Self-disclosure of mental illness in the college classroom: the role of stigma and avoidance

Christopher Gjesfjeld  
*Illinois State University, cgjesfj@ilstu.edu*

Jeffrey Kahn  
*Illinois State University, jhkahn@ilstu.edu*

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To cite this article: Christopher D. Gjesfjeld & Jeffrey H. Kahn (2023): Self-disclosure of mental illness in the college classroom: the role of stigma and avoidance, Social Work in Mental Health, DOI: 10.1080/15332985.2023.2239411

To link to this article: https://doi.org/10.1080/15332985.2023.2239411

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Published online: 27 Jul 2023.

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Self-disclosure of mental illness in the college classroom: the role of stigma and avoidance

Christopher D. Gjesfjeld PhD and Jeffrey H. Kahn PhD

School of Social Work, Illinois State University, Normal, Illinois, USA; Department of Psychology, Illinois State University, Normal, Illinois, USA

ABSTRACT
Many college students identify having a mental health condition, yet students may be ambivalent about self-disclosing their mental health. While stigma and self-disclosure have been examined in research, personal factors may also impact self-disclosure behaviors. The present study examined 150 U.S. college students with a self-identified mental health condition. Research aimed to predict classmate self-disclosure by stigma, avoidance beliefs, and the interaction of these variables. Multiple regression analysis found a significant interaction effect, whereby stigma was negatively associated with self-disclosure only under conditions of low avoidance. Implications suggest that self-disclosure interventions target stigma and avoidance beliefs to encourage greater self-disclosure.

Many U.S. college students are reporting high rates of psychiatric conditions. In a recent college survey of 1,410 college students, after the start of the COVID-19 pandemic, nearly 45% of students had moderate to severe anxiety and over 36% had moderate to severe depressive symptoms (Lee, Jeong, & Kim, 2021). College teachers have also been noticing the mental health concerns in their students. In a report surveying 1,685 higher education teachers, nearly 80% of teachers have had at least one conversation about mental or emotional health with a student (Lipson, Phillips, Winquist, Eisenberg, & Lattie, 2021). These findings demonstrate a significant number of students having mental health concerns, and teachers are increasingly hearing about these concerns from their students.

Is it advantageous for college students to share their mental health identity with others? There have been important findings about how college students disclose their mental health. For example, direct disclosure, or the verbal, direct sharing of one’s mental health, has been associated with greater relationship satisfaction and enhanced personal esteem among college students.
(Taniguchi, 2020; Venetis, Chernichky-Karcher, & Gettings, 2018). In contrast, using humor to disclose, entrapment (e.g. accidental disclosure), or disclosing by way of a third party have been associated with greater distress (Taniguchi, 2020). In other words, direct communication of one’s mental health appears helpful in obtaining support, while the concealment of one’s mental health identity or utilization of indirect disclosure methods appear less effective to those with mental illness. These personal benefits have also been confirmed in a sample of college students experiencing depression in a small qualitative study. Researchers found that students hoped that mental health self-disclosure could bring them closer to others, allow them to be more authentic, and assist them in finding formal and informal support for their mental health (Cooper, Gin, & Brownell, 2020).

Besides these potential personal benefits, the changing of negative social attitudes regarding those with mental illness appears dependent on some individuals from the stigmatized group to self-disclose to others in society. For example, it has also been demonstrated that intergroup contact between individuals and those with mental illnesses can reduce prejudice (Pasek, Filip-Crawford, & Cook, 2017). In a large meta-analysis focusing on anti-stigma interventions, interpersonal contact was found to be a robust predictor of fewer stigmatizing attitudes and potential stigmatizing behaviors. For example, in-person contact with a person with mental illness had a greater effect size on stigma than contact via video (Corrigan, Morris, Michaels, Rafacz, & Rüss, 2012). These findings demonstrate the potential societal impact when those with mental health identities disclose their experiences.

