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RESEARCH ARTICLE

Experiencing Mental Health when Treating Others

Experiences of Mental Health Workers in Relation to Mental Health Problems: Stigma, Perception, and Employment

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Introduction: Mental health problems are among the leading causes of disability, with one in four adults in the UK experiencing a mental health disorder. Even with the increasing knowledge concerning mental health disorders, two-thirds of those experiencing concerns are reluctant to disclose their condition and seek professional help. This perceived stigma has a strongly negative correlation with help-seeking behavior, and disproportionately affects healthcare professionals; 26% of mental health professionals in England are reported to be resigning due to a reduction of well-being.
Aims: This paper seeks to compare the effects of stigma perceived by mental health and non-mental health professionals, the barriers perceived, and the impact of specific disorders on this stigma.
Methods: Using a mixed-methods approach, a survey was conducted to determine the stigma levels and perceived barriers of 108 people; 50% of these participants were professionals working within mental health services. Two focus groups were conducted, one for mental health professionals and one for non-mental health professionals, with four participants in each group.
Results: The survey reported that mental health professionals had a lower level of stigma for specific disorders, although male mental health professionals working for less than five years reported a higher level of stigma and perceived barriers than did females with the same experience – with these then reducing after five years. The overarching focus group theme was "changes needed for disclosure", with each group having four subthemes.
Conclusions: Disclosure stigma remains an issue, with further research needing to be conducted to adapt to a minimally stigmatizing service for mental health professionals.

Keywords: stigma, employment, mental health, barriers, disclosure

Introduction

Within the UK, mental health has become a subject frequently highlighted and discussed across the media; however, there is an argument that while accurate representations of mental health disorders can lead to a reduction in stigma (Haddad & Haddad, 2015), this reduction is not so prevalent across all disorders and identified sections of society, particularly military personnel, and healthcare professionals (Angermeyer et al., 2013; Clement et al., 2015). With one in four adults and one in ten children experiencing mental health disorders in the UK, this has become a common issue (NHS England, 2019). The stigma of mental health reduces recovery rates, increases the time taken to access treatment, and heightens stress from perceived negative attitudes in social groups and employment (Clement et al., 2015; Oexle et al., 2018; Rüsch et al., 2005;). Globally, approximately 800,000 suicides occur every year, with another 16 million people attempting suicide; therefore, early identification and treatment are imperative to reducing these statistics (WHO, 2019).

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People often stigmatize mental health problems, thus preventing individuals from accessing the help they need because they feel they will be subject to prejudice and discrimination (Corrigan & Watson, 2002; Schauman et al., 2019). Both self (internalized) and social (public) stigma have a great impact on the support available for people experiencing mental health concerns (Corrigan & Watson, 2002). Self-stigma often increases when the stigma portrayed by the media and others in society becomes internalized, reducing self-esteem and enforcing the belief that they are defective and unable to recover (Corrigan & Watson, 2002). Social stigma is the public's negative social judgment that can also lead to rejection and even violence due to the perpetuating belief that all mental health patients are dangerous (Clarke, 2004). This has been evidenced through the public's reactions to stereotypes in media, where films depict people with mental health disorders as to be feared, portraying them to be unpredictable and violent (Byrne, 2009; Corrigan & Watson, 2002). Social stigma can vary depending on the disorder: for example, some people are unsympathetic to individuals having certain disorders such as anorexia, as people feel the disorder is self-inflicted; therefore, these people are undeserving of help (Stewart et al., 2006).

Brohan et al. (2012) conducted a systematic review on the disclosure of mental health problems in the workplace, revealing that mental health stigma can reduce career success and opportunities. Brohan et al. (2012) stated that employers would be less likely to hire a candidate with a mental health disorder than someone with a different issue, including a chronic physical disability or other long-term responsibilities (carers or single parents). Stigma can also lead to friendship losses and social rejection, reducing social support (Connolly et al., 1992). Most importantly, however, the stigma of mental health problems can delay treatment as there is a reduction in help-seeking behavior.

The reduction of stigma clearly remains a very important area of research within mental health. A negative correlation has been observed between high levels of internalized stigma, treatment stigma, and help-seeking behaviors (Clement et al., 2015), leading to further detrimental effects on the individual's mental health (Eisenberg et al., 2009). Barrett et al. (2008) argued that this leads to additional problems throughout the treatment process and an increased possibility of adverse outcomes alongside the challenges associated with accessing treatment – the result being that more intensive therapies are required, at greater cost to the provider. The Adult Psychiatric Morbidity Survey (2014) reported that 61% of people with a common mental health disorder in England did not seek help, with long-standing stigma and a reluctance to talk about mental health as a reason for the lack of help-seeking behavior (Lubian et al., 2016). It should be noted, however, that the manifestation of stigma can take many forms, with help-seeking barriers being mainly influenced by internalized stigma, treatment stigma, and disclosure stigma (Clement et al., 2015; Mojtabai et al., 2011).

Clement et al. (2015) conducted a systematic review that suggested help-seeking for mental health concerns is disproportionately affected by stigma in the populations of males, youth, ethnic minorities, military personnel, and healthcare professionals. Healthcare professionals reported more shame, embarrassment and negative social judgment than other groups (Clement et al., 2015). This finding is even more alarming, raising questions around the powerful nature of stigma, even amongst those who work as health professionals, as evidenced by Brohan et al. (2012); Corrigan and Watson (2002); Held and Owens (2012). Thus, considering that healthcare professionals are exposed to mental health information and anti-stigma interventions consistently – more so if they work within the mental health sector – it is important to investigate these differences.

Professionals within mental health services stand at the forefront of reducing stigma in their local community and can greatly impact how others perceive mental health. As previous studies have evidenced, the stigma experienced by mental health service users on a day-to-day basis can substantially affect their mental well-being recovery (Clement et al., 2015; Henderson et al., 2017; Kerby et al., 2008; Wahl, 1999). As mental health professionals are aware of this stigma, were they then to develop mental health problems themselves – they may struggle to separate their preferred self of being strong and competent with that of the stereotyped mental health patient that the media so often portrays as weak or crazy (Clement et al., 2015). This could be one explanation for health professionals' reluctance to seek support themselves.

Brohan et al. (2012) argued that within employment, a preference has existed for the non-disclosure of mental health concerns. Non-disclosure reduces support from employers and reduces help-seeking behavior. Clement et al. (2015) reported that health professionals were disproportionately deterred by the stigma of disclosure when compared to the general population with confidentiality issues and perceived negative social judgment serving as the main deterrents. A need exists to increase help-seeking and reduce disclosure concerns in order to aid mental health well-being and keep our health professionals healthy. To increase help-seeking behavior, the American Psychiatric Association argued that improvements should be made to provide confidential care, therefore reducing anxiety stemming from social stigma and the perceived possibility of losing employment (IBHI, 2010). Within the healthcare sector, the most reported barrier to help-seeking behavior remains disclosure stigma (Clement et al., 2015). BPS (2021) acknowledged that there are a number of key themes to improve Mental Wellbeing for healthcare professionals, including "Caring for the carers".

