The Usefulness and Effects of Mental Health Diagnoses: Examining Public Stigma and Attitudes about Utility

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Doctorate in Clinical Psychology (DClinPsy)

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Declaration

I declare that the empirical research project and the systematic literature review reported on within this thesis are my own work. The thesis has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology and has not been submitted for any other academic award. The thesis has been checked and is complete.

Emily Fulton-Hamilton

(29.05.22)

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Emily Fulton-Hamilton

Thesis Abstract

Systematic Literature Review

A systematic literature review was undertaken to examine the impact of 'depression' labels on public stigma. Seventeen papers including 19 studies were reviewed and their findings synthesised. The results revealed that the nature of findings within this area are heterogeneous, and the available literature possesses multiple methodological implications. However, there is some initial evidence to suggest that 'depression' labels can function as stigmatising phenomena. These labels do not always induce non-blaming understandings, are ineffective at signalling that a person may require support, and have negative impacts related to employment. The implications of conceptualising 'depression' as an 'illness' and suggestions for future research are discussed.

Empirical Research Project

Given the polarised and heated debates about the usefulness of mental health diagnoses, a Q-methodological study was undertaken with the aim of drawing out more nuanced views. Thirty-nine people who had worked in or accessed mental health services, or were academics within this field, sorted 57 statements about the usefulness of mental health diagnoses based on their viewpoints. Three attitudes were identified. 'The Medicalisation of Human Experience' reflected the view that diagnoses lack validity and are only useful for entities such as pharmaceutical companies. 'Illnesses Like Any Other' encompassed the attitude that diagnoses represent valid disorders and possess utility in relation to various areas. However different diagnoses can be stigmatising when poorly understood by others. 'Imperfect Short-Hands' represented the viewpoint that diagnoses are constructs which offer a general reflection of someone's distress, but their utility varies on a case-by-case basis. The findings offer an alternative to current polarised debates and may support professionals to facilitate open discussions about attitudes towards diagnoses with clients.

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Part 1: Systematic Literature Review

Exploring the Impact of Depression Labels on Public Stigma

Abstract

Background

Globally ‘depression’ remains a commonly given mental health diagnosis despite critiques of the validity, utility, and potentially damaging impacts of this construct. Mental health diagnoses have been linked with evoking stigma from others, yet narratives exist which suggest ‘depression’ may be a less stigmatising diagnosis. A prior review observed mixed findings from a small number of studies with regards to the impact of ‘depression’ labels on stigmatised responses from others. Thus, this review examined the impact of ‘depression’ labels on public stigma.

Method

Twenty papers matched the inclusion criteria following a systematic search of four databases. Seventeen papers covering 19 studies remained after quality appraisal.

Results

The nature of the findings within existing literature are heterogeneous and various methodological considerations have implications for the validity of results. Findings did however suggest that ‘depression’ labels elicited stigmatised responses from others, do not always induce non-blaming understandings, are ineffective at signalling that a person may require support, and have negative impacts for employment.

Discussion

The results offer initial indication that ‘depression’ labels may operate as stigmatising phenomenon and therefore signal some caution with regards to their use. However, due to the various potential confounding factors not considered within all studies, further research is needed to offer a more conclusive indication as to whether the use of ‘depression’ labels should be reconsidered. The results offer implications for concepts such as parity of esteem and anti-stigma campaigns which align psychological distress within illness-based frameworks.

Introduction

In this systematic review I examine the impact of ‘depression’ labels on stigmatised responses from others. The concept of stigma is defined before a summary of literature linking public stigma to mental health diagnoses more broadly is presented. A critical account of depression related diagnoses and narratives about their link with stigma are then considered to contextualise the rationale for the present review.

Public Stigma

Stigma reflects a process whereby an individual is deemed to possess an unfavourable quality which resultantly depreciates the perceived value of that individual (Bos et al., 2013). Societal narratives dictate the aversive views about the appraised difference, and a division is created between the individual who is judged to possess the characteristic and those who are perceived not to (Link & Phelan, 2001). Stigma may manifest as an outward process directed at others with the perceived difference, termed ‘public stigma’, or may present as an experience directed inwards towards the self, known as ‘self-stigma’ (e.g., Sharfstein, 2012). In relation to experiences of psychological distress self-stigma likely stems from an awareness of wider public stigma (Vogel et al., 2013). Self-stigma can have detrimental impacts on a person’s perceptions of their worth or abilities (Corrigan & Rao, 2012) and can lessen support- and information- seeking (Lannin et al., 2016). It has been acknowledged that understandings and conceptualisations of stigma can differ greatly within the research literature (Link & Phelan, 2001), thus for the purpose of focus and to support with the clarity of the review results, only one type of stigma will be considered within this review. As public stigma is likely a precursor for self-stigma, implications for targeting public towards mental health diagnoses may also have a subsequent positive impact on self-stigma related to diagnostic labelling. For these reasons, I will proceed solely to consider public stigma within this review. ‘Public stigma’ was conceptualised as the biased beliefs (stereotypes), emotional experiences (prejudice), and behaviours (discrimination) directed at another individual (Corrigan & Larson, 2008).

Mental Health Diagnoses and Public Stigma

Theoretical Conceptions

Amongst the many problems with conceptualising psychological distress in the form of medicalised diagnoses is recognition of the stigmatising effect that such labels can have (e.g., Pilgrim, 2014). It has been suggested that diagnoses operate as categorising phenomena which artificially inflate the perceived likeness between individuals with the same label (Corrigan, 2007). This may lead to a process of social categorisation where aversion is directed towards those within an ‘out-group’; for example, those labelled with a mental health diagnosis (e.g., Tajfel & Turner, 2004). According to the modified labelling approach, the perception that those labelled with a mental health diagnosis would constitute an out-group originates from negative dominant societal narratives about people deemed to be ‘mentally ill’ (Link et al., 1989). It has been suggested that diagnoses support the impression of normalcy within society via a process of attributing unusual behaviours to those with ‘disorders’ (Harper, 2013). Arguments exist with regards to whether it is the diagnostic label or associated behaviours which induce stigmatised reactions (e.g., Link & Phelan, 2012). The notion that stigma is induced by behaviours connected with specific diagnoses is somewhat problematic given the socially constructed nature of the diagnostic categories (e.g., Georgaca, 2013) and the poor reliability for classing particular thoughts, emotions, or behaviours as ‘symptoms’ (Read, 2013). Thus, the contribution of diagnostic labelling in relation to public stigma warrants examination.

Mental health diagnoses operate within a framework reflective of medicalised phenomenon which may further exacerbate their stigmatising nature (Johnstone & Boyle, 2018); their association with ‘health’ may invoke negative views about the longevity of distress (Corrigan, 2007). Differing theories exist with regards to the impact that the perceived origins of a phenomenon may have on stigmatised responses. For example, genetic essentialism advocates that phenomenon presented as rooted in biology will result in enhanced stigmatisation (e.g., Phelan, 2005), whereas attribution theory suggests that stigma will increase when someone is perceived as having more control of their actions (e.g., Boysen & Vogel, 2008). These contrasting theoretical positions are mirrored within a meta-analysis where biological endorsements of psychological distress lessened attributions of blame, enhanced cynicism that psychological distress would diminish, and did not impact desired social distance (Kvaale et al., 2013). This implies that the relationship between the medicalisation of psychological distress and stigma is not straightforward.

Empirical Reviews and Diagnostic Labelling

Reviews of studies which have used experimental designs to explore the effects of diagnostic labelling on stigmatised responses are valuable as they help to delineate the distinct impact of diagnoses in comparison to control conditions. In a meta-analysis conducted within a criminal justice setting, no differences were observed between various mental health diagnostic labels compared to a ‘psychopathy’ label for outcomes concerning hypothesised danger, penalty endorsements, and the success of interventions (Berryessa & Wohlstetter, 2019). Differences did exist when a ‘psychopathy’ label was contrasted with no label, leading the authors to conclude that any label indicating ‘mental illness’, as opposed to specific diagnoses, results in stigmatised responses within a criminal justice setting (Berryessa & Wohlstetter, 2019). Another review observed that distinct diagnostic labels did invoke different stigmatised reactions: labels associated with ‘attention deficit hyperactivity disorder’, ‘schizophrenia’, ‘autism’, and ‘depression’ yielded mixed findings; ‘bipolar’ induced responses indicative of less stigma; and ‘substance abuse’- and ‘anxiety’-related diagnoses did not influence reactions (O’Connor, et al., 2021). Both reviews acknowledged limits to external validity due to solely including studies which employed vignette methodology.

Depression

Despite ‘depressive disorder’ diagnoses being one of the most common diagnoses globally (Global Burden of Diseases Mental Disorders Collaborators, 2022), to my knowledge, no reviews have solely examined the impact of these diagnoses in relation to public stigma. O’Connor et al. (2021) observed ‘depression’ labels were associated with negative views about functioning at work, mixed responses with regards to the desired distance from an individual, and did not impact outcomes associated with various beliefs, emotional responses, or intent to offer support. However, this review did not include all relevant papers. Another review inclusive of a broader range of diagnostic categories also concluded that ‘depressive disorder’ diagnoses are implicated with public stigma, especially when the target was a child (Parcesepe & Cabassa, 2012). However, this review did not solely include studies which had included control labels, and ‘depression’ was conceptualised as reflecting a ‘real disorder’; impacting upon the interpretations which can be drawn with regards to the impact of labelling.

The definition of ‘depression’ is ambiguous (Pilgrim & Bentall, 1999) and biased towards ‘western’ cultural ideals (Dowrick, 2013). Even among academics who ascribe to the construct, differences exist as to whether ‘depression’ should be conceptualised as distinct from, or on a spectrum with, ‘normal’ experiences (Pilgrim & Bentall, 1999). Diagnostic understandings of ‘depression’ also inhibit consideration of the wider societal, cultural, and contextual factors which can negatively impact mood (Pilgrim & Bentall, 1999). The theory that ‘depression’ is the result of a ‘chemical imbalance’ (e.g., France et al., 2007) remains unfounded, with minimal observed brain differences existing between those who fulfil the diagnostic criteria for depression and those who do not (Winter et al., 2021). The idea that ‘depression’ reflects a biological disorder has been found to negatively impact hope for ‘recovery’ and self-beliefs (Kemp et al., 2014). Despite the many flaws associated with ‘depression’ diagnoses, narratives and research exist which suggest they induce less stigma than other diagnostic categories (e.g., Johnstone & Boyle, 2018; Lee et al., 2016). The relatable experience of low mood in response to situational factors (Cooke & Kinderman, 2018) and the notion that the diagnostic term is not dissimilar from colloquial language (Division of Clinical Psychology, 2015) may provide an explanation for this. However, the review presented by O’Connor et al. (2021) suggests that ‘depression’ labels do have some impact on public stigma, and the chemical imbalance theory has implications for the arguments presented by genetic essentialism (e.g., Phelan, 2005) and attribution theory (e.g., Boysen & Vogel, 2008).

‘Depression’ Label Terminology

In accordance with suggestions that diagnostic labels alone may induce stigmatised responses (e.g., Link & Phelan, 2012), this review examined the impact of labels reflective of a diagnosis of ‘depression’. Although it is acknowledged that differences exist with regards to how this diagnosis is conceptualised (e.g., Pilgrim & Bentall, 1999), this review was concerned with the impact of the language (the label) which is used to connote a diagnosis of ‘depression’ irrespective of how ‘depression’ is understood in this regard. The notion that the word ‘depression’ is also associated with colloquial language (e.g., Division of Clinical Psychology, 2015) presents a challenge to reviewing the literature within this area due to possible conflations between ‘depression’ labels signalling a diagnosis or a conversational expression. However, it is noted that within the Diagnostic and Statistical Manual of Mental Disorders, Version 5 (American Psychiatric Association, 2013) the term ‘depression’ is used to indicate the category of diagnoses reflecting ‘depressive disorders’. Therefore this review will examine all labels associated with the term ‘depression’ due to the possible associations that these terms may have with a diagnosis.

Review Aims

In undertaking this review, I aimed to elucidate the impact that ‘depression’ labels have on public stigma responses. The juxtapositions between ‘depression’ being a commonly received diagnosis yet possessing poor evidence as a diagnostic construct, and the narrative that it may be a less stigmatising diagnosis not being firmly replicated within initial reviews (e.g., O’Connor et al., 2021), highlighted that exploration within this area was warranted. It was hoped that assessing the impact of ‘depression’ labels on public stigma responses would offer insights into to the implications of assigning ‘depression’ diagnoses within clinical practice.

Method

Search Strategy

Four electronic databases (APA PsycInfo, Medline, Scopus and Web of Science) were systematically searched on 12 November 2021. The PICO tool (e.g., Thomas et al., 2021), the search terms implemented by O’Connor et al. (2021), and a prior scoping literature search assisted the generation and employment of the following search string: (Anxiety* OR depress* OR OCD* OR “Obsessive Compuls*” OR “Eating Disorder” OR Schizophren* OR “Personality Disorder*” OR bipolar* OR Psychiatr* OR “mental illness*” OR “mental disorder*” OR “Mental Health*”) AND (label* OR diagnos*) AND (stigma* OR discrimin* OR prejudice* OR stereotyp*) AND (vignette* OR video* OR watch* OR audio* OR listen* OR computer* OR experiment* OR task*). The decision to focus on ‘depression’ as opposed to mental health diagnoses more broadly was made after the search, hence the broad range of diagnostic labels within the search string. The initial scope of the review was to investigate public stigma responses to mental health diagnostic labels more broadly, however this literature search yielded a high number of studies which appeared diverse in nature. Examples of this variability included study populations, the control and experimental labels used, the stigma outcomes assessed, and the assessment methods and methodologies employed by the studies. It therefore felt more beneficial to focus the review towards one category of diagnostic label in an attempt to synthesise the literature more meaningfully with regards to public stigma responses. Thus for reasons previously cited within the introductory section, I decided to focus the review on stigmatised responses towards ‘depression’ labels. Filters were applied where feasible, to return fully published peer-reviewed journal articles written in English with human participants. Duplicates were removed from the 7,885 initial returns, resulting in the screening of titles and abstracts for 4,953 articles against the inclusion criteria (Table 1).