**Mental illness, stigma, and self-disclosure**

Even though there may be a personal and social benefit to disclosing, mental illness is still described as a concealable stigmatized identity (CSI) or an “devalued attribute or identity that is not immediately knowable to others” by various scholars (Barreto, Ellemers, & Banal, 2006; Camacho, Reinka, & Quinn, 2020, p. 28; Quinn & Chaudoir, 2009). Despite greater visibility in society of high-profile individuals who experience mental illness, there has been mixed evidence that stigma among young adults has changed considerably in comparison with older cohorts (Bradbury, 2020; Pescosolido, Halpern-Manners, Luo, & Perry, 2021). Mental health stigma is theorized to be constructed from the societal stereotypes that those with mental illness should be feared, are irresponsible, or need to be cared for (Rüss, Angermeyer, & Corrigan, 2005). This stigma is concerning for college students because of the potential for internalizing these negative societal stereotypes and applying these stereotypes to themselves, also known as the “why try?” Effect (Corrigan & Rao, 2012). In various tests of the “why try?” Effect, these negative attitudes, when applied toward the self, have been associated with lower self-worth,
lower self-abilities, harm to self-image, and a lack of capacity (Corrigan, Bink, Schmidt, Jones, & Rüsch, 2016; Corrigan, Niewegowski, & Sayer, 2019). For college students, these outcomes could have a detrimental impact on various academic and social indicators of success in higher education.

For the duration of this article, we will use the term mental health issue to denote individuals who self-identify as having: 1) a current mental health issue; 2) currently use medication for a mental health issue; or 3) current counseling for a mental health issue. Because self-disclosure of identity was our focus rather than psychiatric symptomatology or diagnosis, our focus on mental health self-identity impacts the inclusion and exclusion criteria for our sample. Despite diagnostic tools being helpful to determine current symptom presence or severity of illness, these tools can both underreport or overreport the self-identification of those with current mental health issues. For example, many students could experience untreated mental health symptoms, and consequently not self-identify as having a mental health concern. Asking if they self-disclosed their mental illness would be problematic because self-identification with mental illness starts with the assumption of both 1) symptom awareness but also 2) an appraisal that such symptoms are psychiatric in nature. In this case, solely measuring self-disclosure of individuals with a diagnostic screen could overreport the number that actually identify with having a mental illness. Additionally, diagnostic scales, if used as a proxy for mental health identity, also have the potential in underreporting mental health identity. In large part because of effective treatments and the episodic nature of some psychiatric illnesses, it is possible that a significant number of my population of students are currently asymptomatic or subclinical, in part due to effective psychiatric treatments like medication or counseling. Given these limitations of using diagnostic tools as a proxy for identity, we chose to ask if they identified as having a mental health issue, take medication for a mental health issue, or receive counseling for a mental health problem.

Although stigma has been associated with negative outcomes, students have agency to make personal choices regarding whether to conceal or disclose their mental health identity. Self-disclosure has been defined as “what individuals verbally reveal about themselves to others (including thoughts, feelings, and experiences)” (Derlega, Metts, Petronio, & Margulis, 1993, p. 1). Research investigating the relationship between stigma and self-disclosure in college students has demonstrated some mixed results in terms of the direction of the relationship. Social identity theory suggests a negative association between stigma and the self-disclosure of mental health. To explain this relationship, social identity theory posits that limited disclosure, or concealment, would be used to self-distance oneself from a devalued social identity. This self-group distancing is a process whereby “group members dissociate from their stigmatized ingroup, to avoid the negative experience of being stigmatized, to reap benefits from being less associated with the ingroup, or to better fit in with
a high-status outgroup” (van Veelen, Veldman, Van Laar, & Derks, 2020, p. 1090). By self-distancing from the devalued “mentally ill” identity, some college students with mental health problems may be attempting to “pass” within a more socially valued group. A qualitative account among college students with depression within an academic lab environment confirms this process. These students noted concerns about being deemed less capable, had concerns about gossip about their mental health status, and believed impersonal academic environment was a barrier to the self-disclosure of their depression (Cooper, Gin, & Brownell, 2020). This emphasis on the preservation of social identity is found in other research inquiries. For example, in an examination of 235 college students with various CSIs including various mental illnesses, ecosystem goals were found to be associated with less positive 1st disclosure experiences. These ecosystem goals emphasize the preservation of self-image to obtaining personal desires, whereas ecosystem goals prioritize larger interpersonal relationships goals (Chaudoir & Quinn, 2010).