Preventing disclosure issues and stigma-related facilitators constitute the key factors in help-seeking behavior when in mental health employment. In Brohan et al. (2012), participants reported that they would not disclose concerns if they could "pass off as normal". These participants stated their reason for non-disclosure: the illness is private; they are already having natural adjustments in the job, or feeling that others do not want to know. Those participants, however, who would disclose mental health concerns, reported that this was due to the perceived benefit of gaining adjustments or support, to explain their behavior, or because concealing the disorder was too stressful. Banks et al. (2007) documented that participants remained less likely to disclose to their employer were they female, having a mood disorder rather than symptoms of psychosis, or should they not have any symptoms at work. Participants appeared more likely to disclose if they had the knowledge of legislation and should the employer be perceived to have a high level of emotional support (Brohan et al., 2012).

According to Ellison, Russinova, and MacDonald-Wilson (2003), mental health professionals have a higher disclosure rate than other health services, although the participants that had disclosed as they had reached a crisis point stood more likely to regret the decision than those that had done so under more favorable circumstances.

Clement et al. (2015) acknowledge a research gap in help-seeking within under-represented disorders, including bipolar, personality, and anxiety disorders. Schomerus et al.'s (2016) study argued that stigma against psychosis has increased and the media continues to portray psychosis as violent and aggressive; exacerbating negative stereotypes for this disorder (Klin & Lemish, 2008). Grambal et al. (2016) conducted a study that showed people diagnosed with borderline personality disorder suffered from a higher severity of self-stigma than other disorders.

Over one thousand mental health professionals completed a survey by Unison regarding various aspects of working within a mental health service: 42% of respondents stated they had been violently attacked at work, with verbal and physical abuse seen daily and the health professionals maintaining the belief that it "goes with the job" (UNISON, 2017). Previous research has shown that employment that has a high rate of dangerous incidents leads to a reduction in the mental wellness of staff (Anderson & West, 2011; De Looff et al., 2019; Karaffa & Koch, 2015). 74% of respondents stated they felt stressed at least once a week (UNISON, 2017). This, intertwined with a high level of mental health stigma, reduces help-seeking behavior in the given population and increases the recovery time required (Webb et al., 2016). With 50% of respondents stating they felt that their employer did not look after their mental health and well-being and 26% attributing wanting to leave the sector to their mental health and well-being suffering, this signifies how important caring for health professionals has become (UNISON, 2017).

The aforementioned research has demonstrated the impact of stigma on disclosure and help-seeking behavior regarding mental health disorders, not only for the general public but also for those who work as health professionals, specifically in mental health. The latter remains of significant concern and requires further investigation, especially considering the role of mental health professionals in supporting others while they themselves are less likely to seek help.

Consequently, this study's main aims were to:

1. Investigate the levels of stigma perceived when using the term "Mental Health", and to determine whether emerging mental health problems would be disclosed to employers to gain support at work or if the participant would seek professional involvement.
2. Investigate whether the level of stigma perceived is different when the symptomology of mental health disorders is used rather than the broad term of "Mental Health", and if this stigma was affected by the problems "recently developing" rather than "currently managed".
3. Investigate the barriers to help-seeking.

Through the employed research design and considering demographic factors including whether the participant was currently employed within Mental Health services, the findings will provide a direction in which further research may be required, information on practice, and offer a potential development of interventions to reduce stigma. The focus groups are intended to enhance the understanding of the results from the survey.

Methods

Sample and Procedure

A mixed-method design was implemented: Part 1 – A prospective self-reported online survey was created. Part 2 – Two focus groups were conducted that lasted approximately one hour each; this was in an office meeting room in an NHS hospital.

The survey remained open online for six weeks and took approximately 30 minutes to fill out. One-hundred and eight participants completed it, 71 women (mean age 36.56 ± 11.23 years) and 37 men (mean age 36.41 ±

10.28 years); their ages ranged from 19–60; they volunteered to participate in the prospective survey regarding stigma and barriers to help-seeking behavior. Fully 50% of the participants had worked in mental health services, whilst 77% of participants had cared for a person with mental health issues and 72% had friends or family that received a diagnosis regarding a mental health disorder, with 48% of the participants being diagnosed themselves. Also, 50% of mental health professional participants had worked in mental health for under five years. 90% of the participants resided in the UK, with the majority of participants (53%) from the North-East of England; 10% were international. The sample size was determined using G Power calculations for sufficient power to detect a moderate effect size (.15) with an alpha level of .05 (Erdfelder et al., 1996). Eight participants – five women (mean age 32.00 ± 12.41 years) and three men (mean age 35.67 ± 10.41 years), their ages ranging 21 to 53 – volunteered to participate in the focus group.

Participants were recruited via convenience sampling using social media, trust newsletters, trust research bulletins, and emails to the psychological distribution list. All participants completed the survey voluntarily. Before data was collected, the Newman Institutional Research Ethics Committee (2018-08-1501610/3747) granted ethical approval; the study was approved by the Research and Development department at the NHS trust (CNTWR&D-9/2/18).

The participants read the participant information sheet and informed consent was requested to progress on to the self-report survey and the focus group's commencement; a debrief screen appeared and a personal debrief was offered. Participants were aware of the ethical aspects of the study and that their survey answers remained anonymous. The focus group participants had been pooled from the participants in the survey who had requested to be in part two of the study, and who could attend. The focus group participants were aware that their results would be pseudonymized and cognizant of the confidentiality agreement. The participants were allocated to either focus groups for the mental health professionals (for those working in mental health services) or non-mental health professionals (those not working in mental health services).

Measures

An online survey was developed consisting of three validated surveys as well as further questions used in previous literature.

Demographics

Demographic information was collected from all participants (Table 1).

Table 1. Participants' Demographic Information

Survey Participant Characteristic	*N*	Percentage
Gender		
Female	71	65.7
Male	37	34.3
Age		
Mean (SD)	36.61 (10.78)	
Range	19–60	
Ethnicity		
White	99	91.7
Asian	3	2.8
Black	4	3.7
Other	2	1.9
Location		
Scotland	9	8.3
North East England	57	52.7
North West England	10	9.3
South East England	9	8.3
South West England	2	1.9
Midlands	7	6.5
East Anglia	1	0.9
Northern Ireland	2	1.9
International	11	10.2
Education		
Currently Studying	11	10.2
GCSE/O level/Standards	13	12.0
A level/highers	5	4.6
HNC/HND	10	9.3
Degree	40	37.0
Postgraduate	24	22.2
None	5	4.6
Employment		
Nurse	15	13.9
Student	21	19.4
Other healthcare	30	27.8
Office-based	17	15.7
Self-employed	9	8.3
Non-healthcare professional	13	12.0
No employment	3	2.8
Length working in mental health		
0 years	54	50
Under 5 years	27	25
Over 5 years	27	25
Cared for someone with mental health		
Yes	83	76.9
No	25	23.1

(continued on the next page)

Table 1., continued

Survey Participant Characteristic	*N*	Percentage
Friend/family with mental health		
Yes	78	72.2
No	30	27.8
Diagnosed with mental health		
Yes	52	48.1
No	56	51.9
Focus group participants' characteristics	*N*	Percentage
Gender		
Female	5	62.5
Male	3	37.5
Age		
Mean (SD)	33.37 (11.07)	
Range	21–53	
Length in mental health services		
Mean (SD)	3.25 (1.71)	
Range	1–5	

Internalized stigma

A ten-item Internalized Stigma of Mental Illness [from the Brief version of the Internalized Stigma of Mental Illness (ISMI) scale; Boyd, Otilingam & DeForge, 2014; adapted with permission] measured the internalized stigma currently experienced, with a Cronbach's alpha of .75. Statements were used of negative stereotypes within mental health, with responses coded numerically and summed on a four-point Likert scale *(strongly disagree, disagree, agree, strongly agree)*. This was coded numerically and resulted in a total internalized stigma score between 10 (low stigma) and 40 (highly stigmatized).