Table 1

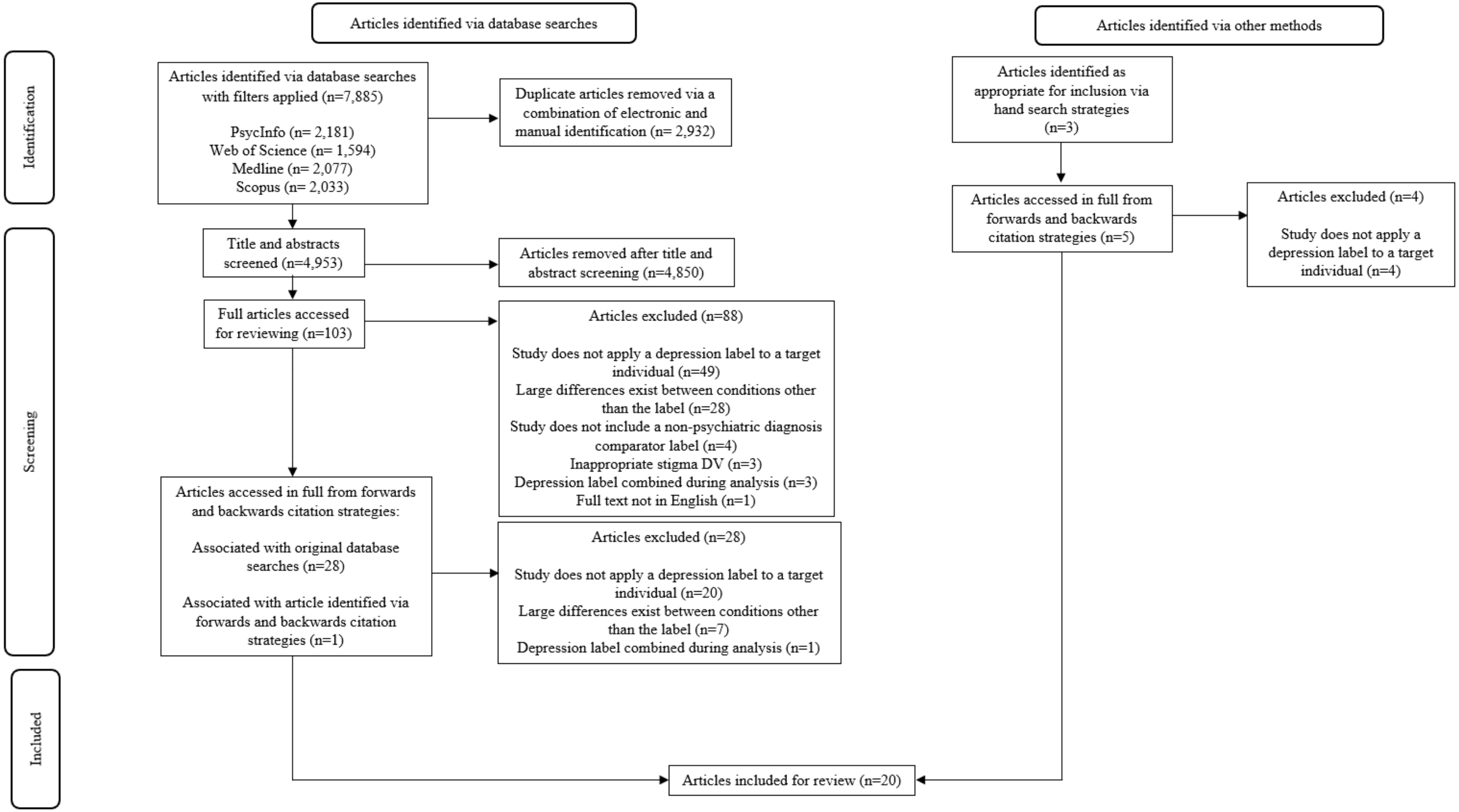
Inclusion Criteria and PICO

PICO Component	Inclusion Criteria	Exclusion Criteria
Population	Human participants. Labelled individual is an adolescent / adult.	Non-human participants. Labelled individual is an infant / child.
Intervention	Primary research, experimental designs – manipulation of whether an individual is given a ‘depression’ label.	Studies pooling the data from different experimental labels within analyses so individual ‘depression’ label results are not presented.
Comparison	Manipulation of whether an individual is given an alternative label.	Comparator labels consisting of different mental health diagnoses. Significant manipulation of other factors between conditions.
Outcome	Quantitative data linked to public stigma directed at an individual: stereotypes (beliefs), prejudice (emotional responses), discrimination (behavioural responses).	Self-stigma / qualitative data.

The online programme ‘Rayyan’ (Ouzzani et al., 2016) supported coding of papers against the inclusion criteria. After the title and abstracts were screened, 103 articles were retrieved and reduced to 15 after full text screening against the inclusion criteria. A further two articles were identified through forwards and backwards citation strategies, and three were identified via handsearching related literature. It was noted that very few studies had used a specific, formal ‘depression’ diagnosis which supported the decision to include studies which considered all labels associated with the language of ‘depression’. Figure 1 depicts the PRISMA diagram (Page et al., 2021).

Figure 1

PRISMA diagram documenting the search procedure.



Data Extraction and Quality Appraisal

A data extraction tool (Appendix A) was designed using information from Li et al. (2021). Quality appraisal was undertaken using the ‘Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields’ (Kmet et al., 2004, Appendix B). This tool was selected due to its suitability for employment with quantitative studies which contain heterogeneous designs and methodologies. The tool yields a score between 0 and 1; higher scores indicate better quality. A score of ≤0.55 was utilised as a lenient criterion (Kmet et al., 2004) for the exclusion of studies, resulting in three papers being removed. Nineteen studies across 17 papers were retained for review. See Appendix C for the quality appraisal scores.

Results

Study Characteristics

Study Properties & Participant Information

The studies were published between 1998 and 2020 and included a total of 6792 participants. All were conducted in the Global North. Females accounted for 54.67 percent of participants, 45.30 percent were male, and the gender of 0.03 percent were unreported. Based on the studies that reported age data, participant ages ranged from 18 to 88 years with a mean of 35.20 years. Participant ethnicity was unreported for over half of participants (56.33 percent) and when it was reported, participants were predominantly from an ethnic-white majority group (66.12 percent).

Manipulation of the Independent Variables

The studies attributed various ‘depression’ labels to characters for experimental purposes; these are listed in Table 2 alongside control labels. The latter included terms indicative of psychological distress (e.g., ‘stress at work’, ‘grief symptoms’) and descriptors linked with physical health (e.g., ‘diabetes’, n=4; ‘migraine’, n=2). Indications that a person was ‘healthy’ or had no difficulties (n=8), and no label (n=6) were also used as comparator conditions.

Most studies manipulated the label assigned to an individual within a written vignette using between-subjects designs (n=16). Two studies involved participants being made to believe they were interacting with another individual during a computer-task, when in fact responses had been pre-programmed. Three studies employed within-subject designs through manipulating the labels assigned to photographs of faces.

Assessment of Stigma

Stigma responses were mostly assessed using self-report questionnaires (n=15). Fourteen studies employed bespoke measures and four used or adapted established measures. The studies mostly reported acceptable psychometric properties for the measures, with one subscale possessing unacceptable psychometric properties (see Appendix D). Behavioural measures of stigma were employed by four studies. In one study, this involved monitoring how often participants altered their own answer after viewing the fictitious labelled individuals answer within a computer-task or observing the frequency in which participants opted to attend the same future study timeslot as the fictitious individual (Lucas & Phelan, 2019). Researchers presumed that fewer altered answers and less frequent selection of the same timeslots as a function of a manipulated label would provide evidence of stigma. Three studies assessed stigma by monitoring the types of errors participants made when attempting to identify a previously seen face from a pool of photographs of the same individual displaying different facial expressions (Cassidy & Krendl, 2018). Stigmatisation was deemed to have occurred when participants systematically selected incorrect faces as a function of the label presented. See Table 2 and Appendix E for more information about the study characteristics.

Table 2

Study Characteristics.

Author	Country	Participant Information	Experimental Labels	Control Labels	Manipulation of Independent Variables	Assessment of Public Stigma
Abdullah & Brown (2019)	USA	n=106 Public	‘Major depressive disorder’	‘Stress at work’	Written vignette (distress behaviours present)	Social distance scale (Link et al., 1987); Attributions questionnaire-20 (Brown, 2008)
Cassidy & Krendl (2018) – Study 1A	USA	n=200 Public	‘Depression’	‘Healthy’	Photographs of faces	Behavioural measure
Cassidy & Krendl (2018) – Study 1B	USA	n=185 Public	‘Depression’	‘Healthy’ / ‘migraines’	Photographs of faces	Behavioural measure
Cassidy & Krendl	USA	n=189 Public	‘Depression’	‘Healthy’ / ‘migraines’	Photographs of faces	Behavioural measure

(2018) – Study 2						
Cormack & Furnham (1998)	UK	n=117 Students	'Depressive'	No label	Written vignette (distress behaviours present)	Bespoke questionnaire
Cuttler & Ryckman (2019)	USA	n=450 Public	'Major depressive disorder' / 'depressed'	No label	Written vignette	Bespoke questionnaire
Dixon et al. (2008)	UK	n=1081 Medical students	'Depression'	'Good health' / 'diabetes'	Written vignette (distress behaviours present)	Bespoke questionnaire (adapted from Lawrie et al., 1998)
Glozier et al. (2006)	UK	n=117 Nurses	'Depression'	'Diabetes' / 'alcohol problems'	Written vignette (distress behaviours present)	Bespoke questionnaire
Gonschor et al. (2020)	Germany	n=852 Public	'Depressive episode' diagnosis	'Grief symptoms'	Written vignette (distress behaviours present)	Bespoke questionnaire based on Eisma (2018) and Eisma et al. (2019); Emotional

						reactions to mental illness scale (Angermeyer & Matschinger, 2003) – adapted; Social distance scale (Angermeyer & Matschinger, 2003; Link et al., 1987) – German version
Hipes & Gemoets (2019)	USA	n=830 Public	‘Depression’	No label	Written vignette	Bespoke questionnaire; Requisite management traits (Schein, 1973); Social Distance Scale (Link et al., 1987) – adapted
Kroska et al. (2014)	USA	n=110 Students	‘Hospitalised for depression’	‘No hospitalisation’	Computer-task interaction (fictional partner)	Bespoke questionnaires
Lawrie (1999)	UK	n=103 Public	‘Depression’	‘Healthy person’ / ‘diabetes’	Written vignette (distress behaviours present)	Bespoke questionnaires

Lawrie et al. (1998)	UK	n=166 Primary care practitioners	‘Depression’	‘Good health’ / ‘diabetes’	Written vignette (distress behaviours present)	Bespoke questionnaire
Lucas & Phelan (2019)	USA	n=184 Undergraduates	‘Hospitalised in the last 12 months for depression’	‘No hospitalisation’	Computer-task interaction (fictional partner)	Behavioural measure
Mendel et al. (2015)	Germany	n=748 Managers	‘Depression’	‘Burnout’ / ‘private crisis’ / ‘disease of the thyroid’	Written vignette (distress behaviours present)	Bespoke questionnaire
Selezneva & Batho (2019)	Canada	n=162 Students	‘Depression’	‘No label’	Written vignette	Bespoke questionnaire
Szeto et al. (2013)	Canada	n=124 Students	‘Depression’	‘Mental disease’ / ‘mental disorder’ / ‘mental health	Written vignette	Bespoke questionnaire; Social distance measure (previously used by Bogardus, 1992; Norman et al., 2008)

				problem’ / ‘mental illness’		
Thibodeau et al. (2015) – Study 2	USA	n=847 Public	‘Depression’	No label / ‘neurological disorder’	Written vignette (distress behaviours present)	Bespoke questionnaire; Empathy scale (Campbell & Babrow, 2004) – adapted
Wadley & Haley (2001)	USA	n=221 Psychology students	‘Major depression’	No label / ‘Alzheimer's disease’	Written vignette (distress behaviours present)	Bespoke questionnaire

Findings

Findings are grouped by dependent variables (see Appendix F for a summary of results for each study). Extraneous methodological considerations which may have impacted stigma responses are also briefly considered.

Danger and Threat

Mixed findings were reported with regards to whether an individual with a ‘depression’ label was conceptualised in a significantly more threatening manner compared to those without this label. Three studies observed this effect (Cassidy & Krendl, 2018; Cuttler & Ryckman, 2019; Dixon et al., 2008) and three studies did not (Abdullah & Brown, 2019; Hipes & Gemoets, 2019; Lawrie et al., 1998). The effect sizes noted by Cuttler and Ryckman (2019) and Cassidy and Krendl (2018) both reflect small to medium, and medium to large, effects. The mixed findings cannot be attributed to differing comparator labels as most comparators yielded both significant and non-significant results. ‘Depression’ labels did not evoke significantly more fear for participants (Abdullah & Brown, 2019; Gonschor et al., 2020) or enhance beliefs that an individual would require enforced treatment (Abdullah & Brown, 2019) compared to labels depicting general psychological distress.

Inconsistent results were also observed with regards to whether a ‘depression’ label elicited safety concerns about an individual caring for children compared to ‘diabetes’ or ‘good health’ comparators. One study reported significantly more concerns in the presence of a ‘depression’ label (Dixon et al., 2008), one reported no significant differences (Lawrie, 1999), and another found that a ‘depression’ label evoked more concerns in comparison to a ‘diabetes’ label but not a ‘healthy’ comparator (Lawrie et al., 1998). These inconsistencies may reflect safeguarding concerns being more salient when participants were healthcare professionals or studying medicine (Dixon et al., 2008; Lawrie et al., 1998) compared to when participants were members of the public (Lawrie, 1999).

Interactions and Proximity with Others

When studies used written vignettes to investigate preferred social distance or views about social interactions with an individual, largely no significant differences were observed between depression and control conditions (Abdullah & Brown, 2019; Cormack & Furnham, 1998; Gonschor et al., 2020; Hipes & Gemoets, 2019; Lawrie, 1999; Szeto et al., 2013; Wadley & Haley, 2001). Only one study employing a written vignette observed that a label of ‘major depressive disorder’ enhanced desired social distance from an individual compared to a descriptor of ‘stress at work’ (Abdullah & Brown, 2019). Although Szeto et al. (2013) found a non-significant result, the medium to large effect size for the difference between the ‘depression’ and ‘mental health problem’ condition suggested the possibility that the depression condition would have been significantly associated with enhanced social distance if the sample had been larger. In studies where participants believed they were interacting with a ‘real’ person, significantly more social distance was observed in response to a ‘depression’ label (Kroska et al., 2014); specifically, participants were less likely to offer their name (Kroska et al., 2014) or select the same future study timeslot as their fictional partner (Lucas & Phelan, 2019). However, no significant differences were observed across labelling conditions with regards to whether participants expressed a desire to meet socially with, or supply their email address to, an individual (Kroska et al., 2014). These results perhaps indicate that ‘depression’ labels operate differently in scenarios indicating different levels of social contact. The differences in desired social distance between studies where participants believed they were interacting with a ‘real’ individual and those that employed written vignettes may reflect the impact of social desirability bias associated with the latter design.

‘Depression’ labels did not significantly impact the view that an individual would be embarrassing (Cuttler & Ryckman, 2019) nor participants’ anticipation of pleasurable emotions linked to interactions with an individual (Dixon et al., 2008; Lawrie et al., 1998; Lawrie, 1999). In one exception, medical students expressed significantly less contentment about having a patient labelled with ‘depression’, compared to a ‘healthy’ patient, on their caseload (Dixon et al., 2008). As differences in contentment were not observed when ‘diabetes’ and ‘depression’ labels were compared (Dixon et al., 2008), it is plausible that the ‘healthy’ comparator label is responsible for this effect. The influence of comparator labels is also evidenced by participants reporting they would be significantly more likely to lend sugar to an individual with ‘depression’ as opposed to ‘diabetes’ (Lawrie, 1999).

A ‘depression’ label resulted in greater intent to offer a hot drink to an individual (Lawrie, 1999) and being more open to a relative moving in (Wadley & Haley, 2001) compared to controls of ‘healthy’ or no label, respectively. In contrast, other studies observed that a ‘depression’ label resulted in less desire for a relative to join a family holiday compared to a label of ‘Alzheimer’s Disease’ (Wadley & Haley, 2001), judgements that someone would be less happy (Cassidy & Krendl, 2018; Cuttler & Ryckman, 2019) and less likeable (Cuttler & Ryckman, 2019), and no difference in perceptions of warmth compared to a label depicting ‘grief symptoms’ (Gonschor et al., 2020). Although significant findings for judgements of happiness and likeability were not consistently replicated across all studies or conditions (Cassidy & Krendl, 2018; Kroska et al., 2014), significant findings may reflect that ‘depression’ labels evoke a perceived duty of care as opposed to signalling a likely enjoyable and desirable interaction.