Despite significant support for this self-distancing approach that explains the negative association between stigma and disclosure, some empirical findings suggest a different process whereby the stress associated with experiencing the strain of mental health issues encourages greater disclosure. From this perspective, it is conceivable that the personal stress associated with stigma could encourage the individual to share their experience with mental health identity. In “I have to talk to somebody:” A fever model of disclosure, Stiles (1987) uses the metaphor of a medical fever to explain the timing of self-disclosure. In this conceptualization, when stress is experienced associated with one’s mental health, the act of self-disclosure helps to “break” the fever, facilitating potential social support. This process has found some more limited support. In a sample of students at 5 Midwestern colleges, increased stress partially mediated the positive relationship between stigma and self-disclosure (Brown, Moloney, & Brown, 2018).

Taken together, self-disclosure research, particularly specific to college students, suggests that the relationship between stigma and self-disclosure is not clear. It is possible that mixed results may be occurring because of the influence of unmeasured variables that may moderate the stigma and self-disclosure relationship. For example, Omarzu (2000) outlines various other factors influencing disclosure decision-making including the personal goals in disclosing, potential strategies, and the weighing of risk and reward that can impact disclosing one’s mental health.

Approach and avoidance beliefs regarding mental health: a contributing factor in disclosure decisions?

With a primary focus on the relationship between stigma and self-disclosure in the literature and mixed results across prior studies, testing other personal
differences that influence self-disclosure of a mental health identity may provide greater clarity. For example, the approach-avoidance goal motivations of those with mental illness may be particularly influential in self-disclosure behaviors. These motivations have been defined in the following way:

Approach motivation may be defined as the energization of behavior by, or the direction of behavior toward, positive stimuli (objects, events, possibilities), whereas avoidance motivation may be defined as the energization of behavior by, or the direction of behavior away from, negative stimuli (objects, events, possibilities). (Elliot, 2006, p. 112)

Conceptualized by Elliot (2006) as key antecedents to behaviors and influenced both by affect-based tendencies and biological-based temperaments, it is noteworthy that these goals imply both a direction toward or away from an object, as well as the intensity of activation or energization. If we center "mental illness identity" as the object/event, avoidance motivations may be considered as a method of self-protection, for example to prevent potential discrimination or beliefs in avoiding embarrassment. On the other hand, approach goals, specific to a “mental illness identity,” may imply personal beliefs to approach others about the facts of one’s mental health.

While one may imagine the potential advantages of approach beliefs to individuals with mental illness (e.g. a desire for others to understand their experience, greater personal authenticity), one can also imagine the protective aspect of avoidance beliefs for other individuals. For example, some individuals with mental illness may make interpersonal efforts to avoid uncomfortable situations or conversations associated with their illness. Their intent may be to reduce the potential of discrimination or avoid potential labeling from others. Unfortunately, the outcomes of avoidance, or behavioral concealment of one’s mental health, appears associated with negative self-confidence and lowered performance (Barreto, Ellemers, & Banal, 2006). Approach motivations, alternatively, may predict a propensity to “come out” and self-disclose mental illness in efforts to “correct the record” about the perception that others have regarding those with mental illness. These approach-avoidance beliefs would seem to be pivotal to decision-making regarding self-disclosure.

Yet empirical research on these beliefs associated with avoidance/approach has been limited, with one notable exception. In one study, a group of individuals with mental illness, when primed with a social rejection example, were more likely to utilize avoidant goals (Lattanner & Richman, 2017).