Stigma within health services

Stigma expected when in health services was measured using the 16-item Mental Illness: Clinicians' Attitudes Scale [from Mental Illness: Clinicians' Attitudes Scale MICA-2 and from Development and responsiveness of a scale to measure clinicians' attitudes to people with mental illness (medical student version) MICAv4; Kassam et al., 2010] evaluated to have a Cronbach's alpha of .72. Responses were coded numerically and summed on a six-point Likert scale *(strongly disagree, disagree, somewhat disagree, somewhat agree, agree, strongly agree)*. This, coded numerically, resulted in a total stigma belief and attitude score between 16 (low stigma) and 96 (highly stigmatized).

Help-seeking and disclosure

Attitudes towards help-seeking and disclosure were assessed using the 15-item Opening Minds Stigma Scale for Health Care Providers [from the development and psychometric properties of a new scale to measure mental illness related stigma regarding health care providers: the Opening Minds Scale for Health Care Providers (OMS-HC); Kassam et al., 2012] was evaluated to have a Cronbach's alpha of .79. Responses to statements were numerically coded from a five-point Likert scale *(strongly disagree, disagree, neither agree nor disagree, agree, strongly agree)*. The total help-seeking and disclosure score ranged between 15 (low stigma) and 75 (highly stigmatized).

Barriers

The perceived barriers to treatment were assessed based on the 15 barriers in the Mohr et al. (2006) research, using a five-point Likert scale that was numerically coded and summed *(not difficult at all, slightly difficult, moderately difficult, extremely difficult, impossible)*. The total barrier score stood between 15 (low stigma) and 75 (highly stigmatized), and was evaluated to have a Cronbach's alpha of .79. There was one open-ended question for any other barriers perceived.

Stigma regarding specific disorders

A selection of case studies was presented for specific mental health disorders, these were symptoms of psychosis (Preda & Bota, 2018), bipolar affective disorder (Selvaraj, 2018), anxiety disorder (NICE, 2011), personality disorder (London Pathways Partnership, personal communication, February 1, 2018), depression (Psyweb, personal communication, February 1, 2018), obsessive-compulsive disorder (Cole, 2018), eating disorder (Langley, 2006), post-traumatic stress disorder (Psyweb, personal communication, February 1, 2018) and dementia (Jacob et al., 1999). An example of the case study for post-traumatic stress disorder was, "Your friend has recently been in a major car accident, following the accident, they have been plagued with nightmares, they now avoid getting into cars and are irritable and nervous all the time". There were four statements following from each case study,

the first two statements served to determine the likelihood of the participant being willing to work with a person having a specific disorder, whether the symptoms were new or established. The second set of two questions served to determine whether the participants were experiencing these symptoms, if they would disclose to someone and seek help, again, whether new or established. The four statements were numerically coded and summed from a 6-point Likert scale *(extremely likely, likely, somewhat likely, somewhat unlikely, unlikely, extremely unlikely)*. The stigma perceived for each specific disorder was rated from 4 (low stigma) to 24 (highly stigmatized).

Focus groups

Semi-structured focus group interviews were conducted to promote consistency and discussion, a series of questions were prepared based on the survey. The focus group was conducted over one day on an NHS hospital site.

Questions put to the focus group covered aspects of barriers to disclosure and help-seeking in employment, any gender differences, and the relation to understanding stigma generally and specifically related to certain disorders. An example of a question in the focus group was, "Do you think it has become easier or harder to disclose to your employers? What do you think would improve disclosure?" Each focus group was audio-recorded and transcribed verbatim. Transcripts were then analyzed via a thematic analysis using the Braun and Clarke (2006) method; originally, in the open-coding stage, there were 13 conceptual labels in the non-mental health professionals' group and 13 in the mental health professionals' group. In the second phase (axial coding), the themes were combined where relevant and this left four subthemes for each group, the thematic analysis was then combined for the overarching theme of each group, and finally, the overall theme of both groups was combined (Braun & Clark, 2006).

Statistical analysis

The quantitative data was assessed using the "Statistical Package for the Social Sciences" (SPSS version 25). A two-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate the differences between those working in mental health services (mental health professionals) and those not working in mental health services (non-mental health professionals). The results assessed the differences expressed when completing the validated surveys – MICAv4, ISMI, and OMS-HC (Boyd, Otilingam & DeForge, 2014; Kassam et al., 2010; Kassam et al., 2012) – also how the two groups differed in the experienced barriers to help-seeking behavior; whether any differences existed between new and established disorders, as well as whether any differences among symptoms of specific disorders were described in a case study and the level of stigma perceived. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity, with no serious violations noted. There was no missing data. Subsequent analyses such as a *T* test and ANOVA were used to identify internalized stigma levels and demographic differences concerning barriers to help-seeking and stigma attitudes towards specific disorders. Partial eta squared (η_p^2) are reported to determine effect sizes; established guidelines indicate that effect sizes of $\eta_p^2 = .01$ are small, $\eta_p^2 = .06$ are medium, and $\eta_p^2 = .14$ are large (Cohen, 1988).

Results

Survey Results

Descriptive statistics

The participant sample's characteristics are detailed in Table 1. The participant sample consisted of 108 participants that included 71 women and 37 men. The mean age of the sample was 25.90 (*SD* = 10.87). The sample consisted of 50% mental health professionals and 50% non-mental health professionals, predominantly of white origin (92%) from North-East England (53%). Table 2 presents the mean and standard deviation of the variables measured.

Attitudes and beliefs towards the disclosure of mental health in employment

When using the umbrella term of *mental health,* the MANOVA revealed that no significant differences appeared in the attitude to stigma and the perception of barriers to help-seeking behavior $F(4, 103) = .97$, $p = .425$; Wilks' $\eta = .96$, $\eta_p^2 = .04$. Internalized stigma was also not statistically different between the mental health professionals