Sympathy and Attributed Responsibility

Two studies containing distress-related descriptions within the written vignettes found that a ‘depression’ label evoked increased sympathy compared to comparators indicating ‘good health’, ‘diabetes’, or no label (Dixon et al., 2018; Wadley & Haley, 2001), and less anger compared to no label (Wadley & Haley, 2001). This may initially appear to reflect that a ‘depression’ label supports the development of a non-blaming understanding of a person’s distress. However, significant effects related to these outcomes were not observed in other studies with comparators including ‘grief symptoms’, ‘healthy’, ‘diabetes’, no label, ‘neurological disorder’, and ‘stress at work’ (Abdullah & Brown, 2019; Gonschor et al., 2020; Lawrie et al., 1998; Lawrie, 1999; Thibodeau et al., 2015). Additionally, one study found that ‘depression’ labels evoked more anger and less sympathy compared to an ‘Alzheimer’s disease’ descriptor (Wadley & Haley, 2001).

When ‘depression’ labels were compared with no label (Cuttler & Ryckman, 2019) or terms implying psychological distress (Mendel et al., 2015) largely no differences were observed for the perceived agency, influence, or responsibility an individual possessed in relation to their psychological distress. Exceptions to this included diminished responsibility being assigned to someone with a ‘depression’ label compared to no label (Thibodeau et al., 2015), and views that someone labelled with ‘depression’ would be more likely to experience similar future difficulties compared to those experiencing a ‘private crisis’ (Mendel et al., 2015). However, the ‘private crisis’ label in the latter study may signal an isolated event. In contrast, when compared to physical health comparators including ‘thyroid disease’ (Mendel et al., 2015) and ‘Alzheimer’s disease’ (Wadley & Haley, 2001), ‘depression’ labels increased attributions of agency, responsibility, and perceptions that distress would occur again. However, no differences were observed in the responsibility assigned to an individual with a ‘depression’ label compared to a ‘neurological disorder’ descriptor (Thibodeau et al., 2015). The contrasting results for outcomes concerning anger, sympathy, responsibility, and perceived agency when the comparators ‘neurological disorder’ (Thibodeau et al., 2015) and ‘Alzheimer’s disease’ (Wadley & Haley, 2001) were used is of interest as both control labels are associated with brain-based phenomena. The studies report differences as to whether participants conceptualised ‘depression’ as a ‘psychological’ or ‘biological’ phenomenon

(Thibodeau et al., 2015; Wadley & Haley, 2001). For example, both studies reported that the presence of ‘depression’ labels enhanced perceptions of medicalised understandings of this diagnosis, however within the Wadley and Haley (2001) study, psychological causes were generally assigned to ‘depression’ more so than ‘Alzheimer’s disease’. This suggests that different conceptualisations of ‘depression’ may have different effects upon stigmatised responses to this label.

Interventions and Distress Management

Within a healthcare context, ‘depression’ labels often resulted in participants reporting greater inclination to refer a person for talking therapy compared to labels indicating ‘good health’ (Dixon et al., 2008) or ‘diabetes’ (Dixon et al., 2008; Lawrie et al., 1998). However, Lawrie et al. (1998) did not observe a significant difference when comparing ‘depression’ and ‘healthy’ labels. This discrepancy may represent a shift in access to mental health support becoming more governed by diagnoses since this study was undertaken. ‘Depression’ labels were significantly more likely to signal medicalised interventions such as antidepressants (Lawrie et al., 1998), and did not impact whether advice surrounding healthy lifestyles would be offered (Dixon et al., 2008; Lawrie et al., 1998). A ‘depression’ label did not result in significant differences in clinicians’ intentions to liaise with other healthcare professionals or specialist services compared to ‘healthy’ comparator labels (Dixon et al., 2008; Lawrie et al., 1998) and significantly reduced chances of a specialist healthcare referral compared to a label of ‘diabetes’ (Dixon et al., 2008; Lawrie et al., 1998). Discrepant findings were observed as to whether a ‘depression’ label significantly increased professionals’ intention to liaise with a patient’s prior doctor (Dixon et al., 2008) or had no impact on this (Lawrie et al., 1998) compared to a ‘diabetes’ label.

Studies consistently observed no significant difference in judgements of a patient’s adherence to treatment when using ‘healthy’ comparator labels and found no impact on the hypothesised time a patient would require compared to ‘diabetes’ (Dixon et al., 2008; Lawrie et al., 1998). One study observed that individuals labelled with ‘depression’ elicited lower expectations in terms of treatment adherence compared to those with ‘diabetes’ labels and were regarded as more time consuming than those labelled as ‘healthy’ (Dixon et al., 2008). However, no differences were observed for these outcomes compared to these labels in another study (Lawrie et al., 1998). It is possible that the differing outcomes between these two studies may be linked to samples consisting of general practitioners (Lawrie et al., 1998) and medical students (Dixon et al., 2008).

When participants were not associated with healthcare contexts, no significant differences were observed in relation to perceptions about an individual’s capacity to manage their own difficulties, the support they may require, or their emotional stability compared to control labels which included ‘healthy’, ‘diabetes’, ‘burnout’, ‘private crisis’, and ‘grief symptoms’ (Gonschor et al., 2020; Lawrie, 1999; Mendel et al., 2015;). Gonschor et al. (2020) found that those labelled with ‘depression’ were judged to be less dependent compared to those labelled as experiencing ‘grief symptoms’. Together these findings may suggest that ‘depression’ labels are not helpful at signalling the support that someone may require. The only scenario where this differed was within a workplace context, where individuals with ‘depression’ descriptors were considered as requiring additional support at work compared to those with ‘thyroid disease’ (Mendel et al., 2015). Inconsistencies were reported with regards to the impact of ‘depression’ labels on perceived use of drugs and alcohol (Dixon et al., 2008; Lawrie et al., 1998; Lawrie, 1999).

Employment

A ‘depression’ label significantly reduced the chances of someone being recommended for employment compared to when no label was present (Selezneva & Batho, 2019). In other findings ‘depression’ labels induced significantly more negative ratings of characteristics which may be implicated with employment prospects, including perceived competence, assertiveness, confusion, organisational skills, and reliability (Cuttler & Ryckman, 2019; Hipes & Gemoets, 2019). However, perceptions of increased incompetence in the presence of a ‘depression’ label were not consistently replicated (e.g., Cuttler & Ryckman, 2019; Gonschor et al., 2020), and no differences were observed for the frequency in which participants altered their own answer after seeing a fictional partner’s answer during a task (Lucas & Phelan, 2019). This latter result reflects that a ‘depression’ label did not impact how influential an ‘individual’ was in relation to the behaviours of others (Lucas & Phelan, 2019).

When appraising characters situated within a workplace context, differences were apparent dependent upon the comparator labels used. ‘Depression’ labels evoked less workplace concerns compared to a label of ‘alcohol problems’ (Glozier et al., 2006), and enhanced perceptions that someone would cope within a demanding environment compared to a label of ‘burnout’ (Mendel et al., 2015). No differences were observed for the latter result when comparing ‘depression’ labels to a ‘private crisis’ comparator (Mendel et al., 2015). Differences were also not present for perceptions of sickness absences or leadership abilities when comparing ‘depression’ labels to ‘burnout’ or ‘private crisis’ control conditions (Mendel et al., 2015). However, when compared to physical health comparators, ‘depression’ labels resulted in perceptions that an individual would be less able to manage workplace stressors, less capable of undertaking a leadership role, would have more absences from work (Mendel et al., 2015), and elicited enhanced workplace concerns (Glozier et al., 2006). ‘Depression’ labels had no impact on perceptions that a manager should adjust their demeanour with an individual (Mendel et al., 2015), which aligns with results showing that ‘depression’ labels did not impact appraisals of an individual’s sensitivity (Gonschor et al., 2020).

Extraneous Methodological Considerations

It is important to attend to additional factors unrelated to the manipulation of ‘depression’ labels which may have impacted stigmatised responses. Nuances associated with depression terminology alongside characteristics associated with participants and the labelled individual are briefly considered.

Depression Terminology. One study investigated whether different terminology used to connote ‘depression’ labels was associated with different stigma responses (Cuttler & Ryckman, 2019). The authors observed that judgements of likeability and happiness were significantly poorer when an individual was described as ‘depressed’ compared to having ‘major depressive disorder’. Furthermore, an individual was rated as significantly less likeable when they were described as ‘depressed’ compared to when no label was given, however this difference was not observed when a descriptor of ‘major depressive disorder’ was used. The opposite of this was observed for ratings of aggression where ‘major depressive disorder’ enhanced perceptions of aggression compared to the no label condition, but the label ‘depressed’ did not. Although these effects were not observed for all perceived characteristics explored by this study, these results highlight that different terminology associated with depression labels may impact public stigma differently. This has implications for the review as multiple different depression labels were used across the studies, and no other study explicitly examined the impacts of using certain labels or language with regards to ‘depression’ labels.

Individual Characteristics. Certain studies investigated whether characteristics associated with participants, or the labelled individual influenced stigmatised responses. Characteristics explored included, age, gender, ethnicity, educational status, own experiences of psychological distress, contact with people who have experienced mental health difficulties, job-related information, political views, relationships with family, and judgements of own power. Character judgements and the manipulation of whether behaviours presented by the labelled individual were usual for them were also investigated. Results varied as to whether these characteristics did influence stigma responses or had no effect, and the specific stigma outcomes impacted alongside the direction of these effects were not consistent across studies (Cassidy & Krendl., 2018; Cormack & Furnham, 1998; Dixon et al., 2008; Glozier et al., 2006; Gonschor et al., 2020; Hipes & Gemoets, 2019; Kroska et al., 2014; Lawrie et al., 1998; Lawrie, 1999; Lucas & Phelan, 2019; Thibodeau et al., 2015; Wadley & Haley, 2001). However, when one study accounted for certain participant factors which were significantly related to stigma outcomes within analyses, differences in stigma responses between the 'diabetes' and 'depression' labelled vignettes were no longer significant (Glozier et al., 2006). As not all studies considered the potential impacts of such characteristics, and the demographics of participants in some studies were homogeneous or unreported, it is possible that some results may be confounded by factors associated with participants or the labelled individual.

Discussion

In this systematic review I explored the impact of 'depression' labels on public stigma responses by examining the results from 19 studies across 17 papers. The findings are considered in relation to existing theory and research, and limitations of the review and suggestions for future research are discussed. Clinical implications are presented before concluding remarks are made.

Review Findings, Existing Theory and Research

The results somewhat emulate prior mixed findings with regards to the impact of 'depression' labels on stigmatised responses from others (O'Connor et al., 2021), however some evidence is presented which suggests that 'depression' labels do reflect stigmatising phenomena. In some cases, 'depression' labels enhanced perceptions of threat, desired social distance, and likely signalled a perceived duty of care as opposed to an inherent enjoyable interaction with an individual. The labels did not always elicit non-blaming understandings or communicate that an individual would need support and tended to signal medicalised as opposed to holistic interventions within a healthcare context. They also had damaging impacts on employment prospects and induced stigma responses in samples consisting of various individuals, including those associated with healthcare. The results highlight the heterogeneous nature of the research within this area and allow comparisons between studies employing different types of methodology and assessment measures. This was particularly salient for social distance and threat-related outcomes which were more likely to yield significant results when study designs possessed more ecological validity and minimised the impact of social desirability bias by employing behavioural assessments or perceived interactions with a ‘real’ individual. Although an adjunct to the focus of the review there was some indication that characteristics associated with the labelled individual or participants may impact public stigma in relation to depression labels. Future reviews could further explore this, for example by investigating phenomenon such as intersectionality (e.g., Oexle et al., 2018) or how the socialisation of individuals possessing different characteristics may impact views about ‘depression’ (e.g., Pilgrim & Bentall, 1999).

A general pattern amongst the findings was that ‘depression’ labels often did not enhance public stigma compared to generic labels indicating psychological distress but appeared to evoke greater stigmatisation in contrast to physical illness controls. This was especially apparent for outcomes related to employment. This may suggest that ‘depression’ labels are conceptualised similarly to general terms indicative of psychological distress, somewhat mirroring prior reviews where different terms suggestive of ‘mental illness’ did not produce different stigma responses (Berryessa & Wohlstetter, 2019). The perceived distinction between physical health and ‘depression’ labels has been previously evidenced where primary care professionals reported recording a physical health label instead of a depression diagnosis for patient complaints (Rost et al., 1994). Stigmatising associations and hypothesised future negative consequences linked with depression diagnoses were among explanations offered for this (Rost et al., 1994). As the distinction between ‘depression’ labels and physical illness controls was especially apparent within workplace contexts, employment guidelines suggesting that the same strategies should be used to support mental health and physical health, and references to concepts such as parity of esteem (e.g., Farmer & Stevenson, 2017) are particularly problematic. Ramifications are also evident for anti-stigma campaigns which attempt to conceptualise ‘mental illnesses’ within the same realm as physical illnesses; the problems with which have already been documented with regards to ‘schizophrenia’ (Read et al., 2006).

It is important to acknowledge that the differential stigmatised responses towards ‘depression’ labels and physical health descriptors were not consistently observed within all studies (e.g., Thibodeau et al., 2015). As discussed, this may reflect a difference in whether ‘depression’ was conceptualised by participants as a biological phenomenon or not. Potential differences in how ‘depression’ was conceptualised may help to explain the divergent outcomes observed in samples consisting of healthcare professionals or medical students, compared to the public (e.g., Dixon et al., 2008; Lawrie et al., 1998; Lawrie 1999). Indeed, research has evidenced that psychiatrists attribute biological understandings significantly more, and psychological understandings significantly less, to ‘depression’ in comparison to the public (Butlin et al., 2019). Furthermore, the differences observed for certain stigma outcomes when different labels connoting ‘depression’ were used (Cuttler & Ryckman, 2019) may also reflect a difference in whether these terms communicated a biological aetiology of ‘depression’ or not. However, a definitive illustration of the overall influence of how participants understood ‘depression’ within this review is difficult to discern as only four studies explicitly considered this (Cormack & Furnham, 1998; Szeto et al., 2013; Thibodeau et al., 2015; Wadley & Haley, 2001). Similarly, it is difficult to fully explore the impact of different ‘depression’ labels on stigmatised responses across the studies within this review as only one study explicitly considered this (Cuttler & Ryckman, 2019). Due to the many areas of heterogeneity between the studies it would also be difficult for this review to discern whether differences in stigmatised outcomes across studies are due to different ‘depression’ labels or another differing factor. This reflects that future investigation into possible associations between different depression labels, public stigma responses, and how depression is conceptualised by individuals would be of value. Although the results of this review suggest that further investigation into these aspects would be of use, prior research has observed that different conceptualisations of ‘depression’ can both have negative impacts on stigma. Whilst biological understandings of ‘depression’ may decrease blame, they also reduce perceived influence over distress management, with the reverse being evident for non-biological understandings (Deacon & Baird, 2009; Hoffman & Addis, 2021). This also reflects the positions adopted by both attribution theory (e.g., Boysen & Vogel, 2008) and genetic essentialism (e.g., Phelan, 2005).