Research does suggest that concealment of one’s mental health can have some costs as it appears cognitively taxing. In an experimental study, female undergraduates with an eating disorder role-played a student without an eating disorder. Even though it was merely a role-play, these students who experimentally concealed their eating disorder had greater levels of thought suppression, secrecy, and intrusive thoughts than female students with an eating disorder who role-played an individual who also had an eating disorder.
(Smart & Wegner, 1999). In other words, not being authentic about one’s mental health experience appeared to take a cognitive toll. In a review of these eating disorder studies, the authors note, “people with concealable stigmas may suffer from a preoccupation with their stigmas, and indicates, too, that this preoccupation introduces automatic and uncontrollable interference effects” (Smart & Wegner, 2000, pp. 232–233).

These themes in approach-avoidance can also be seen in the tenets of Communication Privacy Management (CPM) theory (Petronio, 2013). According to the elements of CPM theory, individuals initially navigate that first, they have the right to protect their private information, and second, whether they desire “authorized co-owners” of certain information. This concept, known as privacy ownership, is how individuals define certain privacy boundaries and determine which individuals have access to private information. Besides privacy ownership, privacy control, or “the engine that regulates conditions of granting and denying access to private information” (p. 9), is also relevant to determining self-disclosure decisions. Petronio (2013) sees various rules, or decision criteria, guiding what is ultimately disclosed or concealed with others. One type, core criteria, are influenced by stable components including prior socialization and personality traits. On the other hand, catalyst criteria, are privacy rules specific to a situation and impacted by motivation, risk-benefit, situation, and emotional needs. These criteria are reminiscent Elliot’s (2006) work that avoidance/approach or privacy management appears to combine both a stable, trait-like component with a more fluid, dynamic aspect.

In our research, we aim to understand how students with low avoidance (e.g. high approach) beliefs self-disclose their mental health, particularly in light of their level of stigma. Based on our reading of the literature, we expect high avoidance may be characterized by internal motivations to withdraw from interpersonal conversations associated with mental health. While this avoidance may be conceptualized as a protective evolutionary mechanism from being “found out,” the implications of avoidance of mental health identity could induce both greater interpersonal isolation and a lack of personal authenticity. As Elliot (2006) notes “approach and avoidance motivation[s] are part of our evolutionary heritage, and we certainly cannot survive, either physically or psychologically, without both types of motivation” (p. 114), yet it is noteworthy that avoidance can be a double-edged sword. It may protect one from potentially experiencing overt discrimination, however, the lack of self-disclosure keeps others from supporting and/or connecting with the individual’s experience.

**Research aims and hypotheses**

In our sample of college students, we aim to understand if avoidance and stigma are either independent predictors of self-disclosure or if they have
an interactive effect on self-disclosure. Heeding the call for the testing of more nuanced models of self-disclosure, we tested both the impact of self-stigma, approach-avoidance, and the interaction term of stigma and avoidance. In terms of approach-avoidance, we developed a scale specifically to examine how individuals may approach or avoid their mental health experiences on a continuum. In addition, we utilized the adapted Devaluation-Discrimination Scale (Link, Mirotznik, & Cullen, 1991) that examines stigma. We hypothesized stigma to be negatively associated with disclosure only under conditions of lower avoidance motivations. In other words, for greater self-disclosure to be possible among students, both lower avoidance/high approach and lower stigma will need to be prerequisites. Under high avoidance, in contrast, we hypothesize a non-significant effect of stigma on self-disclosure due the potentially suppress effect that avoidance is having on self-disclosure. In other words, stigma will not be a significant predictor of self-disclosure when students report high levels of avoidance.

Hypothesis 1: For students with lower avoidance motivation, we hypothesize a negative association between self-stigma and disclosure.

Hypothesis 2: For students with higher avoidance motivation, we hypothesize a non-significant relationship between self-stigma and disclosure.