Table 2. Mean (SD) of survey results

Descriptive characteristic		ISMI Mean (*SD*)	MICAv4 Mean (*SD*)	OMS-vHC Mean (*SD*)	Barrier Mean (*SD*)	SPD Mean (*SD*)	BPD Mean (*SD*)	AD Mean (*SD*)	PD Mean (*SD*)	DN Mean (*SD*)	OCD Mean (*SD*)	ED Mean (*SD*)	PTSD Mean (*SD*)	DA Mean (*SD*)	Established Mean (*SD*)	New disorder-Mean (*SD*)	Combined disorder-Mean (*SD*)	Female (*N*)	Male (*N*)	Age Mean (*SD*)
Full sample	*N* = 108	19.95 (1.96)	35.30 (8.87)	18.42 (4.82)	39.36 (10.26)	10.02*** (2.98)	10.06** (3.26)	8.96 (2.96)	11.94 (4.00)	9.20* (3.37)	9.12* (3.09)	9.19* (3.40)	7.86* (3.18)	8.34* (3.45)	5.47** (1.85)	4.57 (1.74)	84.71* (23.27)	*N* = 71	*N* = 37	36.51 (10.87)
Employment																				
Non-mental health	*N* = 54	20.48 (5.30)	36.20 (9.17)	19.04 (4.75)	41.24 (10.05)	10.94 (3.03)	10.74 (3.52)	9.28 (3.22)	12.33 (4.61)	9.76 (3.82)	9.52 (3.65)	9.83 (3.81)	8.37 (3.53)	8.85 (4.06)	5.96 (1.96)	4.83 (1.70)	89.63 (27.03)	*N* = 38	*N* = 16	35.67 (11.12)
Mental health	*N* = 54	19.43 (5.39)	34.39** (8.54)	17.80 (4.85)	37.48 (10.21)	9.09 (2.64)	9.37 (2.90)	8.63 (2.73)	11.52 (3.42)	8.61 (2.90)	8.69 (2.50)	8.50 (2.99)	7.30 (2.83)	7.76 (2.86)	4.98 (1.61)	4.31 (1.75)	79.46* (18.47)	*N* = 33	*N* = 21	37.35 (10.65)
Gender																				
Female	*N* = 71	18.90** (5.67)	33.90* (8.58)	18.17 (4.93)	39.89 (10.92)	9.89 (2.97)	9.80 (3.45)	8.77 (3.18)	11.99 (4.21)	9.34 (3.42)	8.93 (3.02)	9.31 (3.50)	7.83 (3.29)	8.39 (3.44)	5.55 (1.83)	4.52 (1.72)	84.25 (24.04)	–	–	36.58 (12.47)
Male	*N* = 37	21.97** (4.02)	37.97* (8.91)	18.89 (4.64)	38.35 (8.90)	10.27 (3.02)	10.54 (2.92)	9.30 (2.58)	11.81 (3.80)	8.89 (3.45)	9.43 (3.38)	8.89 (3.44)	7.84 (3.15)	8.14 (3.76)	5.32 (1.92)	4.68 (1.78)	85.11 (23.04)	–	–	36.43 (12.76)
Age																				
19–29	*N* = 35	19.23 (5.97)	37.14 (9.51)	18.77 (4.54)	41.49* (10.10)	10.63 (2.82)	10.71 (2.79)	9.51 (3.11)	12.97 (3.67)	10.14 (3.41)	9.49 (2.47)	9.20 (3.20)	8.26 (3.26)	9.09 (3.31)	5.26 (1.78)	5.14 (1.90)	90 (19.19)	*N* = 25	*N* = 10	–
30–39	*N* = 32	20.44 (4.87)	35.28 (9.16)	19.72 (5.09)	40.78* (10.88)	10.06 (3.31)	10.19 (3.65)	8.91 (2.94)	11.69 (4.88)	8.97 (3.80)	9.63 (3.70)	9.28 (3.93)	7.59 (3.36)	7.78 (3.69)	5.50 (2.11)	4.38 (1.48)	84.09 (27.22)	*N* = 18	*N* = 14	–
40–49	*N* = 25	19.52 (5.59)	34.08 (8.79)	17.24 (4.96)	36.44* (10.24)	9.60 (2.69)	9.48 (3.60)	8.48 (3.04)	10.96 (3.77)	8.44 (3.08)	8.36 (3.33)	9.04 (3.21)	7.72 (3.29)	7.80 (3.25)	5.20 (1.68)	4.40 (1.92)	79.88 (23.98)	*N* = 16	*N* = 9	–
50–60	*N* = 16	21.25 (4.52)	33.19 (6.63)	16.88 (4.16)	36.44* (8.29)	9.25 (3.04)	9.25 (2.98)	8.56 (2.78)	11.63 (3.30)	8.69 (2.92)	8.37 (2.87)	9.06 (3.79)	7.56 (3.01)	8.44 (4.1)	6.31 (1.62)	4 (1.32)	80.81 (23.79)	*N* = 12	*N* = 4	–
Length of service																				
Under 5 years	*N* = 27	20.04 (5.98)	36.48 (9.34)	19.07 (4.65)	38.85* (11.16)	9.74 (2.67)	10.22 (2.98)	9.11 (3.95)	11.85 (3.95)	9.48 (3.29)	9.63 (2.63)	9.04 (3.57)	7.81 (3.27)	8.19 (3.43)	4.63 (1.80)	4.44 (1.74)	85.07* (20.51)	*N* = 18	*N* = 9	31.48 (6.22)
Over 5 years	*N* = 27	18.21 (4.77)	32.30 (7.23)	16.52 (4.79)	36.11* (9.17)	8.44 (2.50)	8.52 (2.61)	8.15 (2.20)	11.19 (2.84)	7.74 (2.18)	7.74 (1.99)	7.96 (2.21)	6.78 (2.24)	7.33 (2.11)	5.33 (1.33)	4.19 (1.78)	73.85* (14.47)	*N* = 20	*N* = 7	43.22 (11.01)

Note: ISMI = Internalized Stigma of Mental Illness Scale, MICA = Mental Illness: Clinicians Attitudes Scale, OMSvHC = Opening Minds Scale Version Healthcare, Barrier = barriers perceived to help-seeking, SPD = psychosis disorder, BPD = Bipolar disorder, AD = Anxiety disorder, PD = personality disorder, DN = Depression, OCD = Obsessive compulsive disorder, ED = eating disorder, PTSD = post-traumatic stress disorder, DA = Dementia, Established = disorder previously diagnosed, New = new symptoms of a disorder, combined = Overall values for the specific disorders

Within each descriptive characteristic category for each outcome, superscripts indicated significantly different scores (*sig at .050, **sig at .010, ***sig at .001) based on MANOVA results.

(M = 19.43, SD = 5.39) and non-mental health professionals (M = 20.48, SD = 5.30), $t(106) = 1.03$, $p = .307$ $\eta^2 = .01$.

However, when the specific symptoms of mental health conditions were described, the MANOVA revealed that significant difference did manifest between mental health and non-mental health professionals in the stigma level of the 9 conditions, $F(1, 106) = 5.21$, $p = .024$, $\eta_p^2 = .13$. Follow-up tests revealed that mental health professionals had significantly lower stigma levels than non-mental health professionals for symptoms of Psychosis ($p = .001$), Bi-polar ($p = .009$), Depression ($p = .014$), Obsessive-Compulsive Disorder ($p = .033$), Eating Disorder ($p = .011$), Post-Traumatic Stress Disorder ($p = .030$), and Dementia ($p = .045$). Stigma levels were not significantly different for Anxiety Disorder ($p = .139$) and Personality Disorder ($p = .076$).

Also, the MANOVA revealed a significant difference between mental health professionals and non-mental health professionals in the stigma level of the 9 conditions, depending on whether the condition was newly developing or previously established, $F(2, 105) = 4.19$, $p = .018$; Wilks' $\eta = .93$, $\eta_p^2 = .07$. Follow-up tests revealed that a significant difference existed for established disorders ($p = .005$) but no significant difference for newly developing disorders ($p = .121$).