Limitations and Suggestions for Future Research

Although the results of the review do suggest that ‘depression’ labels can reflect stigmatising phenomenon there are multiple limitations associated with the available literature. Stigma outcomes investigated within the literature were not homogenous and were often assessed using single items, which has implications for construct validity. Additionally, not all studies attended to the impact of potential moderating factors such as participant characteristics or features associated with the labelled individual. Despite their contested nature (e.g., Galatzer-Levy & Galatzer-Levy, 2007; Pilgrim, 2014) no study investigated participants’ views about the use of psychiatric diagnoses to conceptualise psychological distress. Six different ‘depression’ labels were used across the studies, only one study explicitly explored the impact of different ‘depression’ labels on stigmatised responses, and few explored how participants conceptualised ‘depression’. The importance of these aspects is highlighted by findings indicating that different ‘depression’ labels do have different impacts on stigma responses (Cuttler & Ryckman, 2019). Furthermore, no studies employed designs involving face-to-face contact with a labelled individual, and few used behavioural methods to assess stigma responses. Future research should prioritise attention to these aspects to establish greater clarity surrounding the validity of results, and to further elevate understandings about the impact of ‘depression’ labels on public stigma.

Clinical Implications

It is acknowledged that mental health services in the UK are largely structured around mental health diagnoses, so depression diagnoses may be perceived to possess value and utility in supporting navigation into these services; although evidence suggests this is not always the case (Allsopp & Kinderman, 2021). However, this review offers some initial indication that ‘depression’ labels can signal negative and potentially harmful stereotypes, have undesirable effects on career prospects, and are unhelpful at signalling that support may be required. The aforementioned suggestion for further investigations into the potential confounding factors which may be implicated with stigmatised responses to ‘depression labels’ may provide stronger indications as to whether it would be more helpful to understand experiences of low mood via a framework that does not involve diagnostic labelling. One such alternative could be via psychological formulations, which support to decrease the distinctions imposed by psychiatric diagnoses (Corrigan 2007; Johnstone, 2018). For example, the Power Threat Meaning Framework (Johnstone & Boyle, 2018) could support mental health services, clinicians, and anti-stigma campaigns to attend to contextual factors operating at a societal and community level which can have a negative impact on someone’s mood. Evidence has shown that using the Power Threat Meaning Framework to understand why someone experienced psychosis induced significantly less social distance reactions compared to a diagnosis of ‘schizophrenia’ (Seery et al., 2021), and this model has already gained traction in relation to considering service transformation (e.g., Collins et al., 2022; Read & Harper, 2020). These suggested clinical implications would be contingent upon the suggestions for further investigations identified by this review.

Conclusion

In this review I synthesised the findings from 19 studies across 17 papers to explore the impact of ‘depression’ labels on public stigma. Although the literature and outcomes can appear heterogeneous, evidence does offer initial indications that ‘depression’ labels can reflect categorising and stigmatising phenomenon and should perhaps be used with caution. Implications for championing concepts such as parity of esteem are raised due to ‘depression’ diagnoses largely appearing to be conceptualised in a manner distinct to physical health diagnoses in relation to stigma. To promote greater clarity surrounding the impact of ‘depression’ labels on public stigma, future research would benefit from attending to the various extraneous factors highlighted within this review which may impact on the stigma outcomes being assessed. This further research may offer additional indications as to whether more individualised approaches such as the Power Threat Meaning Framework (Johnstone & Boyle, 2018) should be used to support understandings of experiences of low mood as opposed to diagnostic labels.

References

(*=included in review)

*Abdullah, T., & Brown, T. L. (2019). Diagnostic labeling and mental illness stigma among Black Americans: An experimental vignette study. *Stigma and Health*, *5*(1), 11-21.

Allsopp, K., & Kinderman, P. (2021). The use of diagnoses in mental health service eligibility and exclusion criteria. *Journal of Mental Health*, *30*(1), 97-103.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, *108*(4), 304-309.

Berryessa, C. M., & Wohlstetter, B. (2019). The psychopathic “label” and effects on punishment outcomes: A meta-analysis. *Law and human behavior*, *43*(1), 9-25.

Bogardus, E. S. (1992). Social distance and its origins. *Journal of Applied Sociology, 9,* 216-226.

Bos, A. E., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and applied social psychology*, *35*(1), 1-9.

Boysen, G. A., & Vogel, D. L. (2008). Education and mental health stigma: The effects of attribution, biased assimilation, and attitude polarization. *Journal of Social and Clinical Psychology*, *27*(5), 447-470.

Brown, S. A. (2008). Factors and measurement of mental illness stigma: a psychometric examination of the Attribution Questionnaire. *Psychiatric rehabilitation journal*, *32*(2), 89.

Butlin, B., Laws, K., Read, R. et al. (2019). Concepts of mental disorders in the United Kingdom: Similarities and differences between the lay public and psychiatrists. *International Journal of Social Psychiatry*, *65*(6), 507-514.

Campbell, R. G., & Babrow, A. S. (2004). The role of empathy in responses to persuasive risk communication: Overcoming resistance to HIV prevention messages. *Health communication*, *16*(2), 159-182.

*Cassidy, B. S., & Krendl, A. C. (2018). Believing is seeing: Arbitrary stigma labels affect the visual representation of faces. *Social Cognition*, *36* (4), 381-410.

Collins, G., Fyson, R., Morgan, G. et al. (2022). The power threat meaning framework: development of a document for use in intellectual disabilities services. *The Bulletin of the Faculty for People with Intellectual Disabilities*, *20*(1).

Cooke, A., & Kinderman, P. (2018). “But what about real mental illnesses?” Alternatives to the disease model approach to “schizophrenia”. *Journal of humanistic psychology*, *58*(1), 47-71.

*Cormack, S., & Furnham, A. (1998). Psychiatric labelling, sex role stereotypes and beliefs about the mentally ill. *International Journal of Social Psychiatry*, *44* (4), 235-247.

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social work*, *52*(1), 31-39.

Corrigan, P. W., & Larson, J. E. (2008). Stigma. In Mueser, K. T., & Jeste, D. V., *Clinical Handbook of Schizophrenia*. New York: The Guildford Press.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry*, *57*(8), 464-469.

*Cuttler, C., & Ryckman, M. (2019). Don’t call me delusional: Stigmatizing effects of noun labels on people with mental disorders. *Stigma and Health*, *4* (2), 118-125.

Deacon, B. J., & Baird, G. L. (2009). The chemical imbalance explanation of depression: Reducing blame at what cost?. *Journal of Social and Clinical Psychology, 28*(4), 415-435.

Division of Clinical Psychology. (2015). *Guidelines on language in relation to functional psychiatric diagnosis*. Leicester: British Psychological Society.

*Dixon, R. P., Roberts, L. M., Lawrie, S. et al. (2008). Medical students' attitudes to psychiatric illness in primary care. *Medical education*, *42*(11), 1080-1087.

Dowrick, C. (2013). Depression as a culture-bound syndrome: Implications for primary care. *British Journal of General Practice, 63*(610), 229-230.

Eisma, M. C. (2018). Public stigma of prolonged grief disorder: An experimental study. *Psychiatry research*, *261*, 173-177.

Eisma, M. C., Te Riele, B., Overgaauw, M., & Doering, B. K. (2019). Does prolonged grief or suicide bereavement cause public stigma? A vignette-based experiment. *Psychiatry research*, *272*, 784-789.

Farmer, P., & Stevenson, D. (2017). *Thriving at Work: the Stevenson/Farmer review of mental health and employers*. Retrieved January 20, 2022 from https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

France, C. M., Lysaker, P. H., & Robinson, R. P. (2007). The "chemical imbalance" explanation for depression: Origins, lay endorsement, and clinical implications. *Professional Psychology: Research and Practice, 38*(4), 411.

Galatzer-Levy, I. R., & Galatzer-Levy, R. M. (2007). The revolution in psychiatric diagnosis: Problems at the foundations. *Perspectives in biology and medicine*, *50*(2), 161-180.

Georgaca, E. (2013). Social constructionist contributions to critiques of psychiatric diagnosis and classification. *Feminism & Psychology, 23*(1), 56-62.

Global Burden of Diseases 2019 Mental Disorders Collaborators. (2022). Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry, 9*(2), 137-150.

*Glozier, N., Hough, C., Henderson, M., & Holland-Elliott, K. (2006). Attitudes of nursing staff towards co-workers returning from psychiatric and physical illnesses. *International Journal of Social Psychiatry*, *52*(6), 525-534.

*Gonschor, J., Eisma, M. C., Barke, A., & Doering, B. K. (2020). Public stigma towards prolonged grief disorder: Does diagnostic labeling matter? *Plos one*, *15*(9), Article e0237021.

Harper, D. J. (2013). On the persistence of psychiatric diagnosis: Moving beyond a zombie classification system. *Feminism & Psychology*, *23*(1), 78-85.

*Hipes, C., & Gemoets, D. (2019). Stigmatization of war veterans with Posttraumatic Stress Disorder (PTSD): Stereotyping and social distance findings. *Society and Mental Health*, *9*(2), 243-258.

Hoffman, E., & Addis, M. E. (2021). Dilemmas of agency and blame in men’s talk about depression. *Psychology of Men & Masculinities*, *22*(4), 669-677.

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Kemp, J. J., Lickel, J. J., & Deacon, B. J. (2014). Effects of a chemical imbalance causal explanation on individuals' perceptions of their depressive symptoms. *Behaviour research and therapy, 56*, 47-52.

Kmet, L. M., Cook, L. S., & Lee, R. C. (2004). *Standard quality assessment criteria for evaluating primary research papers from a variety of fields*. Health Technology Assessment Unit Alberta Heritage Foundation for Medical Research.

*Kroska, A., Harkness, S. K., Thomas, L. S., & Brown, R. P. (2014). Illness labels and social distance. *Society and Mental Health*, *4*(3), 215-234.

Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The ‘side effects’ of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical psychology review*, *33*(6), 782-794.

Lannin, D. G., Vogel, D. L., Brenner, R. E. et al. (2016). Does self-stigma reduce the probability of seeking mental health information?. *Journal of counseling psychology*, *63*(3), 351-358.

*Lawrie, S. M. (1999). Attitudes of the general population to psychiatric and physical illness. *Psychiatric Bulletin*, *23*(11), 671-674.

*Lawrie, S. M., Martin, K., McNeill, G. et al. (1998). General practitioners' attitudes to psychiatric and medical illness. *Psychological Medicine, 28*(6), 1463-1467.

Lee, E. H. M., Hui, C. L. M., Ching, E. Y. N. et al. (2016). Public stigma in China associated with schizophrenia, depression, attenuated psychosis syndrome, and psychosis-like experiences. *Psychiatric Services*, *67*(7), 766-770.

Li, T., Higgins, J. P. T., & Deeks, J. J. (2021) Chapter 5: Collecting Data. In Higgins, J. P. T., Thomas, J., Chandler J. et al. *Cochrane Handbook for Systematic Reviews of Interventions. Version 6.2.* Cochrane. Retrieved December 30, 2021 from https://training.cochrane.org/handbook/current/chapter-05

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American journal of Sociology*, *92*(6), 1461-1500.

Link, B. G., Cullen, F. T., Struening, E. et al. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American sociological review*, *54*(3), 400-423.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, *27*(1), 363-385.

Link, B. G., & Phelan, J. C. (2012). Chapter 25: Labeling and Stigma. In C. S., Aneshensel, J. C., Phelan, & A. Bierman (Ed.). *Handbook of the Sociology of Mental Health, Second Edition* (pp. 525-542). New York: Kluwer Academic/Plenum Publishers.

*Lucas, J. W., & Phelan, J. C. (2019). Influence and social distance consequences across categories of race and mental illness. *Society and Mental Health*, *9*(2), 143-157.

*Mendel, R., Kissling, W., Reichhart, T. et al. (2015). Managers' reactions towards employees' disclosure of psychiatric or somatic diagnoses. *Epidemiology and Psychiatric Sciences*, *24*(2), 146-149.

Norman, R. M., Sorrentino, R., Windell, D., & Manchanda, R. (2008). Are personal values of importance in the stigmatization of people with mental illness?. *The Canadian Journal of Psychiatry*, *53*(12), 848-856.

O’Connor, C., Brassil, M., O’Sullivan, S. et al. (2021). How does diagnostic labelling affect social responses to people with mental illness? A systematic review of experimental studies using vignette-based designs. *Journal of Mental Health*, 1-16.

Oexle, N., & Corrigan, P. W. (2018). Understanding mental illness stigma toward persons with multiple stigmatized conditions: Implications of intersectionality theory. *Psychiatric Services*, *69*(5), 587-589.

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—a web and mobile app for systematic reviews. *Systematic reviews*, *5*(1), 1-10.

Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(5), 384-399.

Page, M. J., McKenzie, J. E., Bossuyt, P. M. et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ, 372.* https://doi.org/10.1136/bmj.n71.

Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: The case of mental illness. *Journal of health and social behavior, 46*(4), 307-322.

Pilgrim, D. (2014). Influencing mental health policy and planning: DSM–5 as a disciplinary challenge for psychology. *Review of General Psychology, 18*(4), 293-301.

Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of mental health, 8*(3), 261-274.

Read, J. (2013). Does 'schizophrenia' exist? Reliability and validity. In Read, J., Bentall, P. R., Mosher, L., & Dillon, J. *Models of Madness: Psychological, social and biological approaches to psychosis* (pp. 47-61). Taylor & Francis Group.

Read, J., & Harper, D. J. (2020). The power threat meaning framework: Addressing adversity, challenging prejudice and stigma, and transforming services. *Journal of Constructivist Psychology, 35*(1), 1-14.

Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica, 114*(5), 303-318.

Rost, K., Smith, G. R., Matthews, D. B., & Guise, B. (1994). The deliberate misdiagnosis of major depression in primary care. *Archives of family medicine*, *3*(4), 333-337.

Schein, V. E. (1973). The relationship between sex role stereotypes and requisite management characteristics. *Journal of applied psychology*, *57*(2), 95-100.

Seery, C., Bramham, J., & O’Connor, C. (2021). Effects of a psychiatric diagnosis vs a clinical formulation on lay attitudes to people with psychosis. *Psychosis*, *13*(4), 361-372.

*Selezneva, E., & Batho, D. (2019). Stigma Towards Depression in the Workplace. *Psychology in Russia: State of the Art*, *12*(3), 3-12.

Sharfstein, S. S. (2012). Status of stigma, 2012. *Psychiatric Services*, *63*(10), 953-953.

*Szeto, A. C., Luong, D., & Dobson, K. S. (2013). Does labeling matter? An examination of attitudes and perceptions of labels for mental disorders. *Social psychiatry and psychiatric epidemiology*, *48*(4), 659-671.

Tajfel, H., & Turner, J. (2004). An Integrative Theory of Intergroup Conflict. In Hatch, M. J., & Schultz, M. *Organizational Identity* (pp. 56-65). Oxford University Press.

*Thibodeau, P. H., Fein, M. J., Goodbody, E. S., & Flusberg, S. J. (2015). The depression schema: how labels, features, and causal explanations affect lay conceptions of depression. *Frontiers in psychology*, *6*: 1728. https://doi: 10.3389/fpsyg.2015.01728

Thomas, J., Kneale, D., McKenzie, J. E. et al. (2021). Chapter 2: Determining the scope of the review and the questions it will address. In Higgins, J. P. T., Thomas, J., Chandler J. et al. *Cochrane Handbook for Systematic Reviews of Interventions. Version 6.2.* Cochrane. Retrieved December 30, 2021 from https://training.cochrane.org/handbook/current/chapter-02

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of counseling psychology*, *60*(2), 311-316.