Method

Participant population

College students from a large public university in the Midwest United States had a common attribute of taking one psychology class, and consequently had access to the institutional psychology survey pool in which this survey was part. Participants took this cross-sectional on-line survey between November 12th, 2021, and December 2nd, 2021. They could receive minimal extra credit within their psychology class for participation. The current sample examined only those that endorsed a self-reported mental health diagnosis, use of medication for mental health, or counseling associated with mental health. This group of 150 students with a mental health identity was 50.8% of the entire student sample who took the survey (N = 295). Students participating in our survey tended to be female (89.3%), Caucasian (70.7%), and averaged 20 years of age (M = 19.91). College freshmen (36%) were the largest class in our undergraduate sample of students. See Table 1 for more details regarding study participants. Our study was approved by our Institutional Review Board.
In terms of their mental health, nearly half (49.3%) of the 150 students noted their mental health was currently “fair,” and 20% noted their current mental health as “poor.” While the sample used for analysis combined students who reported current mental health, medication usage for mental health, and mental health counseling, upon disaggregating, we found that 94% \((N = 141)\) endorsed current mental health concern, over a third \((36.7\%)\) reported the utilization of medication for mental health, and a similar amount \((38\%)\) went to counseling. When we asked a qualitative probe about their mental health condition, in which students could endorse one or more mental health conditions, 82.7% \((N = 124)\) of students endorsed anxiety and 57.3% \((N = 86)\) endorsed depression. See Table 2 for more detailed additional information about mental health identification among participants.

### Variables

**Stigma scale**

Our scale to measure stigma was an adaptation of Link, Mirotznik, and Cullen (1991) devaluation-discrimination scale. For several items, the language in the origin scale of “former mental patient” was changed to a “person with a mental illness.” The 12 items measure the degree to which the respondent agrees or disagrees with certain beliefs about those with mental illness, with 1 = “strongly disagree” to 6 = “strongly agree.” Item examples include, “Most people would willingly accept a person with a mental illness as a close friend,” which is reversed scored, and the item, “Most people would be reluctant to date a person who has been hospitalized for a mental illness.” In our sample, we found the 12-item scale had a Cronbach alpha of 0.88. A high score suggests an individual who strongly adheres to negative stereotypes about those with mental illness.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>134</td>
<td>89.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>7.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonbinary/Fluid</td>
<td>5</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>19.91</td>
<td></td>
<td>3.42</td>
<td></td>
</tr>
<tr>
<td>Race ((N = 149))</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>106</td>
<td>70.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latinx</td>
<td>11</td>
<td>7.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>10</td>
<td>6.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biracial/Multiracial</td>
<td>7</td>
<td>4.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>5</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>6.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year in College Fall 2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freshman</td>
<td>54</td>
<td>36.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sophomore</td>
<td>29</td>
<td>19.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior</td>
<td>40</td>
<td>26.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td>27</td>
<td>18.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Our approach-avoidance orientation scale was developed based on the work of Elliot (2006) considering the defining characteristics of approach and avoidance motivations. We intended that this scale attempt to measure the degree to which those with self-identified mental health fall on an approach-avoidance continuum. We believed this measure had potential importance in predicting the self-disclosure of mental health. Based on how approach-avoidance is conceptualized, we hypothesized that those with self-identified mental health concerns would have various motivations regarding sharing their mental health that could impact interpersonal communication. As noted in the work of Petronio (2013), we believed that these privacy beliefs are formed from both stable traits, both from socialization and personality, but also within a specific motivational and goal-based context, in this case within a higher education environment with classmates. We believed those with lower avoidance beliefs, or high approach beliefs, would be inclined to disclose their mental health. In contrast, students with high levels of avoidance would be less likely to disclose to their classmates. To construct this 10-item scale, we used 5 avoidance worded items such as, “I will face social rejection if I share information about my mental health,” and “Concerning my mental health, it is best I avoid the whole issue with others.” We reversed scored approach items.