Help-seeking behavior and barriers perceived

The MANOVA depicted that there was not a statistically significant interaction effect between mental health professionals and non-mental health professionals when assessing help-seeking behavior and barriers perceived, $F(2, 105) = 1.94$, $p = .149$; Wilks' $\eta = .96$, $\eta_p^2 = .04$.

Stigma and barriers perceived by gender

A statistically significant difference appeared in the level of stigma perceived between the full sample of male and female professionals, $F(3, 102) = 4.32$, $p = .007$; Wilks' $\eta = .89$, $\eta_p^2 = .11$. Follow-up tests revealed that women expressed a significantly lower level of stigma for ratings on the ISMI survey ($p = .005$) and the MICAv4 survey ($p = .020$), whereas the OMS-HC survey was not significant ($p = .546$). No significant difference was depicted in the interaction of gender and employment in the ANOVA, when assessing barriers to help-seeking behavior, $F(1, 104) = .48$, $p = .492$, $\eta_p^2 = .01$.

Nevertheless male mental health professionals reported a significantly higher stigma level (M = 39.31, SD = 2.13) than female mental health professionals (M = 31.78, SD = 1.40), $F(4, 40) = 5.17$, $p = .002$; Wilks' $\eta = .66$, $\eta_p^2 = .34$. Follow-up tests revealed statistically significant results for MICA ($p = .010$) but no significant differences for ISMI ($p = .180$), OMS ($p = .831$) and barriers ($p = .235$). There were no gender differences within the non-mental health professionals in relation to stigma level and barriers perceived $F(4, 44) = 2.34$, $p = .070$; Wilks' $\eta = .83$, $\eta_p^2 = .09$, as well as symptoms of specific disorders $F(9, 39) = 1.49$, $p = .187$; Wilks' $\eta = .75$, $\eta_p^2 = .20$.

No significant difference between female and male mental health professionals' stigma was experienced when assessing the stigma symptom level of specific disorders, $F(9, 35) = 0.82$, $p = .588$; Wilks' $\eta = .82$, $\eta_p^2 = .18$, or between the specific disorders stigma level and the length of service, $F(9, 35) = 0.62$, $p = .773$; Wilks' $\eta = .86$, $\eta_p^2 = .14$. However, the ANOVA revealed statistically significant differences when assessing the barriers perceived between women and men, and their length of service, $F(1, 50) = 5.40$, $p = .024$; $\eta_p^2 = .10$. Inexperienced male mental health professionals (< five years) have higher perceived barriers (M = 42.67) than inexperienced female mental health professionals (< five years; M = 36.94). This changes as male mental health professionals working over five years perceive fewer barriers (M = 30.14) than women working over five years (M = 38.20), showing a greater reduction of perceived barriers for help-seeking from men, reducing their perceived barriers as the experience of mental health increases.

Stigma and barriers perceived by age

The MANOVA depicted that no age differences appeared when assessing the stigma level between mental health and non-mental health professionals $F(9, 239) = .91$, $p = .520$; Wilks' $\eta = .92$, $\eta_p^2 = .03$. Nevertheless, a significant interaction effect was revealed from the ANOVA for the barriers perceived by age and employment, since the older the participant was, the fewer barriers were perceived – with non-mental health participants' mean reducing the mean level by 6.11, and mental health professionals' mean reducing the mean level by 2.67, $F(3, 100) = 2.79$, $p = .040$, $\eta_p^2 = .08$.

Stigma level and length of service for mental health professionals

There was a significant difference in the stigma level of the nine case studies between new employees (< five years) (M = 85.7, SD = 20.51) and experienced mental health professionals (> five years; M = 73.85, SD = 14.48), $t(46.76)$ = 2.32, p = .025 η^2 = .09.

Barriers

Further barriers to help-seeking were provided by 20 participants (18.5%) with 50% of them being mental health professionals. These were collated into five main themes of *service barriers, previous experience working in services, negative lived experience of being in services, lack of mental health knowledge,* and *stigma.* (Table 3)

Qualitative Results

Combined themes

The overarching theme from the focus group was the *"Changes needed for disclosure"*. This incorporates the impact that society and stigma has on whether someone feels supported enough to seek help and be supported in their role in the future. The mental health group focused on the issues expected when wanting to disclose, and what would improve their disclosure; the non-mental health professionals discussed how they felt judged as well as the societal expectations of them.

Several subthemes emerged from the two populations (Table 4):

Table 3. Confidence intervals for survey results for the full sample

	95% Confidence Intervals	
	Lower bound	Upper bound
ISMI	18.93	20.97
MICA	33.60	36.99
OMS-HC	17.50	19.34
Barrier	37.39	41.32
SPD	9.45	10.59
BPD	9.43	10.68
AD	8.38	9.52
PD	11.15	12.69
DN	8.53	9.84
OCD	8.50	9.70
ED	8.50	9.83
PTSD	7.22	8.45
DA	7.63	8.98
Established disorder	5.12	5.83
New disorder	4.24	4.91
Combined	80.04	89.05

Note: ISMI = Internalized Stigma of Mental Illness Scale, MICA = Mental Illness: Clinicians Attitudes Scale, OMSvHC = Opening Minds Scale Version Healthcare, Barrier = Barriers perceived to help-seeking, SPD = Psychosis disorder, BPD = Bipolar disorder, AD = Anxiety disorder, PD = Personality disorder, DN = Depression, OCD = Obsessive compulsive disorder, ED = Eating disorder, PTSD = Post-traumatic stress disorder, DA = Dementia, Established = disorder previously diagnosed, New = New symptoms of a disorder, Combined = Overall values for the specific disorders

Table 4. Themes and subthemes generated from focus groups' transcripts

Mental health professionals	Non-mental health professionals
Lack of support – Pressure on the ward – Lack of management support – Lack of trusting relationships – Gender barriers when seeking support	*When to disclose* – Crisis-point/affecting work – Reduction/current in barriers – Whether trust has been established – To help yourself – Feel supported
Future after disclosing – Perceived punishment – Potential of losing employment – Gossip, culture, and confidentiality issues	*Perceived as needing to be strong* – Perceived as not capable of doing the job – Do not want to be a burden – Perceived as needing to be strong (dependent on generation/role/gender)
What affects someone' s decision to disclose – Personal characteristics – Crisis-point – Affecting work – Personal safety – Friends or family worrying	*What affects whether someone would disclose* – Perception of stigma – Gender stereotypes – Build-up of supportive relationships
Increasing knowledge to reduce stigma – Knowledge of terminology – Knowledge of disorders and treatment – Lived experience reducing stigma – Supportive colleagues with lived experience	*Normalized* – Disorder being normalized (anxiety) or not normalized (psychosis) – Training and policies – Incorrect use of terminology – Potential for abuse of mental health sickness policy – The pressure to help as prevalent

Mental health professionals' subthemes

Lack of support. Overall, this theme looked at the support available while working unsocial hours in a ward environment. One participant explained the pressure that one feels on the ward, where another felt that the lack of trusting relationships greatly affected the support available. The theme incorporated gender barriers perceived, as participants felt that society perceives men as being the stronger gender and that they should not discuss mental health concerns. Two participants, however, discussed their concerns of disclosing to a male manager who could potentially lack understanding concerning their issue. As they do not wish to be portrayed as weak, participants felt that without asking for support, mental health professionals put themselves under extreme pressure.