*Wadley, V. G., & Haley, W. E. (2001). Diagnostic attributions versus labeling: impact of Alzheimer's disease and major depression diagnoses on emotions, beliefs, and helping intentions of family members. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *56*(4), 244-252.

Winter, N. R., Leenings, R., Ernsting, J. et al. (2021). More Alike than Different: Quantifying Deviations of Brain Structure and Function in Major Depressive Disorder across Neuroimaging Modalities. *arXiv: 2112.1070.* https://doi.org/10.48550/arXiv.2112.10730

Part 2: Empirical Research Project

Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study

Abstract

Background

Functional psychiatric diagnoses lack evidence of reliability and validity and have been critiqued for pathologizing understandable responses to adversity. However, western mental health services are typically organised around these constructs. Because debates about the utility of the labels have often been polarising, this study was undertaken with the aim of drawing out more nuanced views about the utility of mental health diagnoses.

Method

Using Q-Methodology 39 people who had either worked in or accessed mental health services, or were academics in the field, sorted 57 statements related to the usefulness of mental health diagnoses based upon their viewpoints. These sorts were subjected to an inverted factor analysis to cluster together similar viewpoints. The interpretation of the resultant factors was aided by qualitative data provided by participants loading onto each factor.

Results

Three factors were extracted. ‘The Medicalisation of Human Experience’ reflected the view that diagnoses are invalid, unreliable, and only serve a helpful function for entities such as pharmaceutical companies. The attitude represented by ‘Illnesses Like Any Other’ considered diagnoses as valid and real disorders which are largely helpful for individuals but can cause stigma when specific diagnoses are not understood by others. ‘Imperfect Short-Hands’ depicted the viewpoint that diagnostic constructs helpfully offer a general conceptualisation of what an individual might be experiencing, but their utility and applicability can vary in different circumstances.

Discussion

The factors map onto wider narratives, evidence and epistemological positions concerning the usefulness of mental health diagnoses. The three factors may offer an anchor for professionals to discuss understandings of diagnoses with their clients, to discern their usefulness and effects in individual circumstances.

Introduction

The ‘medical model’ of psychological distress equates conceptualisations of psychological and emotional suffering with physical illness or health (Johnstone & Boyle, 2018). This has been subject to multiple criticisms including via the ‘antipsychiatry’ faction (e.g., Berlim et al., 2003), which encompassed arguments that ‘mental illness’ represents a subjective phenomenon that merely labels undesirable presentations (Szasz, 2006). The medical model classifies psychological distress into distinct diagnoses (Johnstone & Boyle, 2018), which is problematic due to the lack of evidence for the validity and reliability of such diagnoses (e.g., Timimi, 2014). No definitive evidence for consistent biological markers underpinning distinct diagnoses exists despite the myriad of studies which have attempted to investigate this (e.g., Bandelow et al., 2016). Thematic analysis of the Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-5) also revealed that disparate assessment criterion and the same symptomology feature across different diagnoses (Allsopp et al., 2019). Despite this, diagnostic frameworks such as the DSM-5 (American Psychiatric Association, 2013) and the International Statistical Classification of Diseases and Related Health Problems, 11th edition (World Health Organisation, 2019) continue to occupy a dominant position within the Global North. Mental health diagnoses are embedded within practice and research and have wider implications for the organisation of health services, the criminal justice system, and access to welfare support (Szmukler, 2014).

Debating the Utility of Mental Health Diagnoses

Some have expressed that mental health diagnoses should be judged on their utility, for example, the extent to which their application alleviates an individual’s distress (Pies, 2011). Seemingly opposing discourses exist in relation to whether mental health diagnoses are considered as helpful phenomenon or not. Certain narratives suggest that diagnoses offer a shared language (Kendell & Jablensky, 2003) and professionals have highlighted that they can support communication (Dai et al., 2014; Evans et al., 2013; Hitchens & Becker, 2014; Reed et al., 2011). Assisting intervention (Evans et al., 2013; Kendell & Jablensky, 2003; Reed et al., 2011), enhancing comprehension, and offering validation in relation to distress and experiences (Loughland et al., 2015; McCormack & Thomson, 2017), are other commonly cited functions of mental health diagnoses.

In contrast, others suggest that the perceived usefulness of a diagnosis is a product of an individual feeling that their difficulties have been acknowledged, as opposed to a specific function of the diagnosis itself (Kinderman et al., 2013). Diagnostic labels have been criticised for offering little meaningful detail about individual difficulties *(*Kinderman et al., 2013), for discounting adverse systemic and social circumstances (Hichens & Becker, 2014; Kinderman, 2019), and for lacking pertinence to the many conceptualisations of distress due to their 'western' suppositions (Kriegler & Bester, 2014). It is therefore unsurprising that diagnostic labels do not always facilitate understandings about distress (Lester et al., 2020). Others have argued that diagnoses are unable to direct specific interventions (Timimi, 2014), and certain diagnoses are perceived to signal that no support is available (Lester et al., 2020). Classifying distress within diagnostic categories imposes a distinction between what might be considered as a typical and atypical psychological experience (Kinderman, 2019), which may perpetuate stereotyping and thus how individuals are perceived and responded to by others. Indeed, mental health diagnoses have been implicated with experiences of self- and public stigma (Hamilton et al., 2014; Howe et al., 2014; Lester et al., 2020). Stereotypes associated with mental health diagnoses have also been linked with epistemic injustice, whereby a person's ability to offer meaningful insights or information is perceived as markedly degraded (Crichton et al., 2017). Some have raised concerns that ultimately mental health diagnoses risk subjecting already oppressed groups of individuals to further injustices (Kriegler & Bester, 2014).

Polarised Positions and Change

Debates concerning the utility of mental health diagnoses do not appear to attend to the lack of validity and reliability of these constructs. It has been suggested that validity is a pre-requisite for meaningful utility and that longer-term ill effects may arise from relying on a diagnostic system that may appear to possess utility but is not valid (Son, 2019). One suggested example is that the practice and behaviour of healthcare professionals remains governed by concepts without a sound evidential basis (Kinderman, 2019). Considerations about the validity of mental health diagnoses thus appear to be compounded with opinions about the usefulness of these constructs (Kendell & Jablensky, 2003), which produces seemingly dichotomous 'for and against' arguments that lack nuance. These ostensibly polarised viewpoints are evidenced in narrative accounts (e.g., Callard et al., 2013) and qualitative studies (e.g., Hitchens & Becker, 2014) which present views or themes pertaining to opinions about mental health diagnoses within a bipolar manner.

The current debates concerning diagnostic utility also appear unconducive to facilitating change within these discourses. The analysis of clinicians' blogs detailing opinions about mental health diagnoses revealed that the components of language often used may reduce the opportunity for constructive dialogue between those who hold different views, appear focussed on presenting triumph over alternative narratives, and are often provocative as opposed to attending to genuine concerns (Garner et al., 2022). According to systemic positioning theory, mechanisms of change can be facilitated by supporting individuals to observe viewpoints outside of readily accessible dichotomous positions (e.g., Campbell & Groenbeck, 2006). The positive connotation technique stemming from Milan Family Therapy also suggests that attending to positive motives which underpin behaviour can enhance the probability of adjustment within systems (Storms, 2011). Thus, foregrounding more nuanced attitudes which encompass views about both the validity and utility of mental health diagnoses in a non-combative manner may generate a shift away from the current unproductive, polarised, and cyclical debates.

Study Aims

I aimed to fulfil a gap within the literature by empirically investigating the various attitudes which exist with regards to the utility of mental health diagnoses. It was hoped that more nuanced understandings about viewpoints could be conceptualised alongside encapsulating the perspectives of a range relevant individuals.

Method

Design

The study used Q-methodology as it supported investigation into the subjectivity of people's views (McKeown & Thomas, 2013) and assisted individuals to consider alternative stances towards a concept (Webler et al., 2007). Q-methodology was implemented as opposed to a Likert-scale design as, in contrast to Likert-scales, Q-methodology prompts individuals to construe the meaning of individual statements about a topic within the context of other statements present (Ho, 2017; Webler, 2007). This provides valuable insight as to which facets associated with a topic (e.g., views about the validity, reliability, and utility of mental health diagnosis) hold particular salience for an individual (Ho, 2017; Webler, 2007). Q-methodology has also been noted to facilitate more exhaustive analytic investigations into viewpoints compared to Likert-scales (ten Klooster et al., 2008). Q-methodology also identifies different attitudes which are comprised of various components (e.g., Watts & Stenner, 2012); this would be less feasible to achieve using a qualitative design where often results do not provide this level of integration or nuance when considering viewpoints (e.g., Hitchens & Becker, 2014).

Ethical Considerations

The research was granted ethical approval by The University of Leicester School of Psychology Research Ethics Committee (see Appendix G). Participants were given information about the study via a participant information sheet (Appendix H) and completed a consent form (Appendix I). Participants were given the chance to ask questions about the study before and after taking part and were assigned unique codes to support anonymity. A debrief sheet was provided (Appendix J).

Participants

Participants who were involved in the study can be considered within two main categories: those recruited for the purpose of the main research project (the Q-Sort task and post-interview) whose data was analysed for the purpose of the study results, and those who took part in the pilot phases of the project to support with the creation and modification of the research materials (the Q-Set) prior to the main phase of recruitment.

Main Study Participants

Various stakeholder views were sought. Individuals could participate if they were aged over 18 years, living within the UK (where medicalised understandings of distress are the dominant paradigm within mental health services), and had either worked within or accessed mental health services. Academics with an interest in mental health were also eligible to participate.

Q-methodological studies do not make assertions about the representativeness or generalisability of the attitudes or the demographics of the sample, instead the heterogeneity of views about a subject is privileged (McKeown & Thomas, 2013; Stenner et al., 2017). Sample size is driven by attempts to identify a range of different attitudes as opposed to a prescriptive number of participants (Brown, 1980), although recruiting between 30-50 individuals has been suggested as acceptable (McKeown & Thomas, 2013). Therefore, as is characteristic of q-methodology recruitment principles (e.g., Stenner et al., 2017; Watts &

Stenner, 2012), I used my own appraisals to recruit participants who were considered to potentially hold varied attitudes towards mental health diagnosis. Purposive and snowball sampling was used to achieve this (e.g., Baker et al., 2006). Participants were approached directly or via advertisement (Appendix K) through settings such as charities, forums, networks, support services, social media, and university courses. Analysis of the q-sort data was undertaken throughout recruitment (Baker et al., 2006) and a general question about participants' agreement with the use of diagnoses was embedded within the consent form (Appendix I). This aimed to inform purposive sampling such that people who might hold poorly represented perspectives were targeted (e.g., Baker et al., 2006.). Thirty-nine participants took part in the main study, see Table 4 and the results section for demographic characteristics relating to these participants.

Pilot Phase Participants

A purposive sampling strategy was utilised for the two pilot phases with known contacts who met the inclusion criteria, which were the same as the main study, being approached to take part. A total of 26 participants took part in the pilot phases: 17 in phase one and nine in phase two. Twenty-three participants reported having worked in a mental health service / setting, 10 reported accessing a mental health service / peer support group, and four identified as academics working in a field related to mental health (more than one option could be selected). See Table 3 for a summary of the pilot phase participant characteristics.

Table 3

Pilot Phase Participant Characteristics

Pilot Phase Participant Characteristics *(Statistics reported to 1 d.p)*	
Age (years)	x̄: 35.3 (25 – 72)
Ethnicity	White British: 65.4% White: 7.7% British / Mixed (White British / Black) / White European / Asian Indian / Black Caribbean / British Indian / Indian: 3.8% each
Gender	Female: 76.9% Male: 23.1%
Occupation	Mental Health Occupation: 76.9% Unemployed: 11.5% PNS: 7.7% Non-healthcare occupation: 3.8%
Received a Mental Health Diagnosis	Yes: 38.5% No: 57.7% PNS: 3.8%
Used a Mental Health Service / Support Group	Yes: 50% No: 46.1% PNS: 3.8%

Note. PNS = Prefer not to say

Materials

The Q-Set

The q-set, a collection of statements that depict the various outlooks related to a subject of concern (Brown, 1993), consisted of 57 statements about the perceived utility of mental health diagnoses. The q-set was generated via the following process. First, a data concourse was generated by collating naturalistic statements from various existing sources (academic articles; websites; newspaper articles (including reviewing comments sections); books; public facing comments on social media) and running an initial phase of piloting which consisted of four focus groups with 17 people to generate statements (e.g., Watts & Stenner, 2005). The selection of statements from both the existing sources and the focus groups was guided by the research aim (e.g., Watts & Stenner, 2005), thus all statements were linked to views concerning the utility / effects of mental health diagnoses. As this resulted in the accumulation of a high number of statements, a process of refinement, including the removal of statements, took place as the process went along by categorising statements into semantic themes to check for balance with regards to the focus of the statements (McKeown & Thomas, 2013), discarding duplicates (Coogan & Herrington, 2011), and adjusting content such that statements were worded appropriately for the q-sorting task (McKeown & Thomas, 2013). When the number of statements had been reduced in this manner, a working version of the q-set was also further refined through phase two of piloting with 9 participants, which aimed to check for understanding and comprehensiveness of the statements included. Refinement of the q-set ceased when piloting failed to result in further changes, and when a good balance was felt to have been struck between including the range of ways of speaking about the topic (the usefulness and effects of mental health diagnoses) whilst keeping the number of statements within a manageable number for participants (Watts & Stenner, 2005). See appendices L, M, N, O, P for the q-set and themes, details of the specific origins of each of the q-statements, full details of the piloting process, and materials relating to the pilot procedures.

Post-Sort Interview Schedule

An eight item, open-ended, post-sort interview schedule was created to gather more in-depth information about participants' views and their finalised q-sort (See Appendix Q) (Watts & Stenner, 2012).