Table 2. Mental health characteristics of participants (N = 150).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Reported Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>8</td>
<td>5.3</td>
</tr>
<tr>
<td>Good</td>
<td>38</td>
<td>25.3</td>
</tr>
<tr>
<td>Fair</td>
<td>74</td>
<td>49.3</td>
</tr>
<tr>
<td>Poor</td>
<td>30</td>
<td>20.0</td>
</tr>
<tr>
<td>Current Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>141</td>
<td>94.0</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Irregular mental health</td>
<td>6</td>
<td>4.0</td>
</tr>
<tr>
<td>Not currently</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>55</td>
<td>36.7</td>
</tr>
<tr>
<td>No</td>
<td>84</td>
<td>56.0</td>
</tr>
<tr>
<td>Take medication irregularly</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Not currently</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>57</td>
<td>38.0</td>
</tr>
<tr>
<td>No</td>
<td>46</td>
<td>30.7</td>
</tr>
<tr>
<td>Counseling irregularly</td>
<td>11</td>
<td>7.3</td>
</tr>
<tr>
<td>Not currently</td>
<td>36</td>
<td>24.0</td>
</tr>
<tr>
<td>Self-Report Mental Health*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>124</td>
<td>82.7</td>
</tr>
<tr>
<td>Depression</td>
<td>86</td>
<td>57.3</td>
</tr>
<tr>
<td>Attention-deficit/hyperactivity disorder (ADHD)</td>
<td>17</td>
<td>11.3</td>
</tr>
<tr>
<td>Post-traumatic stress disorder or “Trauma”</td>
<td>15</td>
<td>10.0</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder (OCD)</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>6</td>
<td>4.0</td>
</tr>
<tr>
<td>“Not sure,” missing, or other</td>
<td>13</td>
<td>8.7</td>
</tr>
</tbody>
</table>

*Students could report more than one mental health issue.
such as “It is important that others understand my experience with mental illness,” and “Sharing my mental health will help me get closer to others.” We scored items from 1 = “strongly disagree” to 5 = “strongly agree.” High scores indicate a high level of avoidant beliefs in communicating personal mental health troubles or concerns, whereas low scores on the scale would indicate high levels of approach motivation. We found the 10-item scale had a high level of reliability with a Cronbach alpha of 0.81.

Self-disclosure to classmate
One item was used to measure self-disclosure to a classmate. We asked college students, taking this survey between November and December 2021, to think about the time since the beginning of the Fall 2021 semester and reflect on their “most recent verbal sharing.” We asked, “Have you verbally shared your psychological or mental health in-class or with a classmate while working on classroom content (e.g. study group, group project)?” This item was scored continuously with 1 = “not at all” to 5 = “extremely.” In our sample of 150 college students with a mental health identity, 62 students (41.3%) chose to disclose their mental health to a classmate.

Analysis
After preliminary analysis found that disclosure did not differ based on gender in our sample, gender was not included in subsequent testing of our hypothesized model. In our model, self-disclosure to a classmate was predicted by stigma, avoidance, and a stigma-avoidance interaction term. We hypothesized an interaction term would be significant, indicating that the relationship between stigma and self-disclosure would differ over different levels of avoidance. The interaction term was hypothesized given the literature suggests that self-disclosure decisions are embedded in various factors including stigma but also various individual differences (Omarzu, 2000). Given the potentially detrimental effects of both stigma and avoidance on disclosure, only under a condition of lower avoidance did we hypothesize a negative association between stigma and self-disclosure.

Results
A multiple regression model was tested to investigate whether the association between stigma and mental health disclosure to classmates depends on avoidance. See Table 3 for descriptive statistics of study variables. Using the PROCESS Macro Procedure for SPSS for testing interaction effects (Hayes, 2022), stigma, avoidance, and the stigma-by-avoidance interaction term were entered into a simultaneous regression model. Together, the variables predicted mental health disclosure to classmates, $R^2 = .15$, $F(3, 146) = 8.84$, $p < .001$. The stigma-
Table 3. Descriptive statistics and correlations for study variables.