Future after disclosing. This theme encompasses how the participants perceived their future should they disclose a mental health concern. The current organizational culture, potential gossip, and an increase in sickness days ranked among reasons given for non-disclosure to employers.

What affects why someone chooses to disclose. The group discussed what different aspects would encourage someone to disclose their mental health concerns to their employer, including personal characteristics, family or friends worrying and their circumstances at work. All participants in the groups agreed that they would have to reach a crisis point in their mental health before disclosing, although disclosure must occur if the issues start to affect their therapeutic work with their patients or affect the professionals' safety.

Increase knowledge to reduce stigma. This theme was discussed through the participants' increased knowledge from their employment experience, reducing their perceived stigma. The participants discussed the issues with less common disorders that remain stigmatized in society due to the lack of general knowledge.

Non-mental health professionals' subthemes

When to disclose. In this theme, participants discussed when they would disclose to their employers; all the participants agreed that they would only discuss once they had reached a crisis point, or they had to take time away from work. This meant that they would not advise their employers or seek adjustments at work until the issue began to affect their work. They would disclose once they felt ready to help themselves and knew that the employer would be supportive. They discussed early disclosure if barriers were reduced; however, participants often lacked trust with colleagues and management within the employment, increasing the barriers to disclosure.

Perceived as needing to be strong. A recurring theme throughout the focus group involved the perception that certain people needed to be strong, and that disclosing mental health concerns manifested a sign of weakness. One participant advised that within the family, you must be strong and discussing mental health issues would lay a burden on others. Another participant countered this, who felt that by not talking about any issues, they were increasing the burden placed onto the family through their feelings of guilt.

The participants discussed the societal implications that men need to be seen as strong; this also extended to being strong depending on job role, with certain job roles being seen as masculine and, therefore, people in this type of role would not discuss mental health concerns. It was discussed that at the managerial level they must be perceived as strong persons, otherwise, they may be seen as incapable of doing their job, losing the respect of the team, having to take time off work and, potentially, losing their role.

What affects someone's decision to disclose. This theme encompassed the group's perspective as to why some people choose to disclose. Societal expectations affect this such as the older generation feeling that they are unable to share their concerns. The group felt that their perceptions of mental health disorders are influenced by media sources and previous experience thereby influences their disclosure stigma. Their lived experience also influenced men's unwillingness to discuss mental health concerns.

Normalized. Participants felt that by normalizing mental health concerns, they were more likely to disclose if their disorder was prevalent in society; this was improved by the training and policies that support the employees in disclosing mental health. However, this greater awareness also increased one participant's expectation of needing to be observant of these disorders in their colleagues, unnecessarily increasing their own stress.

The participants expressed concern that the normalization and prevalence of mental health concerns could allow people to abuse the system by taking unnecessary time-off. This was elaborated on in terms of how the general population may use incorrect terminology such as stating that they have anxiety when they feel they are experiencing a momentary stressful situation (Table 5).

Table 5. Quotes to support each theme generated from focus group transcripts

Theme	Mental Health Professionals	
	Quotes	
Lack of support	Betty: *I'm the band 5 [Qualified Nurse] on the ward and I'm on my own on the ward and I've got say, I don't know, three of the nurse assistants on that ward … It's not really good, me, like being an anxious melt on the floor when I'm going to be the one that they come to for help.*	Laura: *I think it just depends on how you get on with everyone at work, 'cause some people, I just wouldn't be able to tell them*
	Ruby: you've got to be strong… because you are there to try and help people with mental health issues and if you kind of got them yourself you kind of viewed as if you're bit of a weakness.	Betty: *you're terrified of letting them [colleagues] know because 'oh, yeah, Feyre, she shouldn't really be working in mental health because she's mentally unwell herself'*
Future after disclosing	Ruby: *sometimes when you work on the ward you've got some people that are, kind of, less than professional and will… discuss your sickness with people on the ward. And then you… feel as if when you return to work everyone will know your problems.*	Betty: *the sickness policy… I think that could be a big barrier as well… what if I go and seek help and if I'm off work… and you're going to start thinking about dismissal… do you want to disclose XY because I could have, but I just keep it to myself so I can get on*
What affects why someone chooses to disclose	Feyre: *I suppose if it would start to affect your work, how you would react to the certain patients or if you can feel yourself getting, like, if you felt that you were going to be a danger to someone.* Betty: *it really comes down to personal characteristics rather or not it would be disclosed or not.*	Feyre: *My mum said she's more worried about it than me, she keeps saying oh God she's going to have a relapse, and always asking "Are you ok?"*
Increase knowledge to reduce stigma	Feyre: *I did have to say… I'm having therapy for this and it was out there, and people did react better than I thought*	Betty: *in my past jobs it was probably a little bit more stigma compared to now, now that I work in mental health services… people have more knowledge on mental health.*
	Laura: *I've heard someone… say, ADHD is just for bad behaved people*	When discussing eating disorders: Ruby: *there's a lot of people that still don't understand it and it might just be why don't they just eat! Oh, like you know…* Feyre: *They say "Just give them a steak".*
Theme	**Non-mental Health Professionals**	
	Quotes	
When to disclose	Kevin: *I'd wait until it was at a point where it would affect … To be honest I don't think I'd wait until it affected what I did. I'd wait until the point where it affected what other people did.*	Doris: *if you've worked there a long time, they know what you're like and whether you're helping yourself, to cope with it rather than, like, say, not take medication or not take counseling. So, I think they'd be more supportive if you're already employed. Not a new employee.*
	Doris: *you can just simply bump into them [mental health first aiders] in the corridor, but you would know if you'd ask to speak to them, they would.*	Jim: *I know far too much about people's mental health at work, and I work with the accounting team, but I've got nothing to do with managing advisors, and I hear about it. And it's like, I know I shouldn't.*
		Carlos: *It's the minimum amount of people who you can trust.*
Perceived as needing to be strong	Jim: *So that's mental health issues as well, and if I had them I wouldn't want to put them onto them [family] or let them know about them. I wouldn't want to.* Doris: *But they'd [family] still need to know, so they know it's not them that's causing say, you being sad all the time or you being angry. If sometimes people don't know, they blame themselves.*	Jim: *Yeah because as a husband or a parent you're expected to be the strength, and that's a very ordinary way of looking at it.*
	Kevin: *If someone says "Are you OK?" I just kind of do the general probably quite bloke-y thing of sort of pushing off and go "Yeah, I'm alright."*	Kevin: *I mean, if you're a mechanic and you work in the garage, regardless of age you're less likely to have that conversation.*

(continued on the next page)