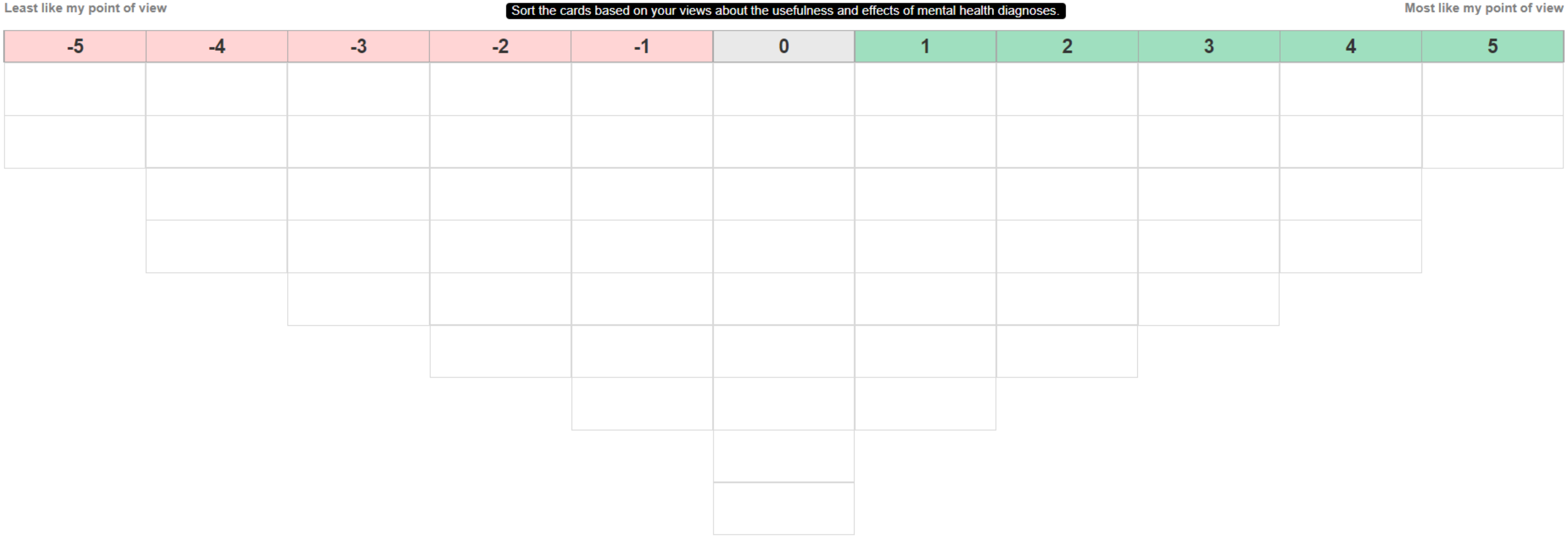
Procedure

Potential participants completed a consent-to-be-contacted form (Appendix I) and a demographic questionnaire (Appendix P). A mutually agreeable time was then arranged for interviews, and participants were given chance to ask questions about the study prior to interviews commencing. All interviews took place one to one over teleconferencing platforms, and the q-sort took place online via Easy HtmlQ software (Banasick, 2021a).

Participants initially placed each of the 57 statements into three categories ('agree', 'disagree' or 'neutral'). This allowed participants to become acquainted with the q-set (Baker et al., 2006), offered a foundation for the next phase of sorting where attention to detail is required, and supported insight for factor interpretation as to where the respective neutral position was located on the grid for individual factors (Watts & Stenner, 2012). Participants then placed the statements onto a sorting grid representative of a quasi-normal distribution (e.g., Watts & Stenner, 2005) ranging from -5 (least like my point of view) to +5 (most like my point of view) (See Figure 2). Participants were asked to position the statements on the grid to reflect their views in relation to the condition of instruction: 'sort the cards based on your views about the usefulness and effects of mental health diagnoses'. The post-sort interview then took place, although participants' verbalisations were also captured during sorting where possible. A Dictaphone or written notes documented verbal responses dependent upon participant preference.

Figure 2

Sorting Grid as depicted within Easy HtmlQ software (Banasick, 2021a)



Sort the cards based on your views about the usefulness and effects of mental health diagnoses.

Analysis

The q-sort data was imported into the software Ken-Q Analysis Desktop Edition (Banasick, 2021b). Correlations between participants' q-sort compositions were calculated and an inverted factor analysis using the centroid method was performed. Four factors with eigenvalues larger than one were initially extracted and subjected to varimax rotation. Further information about the additional criterion which supported consideration of the initial number of factors to extract for varimax rotation can be found in Appendix R. Factors were explored for interpretability as this takes precedence over applying rigorous methods of factor analysis in Q-methodology (e.g., Coogan & Herrington, 2011). As is advocated (e.g., Watts & Stenner, 2012), the four factors were then subjected to judgemental rotation with an aim to support two q-sorts to load exclusively onto each factor (Brown, 1980) and to minimise correlations between certain factors (e.g., Watts & Stenner, 2012). In an attempt to optimise the quantity of participants significantly and exclusively loading onto both Factor 3 and Factor 4, Factors 1 and 3 were judgementally rotated by 10°, and Factors 3 and 4 by -10°. Difficulty was encountered with supporting two or more participants to load onto both Factor 3 and Factor 4 significantly and exclusively, thus a three-factor solution was retained for interpretation. A composite factor array was generated for each factor, showing how participants would have sorted the statements should they load perfectly onto a particular factor. Exemplar participants, those whose sorts significantly ($p<.01$) and, where possible exclusively, associated with a factor, were used to constitute the factor arrays.

Following guidance set out by Watts and Stenner (2012), each factor was interpreted through considering the items that were most strongly dis/agreed with, statements which were significantly ($p<.05$) and generally more dis/agreed with compared to other factors and by examining the factor array holistically. Interpretation was also supported by the interview data (e.g., Van Exel & De Graaf, 2005). Consensus statements, those that did not differ significantly in their positioning across the factors, were also considered (Coogan & Herrington, 2011).

Results

Thirty-nine participants took part in the study. Participants' ages ranged from 18 to 67 years ($\bar{x}$=35.8), 74.3 percent identified as female, 25.6 percent identified as male / cis-male, and 2.6 percent identified as genderfluid. Approximately half of the sample worked in mental health occupations (48.7 percent), 20.5 percent were students, 15.4 percent worked in non-healthcare occupations, 10.3 percent were unemployed, and 2.6 percent worked in either academia or healthcare. Almost half of the sample reported having received a mental health diagnosis (53.8 percent) and 71.8 percent had used mental health services or support groups. See Table 4 for further information about the participants and the loadings of their q-sorts onto the three respective factors. Factor loadings reflect the association between an individual's q-sort configuration and a specific factor; higher numerical factor loadings reflect a higher degree of similarity between an individual's q-sort configuration and the configuration of the factor q-sort (the factor array) (McKeown & Thomas, 2013). Participants who sorted statements within a similar pattern for their q-sort will both load highly onto a specific factor (Watts & Stenner, 2005). The statement rankings across the three factor arrays and consensus and distinguishing statements between factors are displayed in Table 5, alongside the factor eigenvalues, variance, and correlations.

Table 4

Factor loadings (2.dp) and participant information.

Participant	**Category**	**Occupation**	**Factor 1**	**Factor 2**	**Factor 3**
1	1 / 2 / 3	Trainee Clinical Psychologist	**.77***	-.10	.31
2	2 / 3	Clinical Psychologist	**.85***	-.12	.06
3	2	Systemic Family Practitioner	**.37**	.29	**.36**
4	1 /2	Clinical Psychologist	**.84***	-.08	.01
5	2	Trainee Clinical Psychologist	**.78***	.06	.26
6	2	Registered Mental Health Nurse	-.10	**.61***	.09
7	2	Mental Health Practitioner	**.62***	.05	.25
8	2	Senior Psychological Wellbeing Practitioner	**.56**	.26	**.43**
9	1 / 2	Senior Psychological Wellbeing Practitioner	-.17	**.63***	.27
10	1 / 2 / 3	Unemployed	**.49***	-.05	.15
11	2	Clinical Psychologist	**.81***	-.20	-.01
12	2	Mental Health Care Support Worker	-.10	**.73***	.07
13	2	Psychiatrist	**.77***	-.05	-.01
14	2 / 3	Clinical Psychologist	**.34**	**.38**	**.42**
15	1 / 2	Trainee Clinical Psychologist	**.87***	.07	.14
16	1	Student	**.35**	**.42**	.06
17	1 / 2	Trainee Clinical Psychologist	**.35**	**.53**	**.34**
18	1 / 2	Healthcare	.04	**.72***	.15
19	2	Mental Health Nurse	-.05	**.64***	.08
20	1 / 2	Non-Healthcare	**.72***	-.17	-.07
21	1 / 2	Unemployed	.25	**.53***	-.09
22	1	Unemployed	**.78***	-.14	-.27
23	1	Non-Healthcare	**.75***	-.34	-.13
24	1 / 2	Retired Mental Health Officer	**.59**	.11	**.40**
25	1	Non-Healthcare	-.40	**.78***	-.01
26	1	Unemployed	.18	.28	**.59***

27	1 / 2 / 3	Student	.25	**.54**	**.39**
28	2	Family Therapist	**.64***	-.13	-.02
29	2	Student	.07	**.46***	.10
30	1	Non-Healthcare	-.24	**.65**	**.35**
31	1 / 2	Non-Healthcare	.09	**.43**	**.48***
32	2	Mental Health Nurse	**.52**	**.48**	.05
33	1 / 2	Student	**.72***	-.12	.09
34	1 / 2 / 3	Student	**.44***	.10	.09
35	3	Academic	.17	**.46**	**.47**
36	1	Non-Healthcare	-.14	**.51***	.01
37	1	Student	-.20	**.66***	.12
38	1	Student	-.25	**.50***	.20
39	1 / 2	Student	-.00	**.60***	.10

Note. Bold denotes significant loadings (p<.01). * Denotes exemplars. Category 1 = someone who has accessed a mental health (MH) service / peer support group. Category 2 = someone who has worked in a MH service / setting. Category 3 = an academic working in a field relating to MH.

Table 5

Factor arrays, consensus (*) and distinguishing statements (bold). Factor eigenvalues, variance, and correlations.

Statement	**Factor 1**	**Factor 2**	**Factor 3**
1. MH diagnoses suggest relatives are to blame for the diagnosed person's distress	**0**	-5	-4
2. Professionals are good at agreeing on who meets diagnostic criteria for specific MH diagnoses	-3	**-1**	-3
3. MH diagnoses are needed because some symptoms are only partly explained by a person's experiences	**-3**	+2	+1
4. MH diagnoses help people to get support and adjustments associated with work / school	**+1**	**+4**	**-2**
5. MH diagnoses consume a person's identity	**+3**	-2	-2
6. MH diagnoses help people to understand their difficulties	**-1**	**+5**	**+2**
7. MH diagnoses have a positive impact on various areas of a person's life	**-2**	+1	+1
8. MH diagnoses enable oppressive practices (e.g., sectioning and restraint)	**+3**	**-3**	**+1**
9. MH diagnoses accurately represent the symptoms people experience	**-4**	-1	0
10. It is problematic to apply 'western' MH diagnostic criteria to people from 'non-western' cultures or faiths	+2	**0**	+4
11. MH diagnoses make it harder for a person to see similarities between themselves and others who have different MH diagnoses	**+1**	-3	-1
12. MH diagnoses make others take a person's distress more seriously	**0**	+2	+2
13. MH diagnoses highlight an individual's strengths and resources	**-5**	-2	0
14. MH diagnoses make it harder for people to access services offering financial, social, or housing support	0	-2	-3
15. Others interpret everything about a diagnosed person through the lens of their diagnosis	**+2**	0	0

16. MH diagnoses are needed for research	**-1**	+1	+2
17. The initial relief that people may feel when they are given a MH diagnosis is short-lived	+1	0	0
18. MH diagnoses offer more benefits to services than to service users	**+2**	**-3**	**0**
19. MH diagnoses support people to get the right medication	**-1**	+3	+2
20. People from different racial backgrounds get different diagnoses because of cultural / racial biases within the diagnostic system	**+3**	**-1**	**+5**
21. Some MH diagnoses are more stigmatising than others *	+4	+5	+4
22. MH diagnoses remove blame from the diagnosed person	0	0	**-4**
23. MH diagnoses help people to feel they have a shared experience with others *	+1	+2	+3
24. Diagnostic criteria imply there are normal and abnormal ways of thinking, feeling, and behaving	+3	**-1**	+2
25. MH diagnoses enable professionals to safeguard the diagnosed person from risk of abuse	**-1**	+1	+3
26. People use their MH diagnoses to account for their behaviour	+1	+2	**-1**
27. MH diagnoses help people to manage their distress	**-1**	+1	+1
28. MH diagnoses give people hope for recovery / change	**-2**	+3	+4
29. MH diagnoses support psychological understandings about a person’s distress	**-3**	**+4**	**+1**
30. Getting the correct diagnosis is more important than the relationship between service user and professional *	-4	-4	-4
31. MH diagnoses are well supported by biological evidence	**-5**	+1	0
32. MH diagnoses medicalise human responses to distressing circumstances	**+5**	**-2**	**+1**
33. MH diagnoses are more problematic for people whose culture, religion, or family view MH as a taboo or stigmatising subject	+2	+3	**-1**
34. MH diagnoses offer a short-hand description which is easily understood by others	0	0	**+4**

35. MH diagnoses tell us about the likely course and outcome of someone’s distress	-3	0	-1
36. MH diagnoses support people to get the right talking therapy for them	-1	**+3**	-1
37. MH diagnoses are needed for the structuring, funding, and management of mental health services	**-1**	+3	+3
38. Loved ones become less understanding and less supportive because of a MH diagnosis	**0**	-4	-2
39. Diagnosing someone with a MH label increases the chance that they will receive more MH diagnoses in the future	**+1**	-1	0
40. MH diagnoses support professionals to empathise with service users	**-3**	**0**	**-5**
41. MH diagnoses support the financial interests of pharmaceutical companies	**+5**	-2	-3
42. Giving a MH diagnosis is one of the most damaging things a professional can do to a person	**+1**	-5	-4
43. MH diagnoses offer descriptions rather than explanations of people’s problems	+4	**0**	+3
44. MH diagnoses help us to see the link between distress and discrimination	**-4**	-2	-1
45. MH diagnoses support collaboration between professionals and service users	-2	**+2**	-3
46. MH diagnoses are just as valid as diagnoses in the rest of medicine	**-4**	+4	+3
47. MH diagnoses help to ensure that professionals are appropriately trained for the people they work with	**-2**	**+4**	**+2**
48. MH diagnoses act as a barrier to professionals understanding how individuals make sense of their experiences	**+2**	**-3**	**+1**
49. Diagnostic criteria help to ensure people are discharged from services when they no longer need support *	-2	-1	-2
50. We need to be certain about the cause of MH problems for diagnostic labels to be useful	0	+1	**-3**
51. MH diagnoses cause people to experience stigma, discrimination, and exclusion	**+3**	+1	0
52. MH diagnoses are based on made up categories and diagnostic criteria	**+4**	**-4**	**-1**
53. MH diagnoses make it difficult to see a link between adversity and distress	**+4**	-3	-2

54. Men and women get different diagnoses because of gender biases within the diagnostic system	**+2**	**0**	**+5**
55. MH diagnoses make it harder for people to access mental health services	**0**	-4	-5
56. MH diagnoses help people to accept they need support	0	+2	0
57. If we reject MH diagnoses, we reject the role biology plays in a person's distress *	-2	-1	-2
Eigenvalues	9.58	9.13	1.10
Variance (%)	25	23	3
Factor Correlations			
Factor 1	1	-.24	.17
Factor 2	-.24	1	.44
Factor 3	.17	.44	1

The respective neutral position for each factor array was determined using the mean number of cards sorted into the initial agree, disagree and neutral piles for the exemplar participants. The respective neutral values (Table 6) were used to support the interpretation of the factor arrays.

Table 6

Respective neutral positions calculated for each factor array.

Factor	**Agree ($\bar{x}$)**	**Disagree ($\bar{x}$)**	**Neutral ($\bar{x}$)**	**Respective Neutral Position**
1	21	22	14	0
2	25	13	19	-1
3	17	22	18	0

Factor 1: The Medicalisation of Human Experience

Fifteen participants' q-sorts significantly and exclusively loaded onto this factor and thus were considered exemplars. Most (n=11) had used mental health or peer support services, and many (n=9) were employed within mental health occupations.

Description

Mental health diagnoses do not reflect valid or reliable constructs (2:-3; 9:-4; 20:+3; 31:-5; 46:-4; 52:+4; 54:+2) and thus are problematic to apply to make sense of a person's distress.