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stigma</td>
<td>3.25</td>
<td>0.87</td>
<td>–</td>
</tr>
<tr>
<td>2. Avoidance</td>
<td>2.62</td>
<td>0.66</td>
<td>.32**</td>
</tr>
<tr>
<td>3. Disclosure</td>
<td>1.65</td>
<td>0.89</td>
<td>−.16</td>
</tr>
</tbody>
</table>

**p < .01.

by-avoidance interaction was significant ($B = .30, SE = .10, t = 2.88, p < .01$) and significantly impacted the model ($\Delta R^2 = .05, F(1, 146) = 8.28, p < .01$), suggesting that the effect of stigma on disclosure depends on the level of avoidance. Simple slopes for the association between stigma and disclosure were tested at various levels of avoidance: low avoidance (−1 SD), medium avoidance (M), and high avoidance (+1 SD), as suggested by Hayes (2022). Under medium or high levels of avoidance, stigma does not significantly predict disclosure to classmates, ($B = −.02, SE = .08, t = −.22, p = .83$) and ($B = .18, SE = .12, t = 1.53, p = .13$), respectively. However, under low levels of avoidance, stigma negatively predicts disclosure with classmates ($B = −.22, SE = .10, t = −2.19, p = .03$). Figure 1 presents a visualization of the relationships among these three variables.

**Figure 1.** Disclosure to classmates predicted by stigma at different levels of Avoidance. *p < .05

Discussion

Recent research suggests self-disclosure may benefit those with mental health concerns, yet self-disclosure appears influenced by a variety of factors. Given a lack of research that tests other variables other than stigma, we aimed to fill this gap by examining stigma in tandem with a previously unmeasured
variables associated with approach/avoidance beliefs. Our analysis attempted to predict self-disclosure by social stigma, avoidance/approach beliefs about one’s personal mental health, and also the interaction of these variables. We found that for students with low avoidance (e.g. high approach) motivations, the negative association between stigma and disclosure was consistent with social identity theories, whereby lower stigma is associated with greater self-disclosure. For students with moderate to high levels of avoidance motivations, stigma was not associated with self-disclosure among students. This significant interact effect is important because it implies that the influence of stigma on self-disclosure may interact within a context of personal variables.

Our finding supports self-disclosure intervention research with its two-pronged focus on both internalized stigma and the communication of one’s mental illness. We see a close connection between avoidant and approach beliefs and the specific behaviors associated with how one communicates these beliefs. For example, in the group intervention of Honest, Open, and Proud (HOP) developed by Corrigan, Kosyluk, and Rusch (2013), these dual factors are examined in group sessions. In the first group session, the group considers their own identity and how stigma influences the beliefs they have about their identity. In additional sessions, participants consider the practical aspects of how to approach others and communicate one’s mental illness. We see our measure examining the underlying beliefs that impact this potential communication of mental health to others. Our findings suggest that these dual aspects of internalized stigma and avoidance beliefs are important targets of self-disclosure interventions. We also encourage other researchers to consider the use of our 10-item scale to examine the impact of avoidance/approach beliefs on mental health disclosure. These approach-avoidance beliefs are important because they may signal important antecedents to if and how individuals want to communicate their mental illness to others. We encourage future research to examine the relationship between these approach-avoidance beliefs and specific behaviors, as our work did not specific examine the specific self-disclosure behaviors utilized with classmates. Despite asking some open-ended questions, we found that our survey method lacked the ability to deeply understand the complex context in which the self-disclosure situation occurred. We aim to develop a qualitative project that assists in understanding this context in more depth.

**Limitations**

Some limitations of our findings concern both the sample and self-disclosure measurement. Provided that all students, to be in the survey pool, were taking at least one psychology class, it is conceivable that the high rate of disclosure was greater because mental health is merely a more relevant topic in psychology course work. For example, psychology classes could specifically address
mental health content and have an influence on if those with mental illness share their identity. The setting and context are certainly influential on self-disclosure, yet it is difficult in many ways to measure its potential influence. These contextual factors associated with mental health relevance and disclosure setting should be further explored by future researchers. Future research should more fully explicate how certain other educational settings encourage or discourage mental health self-disclosure.

