries or comments you may have.

Kind regards,

XXXXXXXX

Appendix C: Survey on Disclosure of Mental Health Problems

Introduction to Survey

This survey relates to trainee clinical psychologists' experiences of mental health problems. Please answer the questions as honestly as you can. Your responses will be completely anonymous and neither the researchers nor any academic staff at any institution will be able to have knowledge of who has participated and their responses.

You may find some of the questions in the survey distressing. Please prioritise your own wellbeing and if you wish to stop at any time whilst completing the survey, close the tab on your web browser.

Unsubmitted responses will be stored for 7 days before being deleted. In the event that you are interrupted, you may return to the survey within 7 days of starting and pick up where you left off. If you decide to restart the survey after 7 days you will need to follow the link from your email and complete the questions from the beginning.

You may wish to complete this survey in a private space where you will not be interrupted by friends, family or colleagues.

We anticipate that the survey will take 15-20 minutes to complete. We are very grateful for your help in contributing to this research.

This survey has received ethical approval from UCL (ID: 0241/002). Should you wish to contact the research team please email [redacted].

Demographic Information

Gender: M/F/ do not wish to specify /other (please specify)

Measure A (Perfectionism: MPS, Frost et al., 1990)

Please indicate your agreement with each of the following statements

I strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1	2	3	4	5

1. My parents set very high standards for me
2. Organisation is very important to me
3. As a child, I was punished for doing things less than perfect
4. If I do not set the highest standards for myself, I am likely to end up a second-rate person
5. My parents never tried to understand my mistakes
6. It is important to me that I be thoroughly competent in everything I do
7. I am a neat person
8. I try to be an organised person
9. If I fail at work/school, I am a failure as a person
10. I should be upset if I make a mistake
11. My parents wanted me to be the best at everything
12. I set higher goals than most people
13. If someone does a task at work/school better than I, then I feel like I failed the whole task
14. If I fail partly, it is as bad as being a complete failure
15. Only outstanding performance is good enough in my family
16. I am very good at focusing my efforts on attaining a goal

17. Even when I do something very carefully, I often feel that it is not quite right
18. I hate being less than the best at things
19. I have extremely high goals
20. My parents have expected excellence from me
21. People will probably think less of me if I make a mistake
22. I never felt like I could meet my parents' expectations
23. If I do not do as well as other people, it means I am an inferior human being
24. Other people seem to accept lower standards from themselves than I do
25. If I do not do well all the time, people will not respect me
26. My parents have always had higher expectations for my future than I have
27. I try to be a neat person
28. I usually have doubts about the simple everyday things I do
29. Neatness is very important to me
30. I expect higher performance in my daily tasks than most people
31. I am an organized person
32. I tend to get behind in my work because I repeat things over and over
33. It takes me a long time to do something "right"
34. The fewer mistakes I make, the more people will like me
35. I never felt like I could meet my parents' standards

Measure B (Hypothetical Disclosure: adapted from Rüsch et al., 2014)

The following items relate to CURRENT mental health problems.

In general, how likely it is that you would talk to the following people about your mental health, for example telling them you CURRENTLY HAVE the following mental health problems and how they affect you? *If you do not have any of these mental health problems, please imagine that you have.*

Very unlikely Very likely

1 2 3 4 5 6 7

	Having a diagnosis of specific phobia	Having a diagnosis of schizophrenia	Having a diagnosis of major depression
Friend			
Family member			
Member of course staff including academic tutor and research supervisor			
Placement supervisor			
Member of cohort			
Health professional (for example during a health screen at your GP)			

Comments relating to the above questions (optional):

The following items relate to PAST mental health problems.

In general, how likely is it that you would talk to the following people about your mental health, for example telling them you USED TO HAVE the following mental health problems and how they affected you? *If you have not had any of these mental health problems, please imagine that you have.*

Very unlikely Very likely

1 2 3 4 5 6 7

	Having a diagnosis of specific phobia	Having a diagnosis of schizophrenia	Having a diagnosis of major depression
Friend			
Family member			
Member of course staff including academic tutor and research supervisor			
Placement supervisor			
Member of cohort			
Health professional (for example during a health screen at your GP)			

Comments relating to the above questions (optional):

Measure C (Anticipated Stigma: adapted version of PDD, Link, 1987)