> *"... mental health diagnoses are just subjective opinion of the person diagnosing you… three different psychiatrists may give three different diagnoses for…the same person …they're not valid…" (P22)*

"…the actual evidence isn't there…as a scientific concept…[the diagnostic system is] hollow…" (P11)

The relationship between lived experience and suffering is concealed by mental health diagnoses (3:-3; 44:-4; 53:+4). Normal human responses to adversity and social circumstances are pathologized as deficits by framing such responses as 'symptoms' of 'mental illness' (13:-5; 24:+3; 32:+5).

"…[mental health diagnoses] mask how societal structures,…abuse,…or adverse experiences have impacted [someone]…and it makes the person and...professionals see their way of presenting as signs of mental illness and masks the fact that...people are presenting as they do because these are the things they've learned to do to survive…" (P2)

Conceptualising distress within this way can segregate people from others who do not share the same label (11:+1).

"…if you are given a diagnosis that's different to someone else you consider yourself…in a box…that puts an instant block between forging a link between yourselves as people in distress…" (P20)

Mental health diagnoses offer little meaningful use or benefit for those in receipt of them (17+1; 18:+2; 22:0). For example, by presenting distress within a medicalised framework they diminish an individual's sense of agency; negatively impacting hope for change (28:-2) while offering little in terms of enabling individuals to manage distress (27:-1).

"…[a diagnosis] makes you…more passive as to what you can actually do about it…" (P11)

Diagnoses fail to offer useful explanations or information about a person's experiences or their resultant distress (35:-3; 43:+4), making them relatively useless in terms of communicating understandings to professionals and loved ones (1:0; 12:0; 34:0; 38:0; 40:-3; 48:+2).

"…someone will say…"that person has schizophrenia"…then there's lots of nods as if that tells us everything… that's not telling me how that's happened…how they got into services with that label…what experiences they've had in their childhood…any trauma…the diagnostic criteria…just describes what the person might be looking like…or might be reporting…in the here and now…" (P5)

Mental health diagnoses also do not definitively contribute to ensuring that people receive appropriate support in relation to their distress (19:-1; 36:-1; 49:-2; 55:0), social and financial needs (14:0), or their education / workplace (4:+1).

"…I have had lots of patients who receive [a] diagnosis*…and the…relative[s]…have questioned, '*so if there is a diagnosis why is there no treatment*'…"(P13)*

They offer little to no value in guiding service management, research, or supporting professionals within their role (16:-1; 25:-1; 37:-1; 45:-2; 47:-2).

"…in my experience a diagnosis has been both a way of gatekeeping out and gatekeeping…into services…" (P5)

"…we have to…build up an alternative system which is more useful for us as practitioners…" (P13)

Instead, mental health diagnoses serve the most utility for those seeking monetary profit such as pharmaceutical companies (41:+5).

"…the medicalisation of distress has been the greatest achievement of the marketing industry…if you want to sell pills you have to sell illnesses…" (P28)

Diagnoses are powerful and damaging phenomenon (7:-2; 42:+1) which dominate how a person is viewed by themselves and others (5:+3; 15:+2; 26:+1). They impose medicalised narratives onto people, leaving little room for individual understandings (6:-1; 29:-3).

"…the persons story and sense of understanding…is substituted with a professional discourse irrespective of what they think, it's a form of identity theft and it is abuse…" (P28)

This imposed narrative can have negative and stigmatising consequences for an individual in relation to the way they may be responded to or treated by others (8:+3; 39:+1; 51:+3).

"…I was treated really badly when I had that diagnosis… I just couldn't…shake it off…it was really damaging for me…I felt really powerless…" (P22)

Factor 2: Illnesses Like Any Other

Twelve participants exclusively loaded significantly onto this factor. Nine had used mental health services or peer-support groups and four worked in mental health roles.

Description

Mental health diagnoses reflect real conditions (3:+2; 46:+4) which are well supported by evidence (52:-4) and are important for research (16:+1). Professionals might not always agree on the correct diagnosis (2:-1) and the evidence supporting a biological aetiology might not be strong (31:+1), but this does not detract from the reality that the labels reflect real medical conditions that might be caused by biology or biology in combination with adversity (53:-3).

> *"…I'm aware of the different disorders and the diagnoses…there's a lot of evidence and research that's taken place about…what leads to them…is it chemical imbalances in your brain, is it past trauma,…is it something that you've been born with…I don't think it's made up…it's just as relevant as any medical condition…" (P25)*

> *"…there's just not enough research into biological markers for depression or…schizophrenia, does that mean these things don't happen, absolutely not…" (P37)*

Because the diagnoses reflect genuine conditions, factors such as a person's culture, faith, race, and gender have little bearing on whether someone has a condition or not (10:0; 20:-1; 44:-2; 54:0).

> *"…whilst I think it's important to understand non-western cultures and faiths, ultimately health is health, for example cancer doesn't discriminate whether you're a Hindu or a Western European…it affects you anyway…" (P36)*

They do not medicalise human experience (32:-2) nor do they communicate ideas about normal or abnormal ways of being because experiences can be understood in terms of symptoms of conditions (8:-3; 24:-1; 43:0). This also means that mental health diagnoses do not come to define individuals (5:-2; 15:0; 39:-1).

"…these days more people are… seeing it as I have diagnosis of this, not this is what I am… it's something they experience but it's not necessarily something that sets them apart from others…" (P6)

Thus, diagnoses can support normalisation of experiences and connection with others who are trying to manage their condition (11:-3; 23:+2).

"…if you…have that diagnosis and understand that's what you've been experiencing…you can find other people who…may have similar experiences…to have that peer support…" (P9)

Although diagnoses do not support identification of a person's strengths (13:-2), they remove blame from the individual and those close to them (1:-5; 22:0).

"…it isn't the parent's fault, it's an inherited characteristic …" (P12)

Diagnoses have real benefits for those in receipt of them (7:+1; 18:-3; 42:-5), including supporting understanding of one's own difficulties (6:+5; 26:+2; 29:+4). This positively impacts people's views about change and helps people to manage their distress (27:+1; 28:+3; 56:+2).

> *"…[diagnosis has]…given me…a path to follow to try and aim towards improving my mental health …having a sort of explanation to why things might be happening…keeps me more focussed on…making it better and ways of understanding it…" (P21)*

Access to mental health services (55:-4) and other forms of support (4:+4; 14:-2) is enabled by mental health diagnoses. The diagnosis maximises the likelihood that input is tailored to suit the individual's needs; both in terms of evidence-based medication (19:+3) and talking therapies (36:+3).

> *"…there's different guidelines depending on what…diagnosis someone has…if we have a better understanding of what that persons diagnosis is we can offer the recommended therapy or treatment…" (P9)*

Aspects associated with mental health services, such as the running of services (37:+3) and staff training (47:+4), also benefit from the diagnostic system.

> *"… people who might be suffering from…anxiety or depression are most likely to benefit from someone who is trained in that area… it's important that people are trained properly just like it is in any other medical professions…" (P25)*

Despite these benefits, diagnoses don't consistently support other people's understandings and thus interactions towards a person with a mental health condition (12:+2; 34:0; 38:-4; 40:0; 45:+2; 48:-3), and there remains a stigma attached to certain conditions (21:+5).

"…there are certain diagnoses that still have a stigma surrounding them… I think anxiety and depression are quite socially acceptable nowadays…but things like schizophrenia, bipolar… they're not well known, and…[people] don't understand… people aren't educated…" (P18)

When stigma is implicated with mental health diagnoses (51:+1), this is related to perceptions present within an individual's environment (33:+3) as opposed to being a process inherently determined by the diagnosis itself.

"…some of them are [stigmatising], how much…is dependent entirely upon the culture and the sociocultural context within which the diagnosis is made…" (P37)

Factor 3: Imperfect Short-Hands

Two exemplar participants were identified for Factor 3; both had used, and one had worked in, mental health services.

Description

Mental health diagnoses offer descriptor labels for people's problems which help to convey some understanding to others about what someone might be going through (12:+2; 34:+4; 38:-2). Despite reflecting valid constructs (46:+3; 52:-1), the labels offer little in terms of explaining people's difficulties nor their causes (9:0; 26:-1; 31:0; 32:+1; 43:+3; 44:-1; 48:+1; 53:-2) which can result in the attribution of blame to individuals (22:-4). However, explaining people's difficulties is not central to the utility of diagnoses (50:-3).

"…if you don't view it as something which is an absolute truth and all-encapsulating but as a general … way of describing something that captures a general sense of what's going on for

a person that a lot of people can understand, that…is one of the most useful things about diagnoses…" (P14)

The applicability and use of the diagnostic constructs are influenced by the contexts within which they are applied. This is not just limited to how diagnoses are perceived by those around someone (33:-1), but a person's gender, race, faith, or culture (10:+4; 20:+5; 54:+5) can also impact their relevance.

"…a woman might be considered to be hypo- or over the top or manic, whereas a man would be considered to be behaving within the general norm of that gender… and same with…different religious…and different cultural backgrounds…Objectively both of those behaviours are actually the same, it just depends on what cultural lens you are looking at it through, which is showing you what diagnostic criteria they meet…" (P8)

The approach and characteristics of different diagnosing clinicians may also influence whether diagnoses are given or not (2:-3).

"… we're all looking at it from a slightly different perspective depending on your professional background…somebody might be more open-minded to other factors that could…alter that person's presentation whereas another professional might look at it…in…more of a black and white view…looking for those set criteria… with that comes…lots of different…ideas about whether…that's the right diagnosis for that person…" (P8)

The influence of contextual factors on the applicability of diagnoses means that the usefulness of diagnosis is equivocal (7:+1; 18:0), with *"both sides" (P14; P35)* of this argument being admissible in different circumstances. This includes the role that diagnoses play in supporting people to understand and manage their own difficulties (6:+2; 27:+1; 29:+1; 56:0).

> *"……I work with clients who both have had specific mental health diagnoses and those that maybe haven't…I've seen the benefit of both of those different…routes…for some clients … [a diagnosis]can be a…balm to…them being able to process…whatever they are going through…" (P31)*

Alongside the impact that diagnoses can have on a person's identity (5:-2; 15:0; 39:0).

> *"…I can…see why…[a diagnosis consuming an individual's identity] would be…on both sides of that…coin…"(P31)*

This is similarly reflected with regards to whether a diagnosis will help someone to get support, with the label facilitating access to certain types of help, such as via mental health services (55:-5) or social support (14:-3), more than others, like within work or school (4:-2). The labels do not consistently inform the type of intervention someone might need, with a diagnosis directing the most appropriate medication (19:+2) more so than the most suitable type of talking therapy (36:-1).

"…I was really desperate to get a diagnosis because I wanted to get the right treatment and I knew it was like a key to unlock the treatment to help me… but I know for some people they don't feel like that…" (P26)

"…[diagnosis] can be a gateway into services so that can be helpful, however in reality a lot of the patients that I speak to are given a diagnosis and discharged, so having a diagnosis doesn't guarantee that you get the right support you need…" (P8)

Generally, the knowledge that some support will be available gives people hope that change or recovery is possible (28:+4). However, the type of label an individual is given, and how stigmatising this is deemed to be (21:+4; 51:0), can act as another variable which means the utility of the label varies on a case-by-case basis.

"...for some people it certainly does [give hope for recovery and change] because there's ...NICE guidelines that are built around diagnoses and labels… on the other hand some labels are seen as very...fixed or untreatable in inverted commas…and very...stigmatising ... so…it probably depends on what the label or diagnosis is…" (P14)

Diagnostic labels are somewhat important for professionals' training (47:+2), but the relationship between professional and client possesses much higher value than a diagnosis (30:-4). The labels do not contribute to interpersonal experiences such as collaboration or empathy within this context (40:-5; 45:-3).

"…[diagnosis] won't support collaboration where the doctor and the patient are working together…" (P26)

> *"…if you're working within a therapeutic context then you should always be striving for empathic understanding…I struggle to…understand why knowing that one of my clients had a specific diagnosis would then increase my empathy…" (P31)*

However, use of the labels does not tend to result in oppressive or damaging behaviour from professionals towards service users (8:+1; 42:-4).

> *"…there's much more damaging things healthcare professionals can do …there's lots…of greater malpractice that could…go against the code of ethics and…conduct beyond a diagnosis…"(P14)*

Consensus Statements

All factors represented strong views that getting the correct mental health diagnosis was less important than the relationship between an individual and a professional (30: -4; -4; -4); diagnoses were also consistently not considered to be important for determining when a person should be discharged from services (49: -1; -1; -2). This indicates a shared perspective that the therapeutic relationship is of key importance in terms of a person's experience within services, as opposed to this being dictated by diagnoses. Also represented consistently across factors was the notion that some diagnoses are more stigmatising than others (21:+4; +5; +4), and that diagnoses might support people to feel connected to others in similar circumstances (23:+1; +2; +3). No factors reflected the view that rejecting mental health diagnoses would subsequently deny the role of biology within psychological distress (57: -2, -1, -2).

Discussion

In undertaking this Q-methodological study I aimed to elucidate some of the diverse attitudes that exist with regards the utility of mental health diagnoses. Three factors were identified: ‘The Medicalisation of Human Experience’, ‘Illnesses Like Any Other’, and ‘Imperfect Short-Hands’. The results are now considered with regards to pre-existent theory and literature, before attending to limitations, clinical implications, and ideas for future research.

Links to Existing Theory and Research

The view encompassed by Factor 1 (‘The Medicalisation of Human Experience’) was that mental health diagnoses are invalid, unreliable, and critically lacking in empirical evidence. Such arguments have previously been evidenced within wider debates and discussions (e.g., Johnstone & Boyle, 2018; Timini, 2014; Whooley, 2010). With regards to utility, Factor 1 reflected the view that mental health diagnoses are unhelpful concepts for most, with pharmaceutical companies being the only entity for whom the diagnoses serve a useful function. This echoes the notion of ‘disease mongering’ (e.g., Cosgrove & Wheeler, 2013), which accuses the DSM of manipulating and promoting certain ‘disorders’ for pharmaceutical profits. Indeed, many of the DSM working group had associations within the pharmaceutical sphere (Cosgrove & Wheeler, 2013). The attitude demonstrated by this factor appears to align with the epistemological position ‘radical constructivism’, which posits that perceptions of ‘symptoms’ and the associated diagnostic labels are created and perpetuated by structures which may benefit from organising distress in this manner, such as western psychiatry (e.g., Pilgrim, 2007).

In contrast, Factor 2 (‘Illnesses Like Any Other’) reflected the viewpoint that mental health diagnoses represent real disorders or conditions akin to those within physical health. Similarly to pre-existing arguments (e.g., Hayes & Bell, 2014), the cause of mental health diagnoses was not considered to be solely biological, with acknowledgement that adversity such as trauma could also likely contribute to the development of such disorders. As reflected in prior research (Loughland et al., 2015; Reed et al., 2011), mental health diagnoses were considered to offer understandings for the individual experiencing difficulties and guide appropriate interventions. Instances where diagnoses were deemed to be less useful were when understandings are not successfully communicated to others, a notion akin to the concept of ‘mental health literacy’ (Jorm et al., 1997), and when people have stigmatising attitudes about the different disorders. The view represented by this factor is evidenced in anti-stigma campaigns which frame psychological distress as a ‘normal illness’ or attempt to enhance knowledge and understandings about diagnoses (e.g., Stuart, 2016). The attitude depicted by this factor reflects the position of ‘medical naturalism’ which regards mental health diagnoses as valid disorders that have observable effects for an individual across contexts and time (Pilgrim, 2007).

