Reported mental health difficulties have been on the rise since the COVID-19 pandemic; nearly half of Americans surveyed experienced significant symptoms of anxiety and depression in 2021 (*COVID-19 Mental Health Information and Resources | National Institutes of Health*, 2023). Self-disclosure of such symptoms is related to a range of positive outcomes, such as enhanced social support and improved quality of life (Mayer et al., 2022; Taniguchi, 2022a, 2022b). In addition, disclosure is a necessary precursor to receiving treatment, for those who need it. Furthermore, lack of disclosure can lead to exacerbated psychological distress and diminished quality of life (Weisz & Quinn, 2017). Despite the array of benefits, many people do not disclose their mental health struggles (Ibrahim et al., 2019; Lannin et al., 2020). Because self-disclosure is a crucial link in the path to receiving treatment and improving quality of life, it is important to understand what factors influence likelihood of self-disclosure.

People may self-disclose to a variety of targets, such as friends, family, mental health professionals, and primary care providers. Previous research indicates that college students are more likely to self-disclose to family or friends rather than formal targets like health care professionals (Hinson & Swanson, 1993; Taniguchi, 2022b). Older adults, on the other hand, may be more likely to seek help from medical providers due to increased concern for privacy (Reynolds et al., 2022). Cultural differences may also contribute to differences in preferred targets of self-disclosure and help-seeking for emotional distress among different racial and ethnic groups (Ayalon & Young, 2005; Bhui & Bhugra, 2002; Lipson et al., 2022; Snowden, 1998). Thus, accounting for the target of self-disclosure is an important factor in this area.

A well-documented correlated of self-disclosure and help-seeking across targets is self-stigma (Budenz et al., 2022; Downs & Eisenberg, 2012; Fox et al., 2018; Ibrahim et al., 2019; Mulfinger et al., 2019; Pfeiffer & In-Albon, 2022). Self-stigma occurs when people perceive negative stereotypes about mental illness in society and subsequently incorporate these stereotypes into their own self-image (Corrigan et al., 2006). While research indicates that self-stigma inhibits self-disclosure to both formal and informal targets, past research has not investigated whether the relationship between self-stigma and disclosure differs for varying targets (e.g., friends versus primary care physicians). Further, there is a dearth of research on the mechanisms through which self-stigma itself may predict self-disclosure.

One such mechanism linking self-stigma and self-disclosure may be self-efficacy, which is a person’s belief in their ability to improve their symptoms. Self-stigma has been directly linked to impaired self-efficacy (Corrigan et al., 2006, 2016). In turn, a decreased belief that one can improve is likely to diminish the odds of self-disclosing symptoms of mental illness to medical doctors or mental health professionals, but this path has not yet been tested empirically.

Another mediator of the relationship between self-stigma and self-disclosure may be shame proneness. Self-stigma of mental illness is positively linked to shame proneness (Hasson-Ohayon et al., 2012; Klik, 2015), and shame proneness has been linked to diminished self-disclosure attitudes and behaviors (DeLong & Kahn, 2014; Dunford & Granger, 2017). The relationship between shame proneness and self-disclosure may vary further, based on the relationship between the discloser and target. DeLong and Kahn (2014) found that anticipated risk of disclosure mediated the relationship between shame proneness and self-disclosure, suggesting that the level of trust one has in another person may influence the link between general shame proneness and self-disclosure to a specific individual. Therefore, shame may be a mechanism through which self-stigma inhibits self-disclosure, and this path may itself be moderated by trust in the target of disclosure.

Finally, prior research indicates that the nature of the presenting psychological distress influences likelihood of disclosure. For example, in a sample of college students, severity of depressive symptoms was related to lower likelihood of discussing mental health with peers, whereas severity of anxiety symptoms was not (Woodhead et al., 2021). One key form of mental health symptoms that may differ from others in this regard is suicidal ideation. Disclosing suicidal ideation can lead to more extreme consequences than disclosing general emotional distress, as reports of suicidal ideation can lead to involuntary hospitalization, increased stigma, and fear-based negative reactions from others (Hom et al., 2017; Love et al., 2021). Because the decision to disclose suicidality is distinct from the decision to disclose general emotional distress, it is reasonable to examine both forms of disclosure separately; however, no such research has yet been reported.

This proposed project aims to expand on the existing literature by 1) examining pathways through which self-stigma predicts self-disclosure, 2) assessing potential differences in these pathways for distinct disclosure target groups, and 3) investigating potential differences in these pathways for disclosure of emotional problems and disclosure of suicidal thinking. I aim to test the following overarching model (for disclosure of emotional distress and suicidal thinking separately):

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Specifically, I will test the following hypotheses:

1. Self-stigma of mental illness will negatively predict disclosure of emotional distress and suicidal thinking to all targets.
2. Self-efficacy will account for a significant portion of the variance in the relationship between self-stigma and disclosure specifically to doctors and therapists, with high stigma predicting lowered self-efficacy, and lowered self-efficacy in turn predicting lowered disclosure.
3. Shame proneness will account for a significant portion of the variance in the relationship between self-stigma and disclosure to all targets, with high stigma predicting high shame proneness, and high shame proneness in turn predicting lower disclosure.
4. Trust will moderate the relationship between shame proneness and disclosure such that trust will weaken the negative association of shame proneness with disclosure.