Please consider each of these mental health problems and rate them according to a 6-point scale:

Strongly agree agree agree slightly slightly disagree disagree strongly disagree
1 2 3 4 5 6

	Having a diagnosis of specific phobia	Having a diagnosis of schizophrenia	Having a diagnosis of major depression
Most people would willingly accept someone CURRENTLY experiencing the following mental health problem as a close friend			
Most people believe that a person who is CURRENTLY experiencing the following			

mental health problem is just as intelligent as the average person			
Most people believe that someone CURRENTLY experiencing the following mental health problem is just as trustworthy as the average citizen			
Most people would accept someone CURRENTLY experiencing the following mental health problem as a teacher of young children in a school			
Most people feel that CURRENTLY experiencing the following mental health problem is a sign of personal failure			
Most people would not hire someone CURRENTLY experiencing the following mental health problem to take care of their children			
Most people think less of a person who is CURRENTLY experiencing the following mental health problem			
Most employers will hire someone CURRENTLY experiencing the following mental health problem if he or she is qualified for the job			
Most employers will pass over the application of someone CURRENTLY experiencing the following mental health problem in favour of another applicant			
Most people in my community would treat someone CURRENTLY experiencing the following mental health problem just as they would treat anyone			
Most young women/men would be reluctant to date a man/woman who is CURRENTLY experiencing the following mental health problem			
Once they know a person is CURRENTLY experiencing the following mental health problem, most people will take his/her opinions less seriously			

	Having a diagnosis of specific phobia	Having a diagnosis of schizophrenia	Having a diagnosis major depression
Most people would willingly accept someone who has IN THE PAST experienced the following mental health problem as a close friend			
Most people believe that a person who has IN THE PAST experienced the following mental			

health problem is just as intelligent as the average person			
Most people believe that someone who has IN THE PAST experienced the following mental health problem is just as trustworthy as the average citizen			
Most people would accept someone who has IN THE PAST experienced the following mental health problem as a teacher of young children in a school			
Most people feel that having IN THE PAST experienced the following mental health problem is a sign of personal failure			
Most people would not hire someone who has IN THE PAST experienced the following mental health problem to take care of their children, even if he or she had been well for some time			
Most people think less of a person someone who has IN THE PAST experienced the following mental health problem			
Most employers will hire someone who has IN THE PAST experienced the following mental health problem if he or she is qualified for the job			
Most employers will pass over the application of someone who has IN THE PAST experienced the following mental health problem in favour of another applicant			
Most people in my community would treat someone who has IN THE PAST experienced the following mental health problem just as they would treat anyone			
Most young women/men would be reluctant to date a man/woman who has IN THE PAST experienced the following mental health problem			
Once they know a person has IN THE PAST experienced the following mental health problem, most people will take his/her opinions less seriously			

Comments relating to the above questions (optional):

Measure D (Lived Experience)

The following part of the questionnaire relates to your own experiences of mental health problems

Have you ever experienced a mental health problem?

This includes but is not limited to mental health problems as defined by DSM and ICD criteria, whether or not you have received a diagnosis. For the purpose of this question mental health problems refer to psychological and behavioural difficulties that have diminished your capacity for coping with the ordinary demands of life.

Y/N

(if no, survey ends)

Please indicate which of the following mental health problems most closely match yours and whether you experienced them in the past or are experiencing them at present.

	Experiencing currently	Experienced in the past
Anxiety (excluding OCD, panic and phobia)		
Panic disorder		
Specific phobia		
Obsessive compulsive disorder		
Social phobia		
Major depressive episode		
Eating disorder		
One-off psychotic episode		
Schizophrenia		
Bipolar disorder		
Adjustment disorder		
Post traumatic stress disorder		
Drug or alcohol dependence		
Other (please specify):		

Measure E (Disclosure of Lived Experience: adapted from Rüsch et al., 2014)

'How likely is it that you would talk to the following people about **X(from measure D)** that **you experienced in the past/are currently experiencing?**

Very unlikely Very likely

1 2 3 4 5 6 7

1. Friend
2. Family member
3. Member of course staff including academic tutor and research supervisor
4. Placement supervisor
5. Member of cohort
6. Health professional (for example during a health screen at your GP)

Comments relating to the above questions (optional):

Appendix D: Letter Confirming UCL 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.