Table 5, continued

Theme	Non-mental Health Professionals	
	Quotes	
Perceived as needing to be strong	Jim: *I think I'm with Doris, where it can be seen as a sign of weakness. Depends on what position you're in as well. So, if you manage a team or anything like that and it's showing your competence...* Doris: *Yeah, especially if you're somebody in authority.*	Jim: *If you started to get depressed and struggling with it, that they'd see that as if you're not capable of doing your role?* Carlos: *Yeah, I think so… I think people think "Oh, I don't want to say anything because they'll sign me off work and that's it."*
What affects whether someone would disclose	Doris: *people think that you're barmy or 'round the bend, as people put it, if you report it.*	Kevin: *I've watched a few films. And when people have got a personality disorder, it tends to be the one that is always the serial killer.*
	Jim: *I think that from a male perspective, for me and my friends, we rarely talk about anything that would lead into mental health.* Carlos: *I think males are less likely to speak out.*	Jim: *the younger generation is willing to talk a lot more about mental health than, yeah, my generation*
Normalized	Kevin: *So, yeah, I think if you're in an organization where it's more policy-driven, where they're more aware, where they've got a higher level of training around mental health, you feel more open to that.*	Doris: *And I said I'm worried in case the person next to me is depressed, and I'm not picking it up, because I feel as if I should.*
	Jim: *It's become more acceptable isn't it, to discuss anxiety, depression has become where I think personality disorder, I don't know anybody with one.*	Kevin: *So, I think there's something, to be honest, needed around workplaces and making sure there is terminology that people understand. Because I talk about stressed if I'm late. I talk about depressed if I've just really watched a crappy episode of EastEnders and something's happened.*
	Carlos: *I think if I had a personality disorder I would be less likely to come and tell someone, whereas if I had, like, anxiety, depression I would be ...* Jim: *It's so rare I think you tend to keep it in where anxiety and depression, it's very common now to be open about it.*	Carlos: *I think sometimes we don't know enough about them. It's like if I worked with someone and they said to me one day "I've got schizophrenia." It would be like, well I personally, it wouldn't bother me. But some people would look on and think "Oh, I don't want to spend much time with them if they're schizophrenic."*
Common Themes	Mental Health Professionals	Non-mental Health Professionals
	Quotes	
Lack of knowledge	Betty: *"I think it's like that with anxiety and personality disorder. Because you can get someone who, likes, say, "I'm really anxious about that", but when you look at them, when I look at them, I think well, you're not giving out any anxiety-like, indicators to me, they just say "I'm anxious about that"*	Kevin: *I think the general impression is that a personality disorder's also more dangerous to the people around you,*
	Betty: *"I know it's quite big on like personality disorders, just again, "it's just bad behavior, just bad behavior kicking off for no reason what so ever". So, I think there's still a lot of, even though there's more information and more stuff out there, there is still deep down there is still a lot of stigma about a lot of mental health conditions".*	
Gender differences and seeking female support	Feyre: *I think it would be really hard for a man to tell someone that they were having to struggle with the mental health. They'll probably just "man up". Well, see it as "man up" and just deal with it.*	Jim: *I would generally more open up to a female* Carlos: *Yeah. I think I would as well.* Jim: *Again, the sort of the weakness thing, I think. The male pride* Doris: *I think that, it's 'cause women are seen, or deemed, to be more approachable, you know what I mean? It's not always true*
	Betty: *I'd feel more comfortable telling a female…. some things I just feel like I don't really want to share with a male because. I don't know really* Ruby: *sometimes that impression that they [Male management] might not understand, kind of if it was something to do with women problems. You kind of feel like those just wouldn't be able to relate.*	Doris: *"Because men are supposed to be the leader and things like that. And it's like a chink in the armor. Like I never, ever saw my dad talk about anything like that, 'cause as you said it was a generation that just didn't talk about it."*
Abuse of system	Betty: *Because people could ring up, have sickness related to…drinking the night before but then decide to have a week off but then they'll go through exactly the same protocol as if someone who is genuinely ill and poorly and needs time off, to you know, get better again, I don't think, personally, that, that's fair.*	Kevin: *If someone came into me or to our organization and said "I've got an eating disorder. I need to have Tuesdays off from now onwards, there'd still be a skepticism in my head that goes "Have you? Maybe you're just looking for Tuesdays off."*

Discussion

This study's purpose was to investigate the levels of perceived stigma concerning the disclosure of mental health concerns within employment when using the term "Mental Health", and whether this is different when using the symptomology of mental health disorders. The study also aimed to investigate the perceived barriers to help-seeking behavior, with a focus on mental health professionals versus non-mental health professionals. Both aspects of the survey were assessed in terms of employment, age, and gender, and regarding the mental health professionals, also in terms of the length of service.

The survey's key findings indicated that mental health professionals do not have significantly higher levels of perceived stigma or barriers to help-seeking than non-mental health professionals. Inexperienced male professionals had a higher level of perceived stigma than both inexperienced and experienced women. Male mental health professionals' level of perceived stigma reduces significantly once they garner experience in the field. Disorders that are established and diagnosed, as well as symptoms relating to specific disorders, remain significantly less stigmatized amongst the mental health professionals than amongst the non-mental health professionals; thereby showing that although working in the mental health profession can increase the number of dangerous situations the participant faces, this does not lead to an increase in stigma. Findings show that there is a decrease in stigma towards those with mental health problems, with men initially being affected more by stigma than are women, with this stigma reducing as they gain more experience, whereas the social influences that the non-mental health professionals experience still significantly affect their stigmatization of certain disorders.

The overarching theme for the focus groups remained the "changes needed for disclosure", with the mental health group laying the focus on improvements needed, while the non-mental health discussion focused on the pressures from societal expectations leading to being judged. The participants reached the conclusion that changes are required in government legislation, company policies, and anti-stigma campaigns in order to improve openness and reduce the judgment of mental health concerns.

Stigma in Healthcare

An important aspect of help-seeking behavior is the reduction of stigma. Previous research has documented that the reduction of stigma is not prevalent across healthcare professionals (Angermeyer et al., 2013; Clement et al., 2015); the results of this study showed that, concerning mental health professionals, the levels of stigma are not significantly different from those of the non-mental health professionals' group. The results focus on professionals working in mental health – which would not be generalizable to other areas of healthcare, as mental health professionals are more aware of mental health disorders and the effect this has on the lives of the service users – this could also be influenced by training received whilst working in mental health.

Generally, demographic aspects have little influence on stigma and barriers. An interesting area within the mental health analysis involved stigma reduction in mental health professionals, as once the professional becomes experienced (over five years in employment) a reduction of perceived stigma results. This could be due to the experience of working with mental health service users, as this was evident across the different ages. This stigma reduction occurred more in men professionals than women. This possibly derives from men having a higher level of stigma compared to women when they start employment within mental health.

Stigma with Specific Disorders

Stewart, Keel, and Schiavo (2006) argued that certain mental health disorders can be more stigmatized if they are portrayed as self-inflicted. The findings must be considered with caution as the survey respondents were not representative of the general population or the target group previously researched. Our research does not support this argument as personality disorders, symptoms of psychosis, and bi-polar disorder were the most stigmatized in this survey, significantly more so by non-mental health professionals. This indicates that a lack of the understanding of etiology for a disorder served as a closer indicator of an increased stigma level than preconceived assumptions.

This study found that mental health professionals' level of stigma stood significantly lower than with the non-mental health professionals when assessing the symptomology of mental health disorders. As the case study of each disorder provided a narrative of the symptoms, rather than stating the name of the disorder, the social desirability bias lessened. A person without any experience of a specific disorder may feel that they would not express or perceive stigma; however, when asked if they would work alongside an individual with this mental health issue, the stigma

was more likely to become evident. Working in mental health has, however, allowed the person to understand different disorders and how they affect people; therefore, they would be more understanding and less likely to stigmatize.