The extant literature is not robust enough to support a specific hypothesis about differences in the proposed pathway based on disclosure of emotional distress versus disclosure of suicidal thinking. Therefore, I will evaluate these potential differences as an exploratory research aim.

**Proposed Methods**

**Participants** I am proposing to conduct ~~a secondary~~ data analysis of a SONA study that my mentor, Dr. Tonge, and I conducted over Fall 2022. I am also proposing to collect additional data from the SONA subject pool in Summer 2023 and Fall 2023, as well as community data from Prolific in Summer 2023. In Fall 2022, we collected data from 144 students, although some measures included in my proposed project were not included in this sample (detailed below). Summer data collection is ongoing (with all proposed measures included), and we anticipate collecting data from at least 150 more students in our SONA sample over Summer and Fall 2023. We anticipate enrolling XX participants from Prolific. Prolific allows researchers to selectively sample based on responses to demographic and general background questionnaires. Because a primary variable of interest in this study is self-stigma of mental illness, we will recruit only participants with a self-reported diagnosed mental health condition as indicated on their Prolific demographic questionnaire.

**Procedures.** Participants will locate the study Qualtrics link through the SONA systems website or through the Prolific website. They will be directed to complete an online consent form and confirm that they are 18 years of age or older. After consenting, they will then be directed to complete brief demographics measures and then all other study measures. Finally, they will view a debriefing form explaining key goals of the survey, and will be automatically granted either course credit through SONA systems or monetary compensation through Prolific.

**Measures.** I will assess self-efficacy through a subscale of the International Personality Item Pool (IPIP; Ehrhart et al., 2008), shame proneness through the Test of Self Conscious Affect-3 (TOSCA-3; Tangney et al., 2000), self-stigma of mental illness through the Internalized Stigma of Mental Illness scale (ISMI; Ritsher et al., 2003), and self-disclosure through the General Help Seeking Questionnaire (GHSQ; Wilson et al., 2006). An exploratory factor analysis of GHSQ data collected in the Fall 2022 semester revealed three factors of help-seeking targets: formal targets (i.e., doctor, therapist), family members, and friends/intimate partners. Pending validation of this factor structure in the new data, I will assess separate help-seeking pathways for each of these factors. All of these measures were included in Fall 2022 data collection and will be included in the second Sona System data collection and the Prolific data collection.

The measurement of trust is more complicated. The Fall 2022 data collection included measures of general trust through the IPIP and provider-specific trust through the Trust/Respect Scale (TRS; Crits-Cristoph et al., 2019). Because my hypotheses involve trust relative to each type of disclosure target, , I will adapt the six trust items from the IPIP for each of the three subgroups in my follow-up data collections, resulting in three near-identical trust scales, with only the target of trust altered appropriately for each scale (e.g. “trust my doctor/therapist,” “suspect hidden motives in my friend/intimate partner,” “trust what my family member says,” etc.). I will use the Trust/Respect Scale (TRS; Crits-Christoph et al., 2019) as a measure of the convergent validity of the adapted IPIP items as indicators of specific trust in doctors/therapists. I will also include the Relationship Assessment Scale (RAS; Hendrick, 1988) adapted separately for friends/intimate partners and family members to evaluate convergent validity of the adapted IPIP items as indicators of specific trust in friends/intimate partners and family members. Participants will be instructed to keep the same friend/intimate partner, family member, or doctor/therapist in mind when completing scales referencing the same person (e.g. IPIP trust items regarding family members and RAS regarding family members).

**Proposed Analysis.** I will use R to conduct statistical analyses for this project. I plan to use path analysis to assess the fit of the hypothesized model. I will first evaluate the model without the trust moderator, examining significance of direct and indirect effects of self-stigma, shame proneness, and self-efficacy on disclosure, and evaluating overall model fit. I will then add trust and the trust\*shame interaction terms into the model to assess potential moderation of trust in the relationship between shame and disclosure.

**Limitations and Contingency Plans.** In our pilot data collection, we found relatively low levels of variability of self-stigma, likely due to the fact that we utilized a nonclinical undergraduate sample. In order to increase the variability of psychological distress and self-stigma in our sample, we plan to recruit only participants with diagnosed mental health conditions in our Prolific sample. However, it remains possible that we lack the variability needed in self-stigma to carry out our planned analyses. Should this happen, I will focus on self-efficacy and shame-proneness as proxy variables for self-stigma. This study is cross-sectional and therefore we will not be able to conclude true mediation.

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