Generalizability outside of a college sample is limited given the demographics of our study’s participants, a predominately White female college sample in the U.S. Midwest. Men were only about 7% of our sample. Although preliminary analysis found no difference between men and women on the self-disclosure variable, more men in the sample would have improved statistical power to find any significant difference. Further research should explore if various findings can be replicated with male college samples, because some research has noted that men are less willing to disclose their mental health than women (Brown, Moloney, & Brown, 2018). However, in one study, it was interesting that college men were more likely to have an interest in joining a self-disclosure group for mental health disclosure than college women (Corrigan, Bink, Schmidt, Jones, & Rüsch, 2016). We also encourage researchers to examine these research questions in racially diverse populations. While we did have nearly 30% of students identify as non-White, provided that no more than 11 individuals identified as a specific racial group, we did not have statistical power to find significant between-group differences on any of the three research variables.

Implications

These findings support self-disclosure interventions that target both internalized stigma but also address how individuals intend to communicate their mental health identities to others. We see important connections for how stigma, avoidance-approach beliefs, and self-disclosure may impact the academic and social success of college students. First, we see self-disclosure as promising for the self-development and personal authenticity of students. Self-disclosure of mental health identity has the potential for increasing the authenticity that students can feel in higher education settings and improve their connects to the classroom and to the other students around them. In addition, it can help combat the consequences of internalized stigma associated with “why try?” Effect. As an identity that can be concealed, unlike visible identities like gender or race, we are also concerned that mental health identity has been often ignored in discussions by various educators in higher education settings. We see this as shortsighted as mental health issues can have an impact on nearly every facet of student life including academic, personal, and social life. We hope social workers,
within various roles in higher education, can be champions for these students as they navigate higher education and thrive as individuals with mental illness.

Another implication of this research concerns the role of avoidance. Whereas avoidance is often couched in negative terms, and indeed avoidance can have negative effects on stress and well-being (Holahan, Moos, Holahan, Brennan, & Schutte, 2005), it was only when avoidance was low that stigma and self-disclosure were negatively associated. This makes intuitive sense because one’s avoidance would likely need to be low for a student to even consider self-disclosure. When avoidance was high, stigma did not lead to lower self-disclosure. Whereas we would not go so far as suggest that students should lean toward avoidance as a general practice, this finding does illustrate how the context affects mental-health stigma’s role in people’s disclosure behaviors. Stigma about mental-health issues and (a lack of) help-seeking are logically connected, and an approach (versus avoidance) orientation is also logically connected to help-seeking (Henderson, Evans-Lacko, & Thornicroft, 2013). We therefore view approach versus avoidance orientations as playing an important role in mental-health stigma that may be under-appreciated in the current literature.

Finally, we hope our work can promote interest in the mental health identity of college students for future researchers and the messages told to them by other in their environment. Despite literature suggesting the benefits of supportive parental messages regarding mental health (Flood-Grady, Starcher, & Bergquest, 2023), more research is necessary to understand mental health disclosure and the potential impacts of messages from classmates and teachers. While research associated with self-disclosure of other CSIs has given some direction to future research, mental health identity is unique from other “identities” because of how it is associated with the dominant medical model. We are encouraged, however, that mental health self-disclosure can have a positive influence in dispelling societal stigma about those with mental illness. Just as ableism, sexism, and homophobia can be interrogated in classrooms and campuses, we are optimistic that these educational spaces can critique mental health stigma and empower students experiencing mental health issues.

**Disclosure statement**

No potential conflict of interest was reported by the author(s).

**ORCID**

Christopher D. Gjesfjeld PhD [http://orcid.org/0000-0003-2227-286X](http://orcid.org/0000-0003-2227-286X)

Jeffrey H. Kahn PhD [http://orcid.org/0000-0002-1688-9428](http://orcid.org/0000-0002-1688-9428)
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