Mental health professionals participating in the focus group evidenced more understanding of specific disorders than the non-mental health professionals, leading them to understand the effects of stigma more fully. This could also be related to the potential for the non-mental health professionals focusing on anxiety and depressive disorders when completing the MICAv4, ISMI and OMS-HC surveys, and so produce a lower stigma score since they did not consider other disorders such as psychosis or bipolar disorder. When the case study described different disorders, therefore, the non-mental health professionals generated a higher stigma level. It is interesting to note that although mental health professionals had lower stigma levels than non-mental health professionals for the symptomology of disorders, no differences existed between the two groups if the symptoms were newly developing rather than already being managed. This may be linked to the experiences that mental health professionals have of service users being successfully treated and thus the stigma levels are reduced by their belief in the mental health services and the support these services offer.

This research evidenced that mental health professionals reported barriers not significantly different from the non-mental health professionals, thus indicating even with the increase in knowledge, experiences and a reduced level of stigma towards other people, the powerful nature of self-stigma within mental health and demonstrates that this issue needs urgent rectification to reduce help-seeking barriers.

Disclosure Stigma in Employment

Disclosure stigma was evident throughout the focus groups, as all participants advised they would need to reach a crisis point before disclosing due to the fear of their colleagues' perception and believing the culture of the organization to be one of gossip. The non-mental health professionals would not disclose at an interview stage, stating they would seem weak; this supports Brohan et al. (2012). Although established disorders were less stigmatized in mental health services, the participants in this group still would not disclose until the symptoms were affecting their work or safety. Further research would be interesting to explore perceptions of the crisis point, whether it would vary from the first instance of someone else noticing any changes or would the professional need to have something more substantial occur such as a panic attack during work.

Interestingly, participants from both groups, both male and female participants, advised that they would be more comfortable disclosing mental health concerns to a female colleague rather than a male – the belief being that women are perceived more understanding, or men more likely to believe mental health issues are a weakness. Men may perceive that talking to another man would make themselves more vulnerable than were they to talk to a woman.

Reasons for Disclosure

There are many reasons to disclose to an employer. Brohan et al. (2012) theorized that the main reasons for disclosure were to gain adjustments, explain behavior, or because concealing remains stressful. All participants in the focus groups advised they would disclose a mental health concern once they had reached a crisis point and they needed to attend therapy or appointments during working hours. They explained that the barriers to disclosure were complex and varied for each person: this ranged from having the right person to speak to, to having a trusting colleague, their own perception of stigma, and the support they received from their employer. The participants also advised on ways that could improve their disclosure, including having designated people they could speak to that would be non-judgmental, having policies that support disclosure, and reduction of perceived punishment. Mental health professionals may be more aware of what services and self-help options are available; therefore, able to seek help outside of employment more readily. Due to the nature of their employment, mental health professionals in the focus group advised that they would find concealing the disorder stressful.

Reasons for Non-Disclosure

When people experience mental health concerns, they are sometimes reluctant to seek help (Lubian et al., 2016). Mental health professionals reported less difficulty across each barrier in the survey than the non-mental health group, although this was not significantly different. Other reasons for non-disclosure, generated by the focus groups, were being perceived by society as weak or incompetent when in a leadership role.

The research by Brohan et al. (2012) advised on the various reasons why people would not disclose. This research supported some of the reasons; for example, a participant in the non-mental health group advised they

would not disclose at an interview as there was no trust built-up and they felt they would be discriminated against. Within the mental health group, the participants were concerned that they would worry about being treated unfairly, believing their anxiety would increase should they disclose, regardless of the actual outcome. Both groups remained concerned about losing credibility and the culture of gossip amongst their colleagues.

Brohan et al. (2012) evidenced that women would be less likely to disclose, although many previous studies generate these findings, as different methodologies are used with different measurement tools – this must be taken into account when comparing the findings. This study revealed no significant gender differences for barriers or the perception of stigma. However, gender differences were discussed in the focus groups with participants believing that men would be less likely to disclose or seek-help; although, this was contradicted by a participant who felt that men would disclose if in the right environment. Both groups discussed that certain disorders increase their disclosure stigma, including an eating disorder, personality disorder, or psychosis, due to the high level of stigma attached to the diagnosis in society. Participants would be more likely to disclose should they have anxiety or depression, as society has these more normalized. This is then affected by the use of the terminology in everyday life, participants advised that the incorrect use of terminology often occurs, thereby undermining the severity of both anxiety and depression. This could stem from a lack of knowledge about the disorders and a lack of accurate associations in the media.

Stigma Reduces Help-Seeking Behavior

Previous research has shown that working in healthcare increases internalized stigma and this then leads to reduced help-seeking behavior (Clement et al., 2015; Hawke et al., 2013). The current research does not support this, as ISMI results present no significant difference between the groups. This research shows that mental health professionals do not have a higher level of internalized stigma than people that do not work in these services, although when gender is analyzed, a significant difference manifests regardless of employment.

Policy Issue

In the non-mental health group, the discussion addressed a potential mental health policy for sickness, and should time away from work be given for mental health issues, then this policy could be abused. Within the mental health focus group, however, the participants discussed how the policy for physical health sickness was already being abused, whereas someone who is genuinely mentally unwell can face discipline if the problem is chronic. This difference between the two groups is important. It shows the development of understanding mental health and the impact this has on policies. It highlights the impact and power that support – and appropriate training – can have, as well as their impact on stigma, employment, and other areas.

Strengths and Limitations

These findings must be taken in the context of the study's limitations. This survey's limitation involves the homogenous demographics as 54% were based in England's North-East, and so the results may not be generalizable to other areas. A national study may provide differing results regarding the perspective of both mental health and non-mental health professionals' attitudes towards stigma. Furthermore, by using vignettes rather than statements, a more valid response could be generated, as vignettes help the participant to imagine themselves in the situation better than statements. This could be improved by using a retrospective design one that assesses what participants have previously experienced when they accessed mental health treatment; the stigma associated with it would be more beneficial than what they are perceiving their stigma and barriers to be in the present.

Conclusion, Implications and Future Directions

Stigma continues to be an issue with mental health professionals avoiding disclosure, and policymakers must make changes within this sector to create a better service that reduces the anxiety of disclosing mental health concerns. It is a must to create a research base to establish a minimally stigmatizing service. Mental health professionals who want to disclose for different reasons, however, still feel unable to do so; this can be improved by having the correct services and policies in place. Improvements regarding interventions tailored to mental health service professionals can increase help-seeking behavior and enhance mental well-being.

Areas for future research include developing a less stigmatized service and reducing the barriers experienced in mental health services. This could be improved upon by exploring the retrospective accounts of barriers faced by people that have sought help. Future research could be conducted on interventions to increase discussion and help-seeking behaviors, as well as enhancing the effectiveness of these interventions.

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This manuscript is the authors' original work.
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All participants engaged in the research voluntarily and anonymously, providing their written informed consent to participate in this study.
Data are stored in coded materials and databases without personal data, and the authors have policies in place to manage and keep data secure.

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