Somewhat similarly Factor 3 (‘Imperfect Short-Hands’) represented the view that diagnoses are valid, but in contrast to Factor 2, they were conceptualised as constructs as opposed to disorders. The perceived utility of this was that diagnoses offer a framework which can give a general understanding about what might be going on for a person; this is evidenced in wider discourses and research literature (e.g., Dai et al., 2014; Evans et al., 2013; Hitchens & Becker, 2014; Kendell & Jablensky, 2003;). Also reflecting wider opinion (e.g., Jablensky, 2016) was the equivocal view surrounding the utility of diagnoses, with this being deemed as dependent upon contexts and individual circumstances.

Factor 1 uniquely reflected the view that diagnoses impose medicalised understandings onto an individual, ignoring the impact of harmful lived experiences and actively removing individualised understandings; this reflects the concept of epistemic injustice (e.g., Crichton, 2017). Prior evidence which reflects this viewpoint showed that traumatic experiences were recorded less within the medical reports of people who had received a diagnosis of psychosis compared to other individuals in secondary healthcare (Neill & Reid, 2021). Thus, the view displayed by Factor 1 suggests diagnoses are harmful phenomenon that can result in experiences of powerlessness (e.g., Van Den Tillaart et al., 2009), negative self-perceptions, and increased psychological distress (e.g., Johnstone & Boyle, 2018) for individuals. Factor 3 reflected a somewhat similar viewpoint that diagnoses can be unhelpful for individuals, but in contrast to Factor 1, this is context or situation dependent and thus would not apply for everyone. Perceptions about the impact of personal characteristics on the suitability and usefulness of diagnoses within Factor 3 mirror wider concerns about the cross-cultural applicability of ‘western’ suppositions underpinning mental health diagnoses (e.g., Canino & Alegría, 2008; Kriegler & Bester, 2014). Indeed, racialised groups have been observed to receive ‘psychotic’/ ‘schizophrenic’ diagnoses more regularly than individuals affiliated with the racial ‘majority’ (Schwartz & Blankenship, 2014). Additionally, the white, ‘western’ assumptions of UK mental health services have been implicated with poor experiences for individuals with African-Caribbean heritage (Mclean et al., 2003). Thus, from this viewpoint, diagnostic labels could result in individuals from already persecuted groups experiencing further oppression, feeling ostracized or misunderstood (e.g., Aggarwall, 2013). It is thus unsurprising that calls have been made for psychiatry to participate in a process of decolonisation (Bracken et al., 2021). Factor 2 distinctively reflected the view that someone who had been given a mental health diagnosis would experience themselves as having a ‘disorder’ or ‘condition’. Whilst some evidence suggests that conceptualising psychological distress within the realm of physical health conditions can serve to reduce experiences of blame, this has also been found to have a detrimental impact upon the beliefs an individual has about themselves and their difficulties (Larkings & Brown, 2018).

Views about the validity and utility of mental health diagnoses reflected within Factor 1 represent wider discourses that a reform of mental health provisions and current diagnostic understandings is needed (e.g., Johnstone & Boyle, 2018; Kinderman, 2015; Vanheule et al., 2019). This factor also highlights that multiple mental health professionals will be practising within services that do not align with their own views or values concerning the nature of distress (e.g., Cooke et al., 2019). In contrast, the view reflected by Factor 2 would likely advocate for the continuation of the current diagnostic paradigm which operates within many mental health services. It is interesting to observe that the views within Factor 1 were mostly representative of mental health professionals, whereas the opinions within Factor 2 mostly consisted of those who were not associated with a current mental health occupation. This may reflect a process of 'hermeneutical injustice' whereby individuals within healthcare careers might have increased access to alternative understandings of psychological distress through different modes of education or training, compared to those who remain solely exposed to dominant discourses surrounding medicalised understandings of distress (e.g., Ritunnano, 2022). Factor 3 reflected a view which appeared to maintain a central position in relation to the utility of mental health diagnoses. Other attempts to adopt central positions in relation to the medical model have been suggested to ultimately maintain the operation of medicalised understandings (Read, 2005). Thus, despite acknowledging that mental health diagnoses are unhelpful for some individuals, this viewpoint is unlikely to wholly oppose the use of the diagnostic system within services.

Given the seemingly distinct viewpoints evidenced by the three factors, it is interesting to note that five statements of consensus were present; one of which reflected powerful views that a good therapeutic relationship was superior to an accurate diagnosis. A positive therapeutic relationship has been associated with beneficial therapeutic effects irrespective of whether medical or psychological interventions are implemented (Krupnick et al., 1996). This suggests that the therapeutic alliance operates outside of the sphere of the conceptualisation of distress, and thus reflects a facet where views can be shared across the three viewpoints. As has been evidenced in prior research (Huggett et al., 2018), all factors also strongly represented the view that some diagnoses are more stigmatising than others. It is however likely that viewpoints represented by the three factors might have differential explanations for this. For example, the view evidenced by Factor 1 might link this to problems with the diagnostic labels themselves, Factor 2 may associate this with the lack of understandings that others have about the nature of certain mental health conditions, and Factor 3 could connect this to others' views about the diagnostic constructs.

Reflexivity

In Q-methodology it is acknowledged that the researchers own subjectivity and opinions impact multiple stages of the research process such as the generation of the study materials and results (e.g., Brown, 1993; Sneegas, 2020). At the start of the research process I was conscious that I held critical views towards the utility of mental health diagnoses and thus had predetermined views and attitudes about the very topic I was beginning to research. Participating in the study myself during the recruitment phase (e.g., Robbins & Krueger, 2000; Warner, 2009) supported me to deepen my understanding about my own position within the research, and thus the position from which the research had been conducted, by observing which factor my attitude aligned with (e.g., Brown, 1993). During data collection, analysis, and interpretation I was keen to ensure that the views and voices of all participants were heard, including those which did not align with my own opinions or positioning. Thus I engaged in reflective discussions about this with my research supervisor where necessary to support with this process.

Limitations

Notwithstanding efforts to recruit individuals who believe mental health diagnoses exclusively relate to biological phenomena, these perspectives were not strongly represented by any of the factors. This potentially highlights a missing viewpoint given the prevalence of narratives about chemical imbalances (e.g., Moncrieff, 2008). The antagonistic landscape of the dialogue between individuals who hold different views about mental health diagnoses (e.g., Johnstone et al., 2019) may have prevented people with certain views from wishing to participate. Although Q-methodology is not solely governed by statistical processes as the theoretical intelligibility of factors is also of great importance (e.g., Coogan & Herrington, 2011; Watts & Stenner, 2012), it could be suggested that factor 3 may need to be interpreted more cautiously than the other factors. This is due to indications that there may be more than one viewpoint compounded within this factor. This is signalled by the difficulties encountered when attempting to support two q-sorts to load significantly and exclusively onto all four factors originally extracted (resulting in the retention of a three-factor solution), and an observation that the two exemplar participants for factor 3 may have different views about the validity of diagnoses as indicated by their individual q-sorts.

Directions for Future Research & Clinical Implications

The three factors highlight the subtleties and nuance of different attitudes towards mental health diagnoses by encompassing views about validity, reliability, and utility within each viewpoint. This offers an alternative to the polarised discourses about the usefulness of mental health diagnoses as it reflects that the attitudes people hold about this topic do not just exist within a ‘for’ and ‘against’ dichotomy. The elements of consensus identified across the three viewpoints may also aid less combative discussions within this area, and in line with the suppositions of positioning theory and positive connotation techniques (Campbell & Groenbeck, 2006; Storms, 2011), the three factors may also aid individuals to consider alternative attitudes towards diagnoses. The research might also support the adoption of meta-positions when considering or discussing attitudes towards diagnoses which is particularly salient for mental health professionals working with clients who might hold different attitudes about diagnoses to themselves. Supporting professionals to adopt meta-positions in relation to this topic will aid with client-centred discussions, and might also serve to reduce experiences of epistemic injustice for some individuals by reinstating power which may have been removed by previously imposed diagnostic understandings.

As has been done with Q-methodological research of other subject areas (Nitzburg, 1980), a nomothetic scale of the three attitudinal stances towards mental health diagnoses could be created using the differentiating statements between factors identified within this study. Future research could use this attitudinal measure to explore how prevalent each of the three attitudes are, either generally within the population or within certain cohorts of individuals. The attitude measure could also be used in conjunction with measures which assess other phenomenon associated with mental health, such as stigma or compassion, to investigate whether certain attitudes towards mental health diagnoses are associated with increased or decreased levels of such phenomenon.

Conclusion

Prominent dialogues surrounding the usefulness and effects of mental health diagnoses often manifest as unconstructive debates, creating an impression of wholly divergent views. This research addresses a gap in the literature by identifying and interpreting three attitudes which exist towards mental health diagnoses: ‘The Medicalisation of Human Experience’, ‘Illnesses Like Any other’, and ‘Imperfect Short-Hands’. The three attitudes shared some realms of agreement, with the value of the therapeutic relationship and the stigmatising nature of different mental health diagnoses being particularly salient. The research may support helpful conversations between individuals and could be used as a tool to facilitate open conversations with clients.

References

Aggarwal, N. K. (2013). From DSM-IV to DSM-5: an interim report from a cultural psychiatry perspective. *The Psychiatrist*, *37*(5), 171-174.

Allsopp, K., Read, J., Corcoran, R., & Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry research, 279*, 15-22.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Baker, R., Thompson, C., & Mannion, R. (2006). Q methodology in health economics. *Journal of Health Services Research and Policy, 11*(1), 38-45. doi:10.1258/135581906775094217

Banasick, S. (2021a). *Easy HtmlQ Version 2.0.3*. Retrieved February 02, 2022 from https://github.com/shawnbanasick/easy-htmlq

Banasick, S. (2021b). *KenQ Analysis Desktop Edition*. Retrieved 20 March, 2022 from https://github.com/shawnbanasick/kade

Bandelow, B., Baldwin, D., Abelli, M. et al. (2016). Biological markers for anxiety disorders, OCD and PTSD–a consensus statement. Part I: neuroimaging and genetics. *The World Journal of Biological Psychiatry, 17*(5), 321-365.

Berlim, M. T., Fleck, M., & Shorter, E. (2003). Notes on antipsychiatry. *European archives of psychiatry and clinical neuroscience*, *253*(2), 61-67.

Bracken, P., Fernando, S., Alsaraf, S. et al. (2021). Decolonising the medical curriculum: psychiatry faces particular challenges. *Anthropology & medicine, 28*(4), 420-428.

Brown, S. R. (1980). *Political subjectivity: Applications of Q methodology in political science*. Yale University Press.

Brown, S. R. (1993). A primer on Q methodology. *Operant Subjectivity, 16*(3/4), 91-138.

Callard, F., Bracken, P., David, A. S., & Sartorius, N. (2013). Has psychiatric diagnosis labelled rather than enabled patients?. *BMJ*, 347:7920, 20-21.

Campbell, D., & Groenbeck, M. (2006). Chapter 3: Putting the model into practice. In Campbell, D., & Groenbeck, M. *Taking positions in the organization* (pp 33-42). London: Routledge.

Canino, G., & Alegría, M. (2008). Psychiatric diagnosis–is it universal or relative to culture?. *Journal of Child Psychology and Psychiatry*, *49*(3), 237-250.

Coogan, J., & Herrington, N. (2011). Q methodology: An overview. *Research in Teacher Education, 1*(2), 24-28.

Cooke, A., Smythe, W., & Anscombe, P. (2019). Conflict, compromise and collusion: dilemmas for psychosocially-oriented practitioners in the mental health system. *Psychosis*, *11*(3), 199-211.

Cosgrove, L., & Wheeler, E. E. (2013). Drug firms, the codification of diagnostic categories, and bias in clinical guidelines. *Journal of Law, Medicine & Ethics*, *41*(3), 644-653.

Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. *BJPsych bulletin*, *41*(2), 65-70.

Dai, Y., Yu, X., Xiao, Z. et al. (2014). Comparison of Chinese and international psychiatrists' views on classification of mental disorders. *Asia‐Pacific Psychiatry*, *6*(3), 267-273.

Evans, S. C., Reed, G. M., Roberts, M. C. et al. (2013). Psychologists' perspectives on the diagnostic classification of mental disorders: results from the WHO-IUPsyS Global Survey. *International Journal of Psychology*, *48*(3), 177-193.

Garner, B., Kinderman, P., & Davis, P. (2022). The 'rhetorical concession': a linguistic analysis of debates and arguments in mental health. *Journal of Mental Health*, 1-6. https://doi.org/10.1080/09638237.2021.2022631

Hamilton, S., Lewis-Holmes, E., Pinfold, V. et al. (2014). Discrimination against people with a mental health diagnosis: qualitative analysis of reported experiences. *Journal of Mental Health*, *23*(2), 88-93.

Hayes, J., & Bell, V. (2014). Diagnosis: one useful method among many. *The Lancet Psychiatry*, *1*(6), 412-413.

Hitchens, K., & Becker, D. (2014). Social work and the DSM: A qualitative examination of opinions. *Social work in mental health*, *12*(4), 303-329.

Ho, G. W. (2017). Examining perceptions and attitudes: A review of Likert-type scales versus Q-methodology. *Western journal of nursing research*, *39*(5), 674-689.

Howe, L., Tickle, A., & Brown, I. (2014). 'Schizophrenia is a dirty word': service users' experiences of receiving a diagnosis of schizophrenia. *The Psychiatric Bulletin*, *38*(4), 154-158.

Huggett, C., Birtel, M. D., Awenat, Y. F. et al. (2018). A qualitative study: experiences of stigma by people with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*(3), 380-397.

Jablensky, A. (2016). Psychiatric classifications: validity and utility. *World Psychiatry*, *15*(1), 26-31.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Johnstone, L., Boyle, M., Cromby, J. et al. (2019). Reflections on responses to the Power Threat Meaning Framework one year on. *Clinical Psychology Forum*, No. 313, pp. 47-54.

Jorm, A. F., Korten, A. E., Jacomb, P. A. et al. (1997). “Mental health literacy”: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical journal of Australia, 166*(4), 182-186.

Kendell, R., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American journal of psychiatry, 160*(1), 4-12.

Kinderman, P. (2015). Imagine there's no diagnosis, it's easy if you try. *Psychopathology Review, 2*(1), 154-161.

Kinderman, P. (2019). *A manifesto for mental health: Why we need a revolution in mental health care*. Springer Nature.

Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. P. (2013). Drop the language of disorder. *Evidence-Based Mental Health*, *16*(1), 2-3.

Kriegler, S., & Bester, S. E. (2014). A critical engagement with the DSM-5 and psychiatric diagnosis. *Journal of Psychology in Africa*, *24*(4), 393-401.

Krupnick, J. L., Sotsky, S. M., Elkin, I. et al. (2006). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Focus*, *64*(2), 532-277.

Larkings, J. S., & Brown, P. M. (2018). Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *International Journal of Mental Health Nursing*, *27*(3), 928-941.

Lester, R., Prescott, L., McCormack, M. et al. (2020). Service users' experiences of receiving a diagnosis of borderline personality disorder: A systematic review. *Personality and Mental Health*, *14*(3), 263-283.

Loughland, C., Cheng, K., Harris, G. et al. (2015). Communication of a schizophrenia diagnosis: a qualitative study of patients' perspectives. *International Journal of Social Psychiatry*, *61*(8), 729-734.

McCormack, L., & Thomson, S. (2017). Complex trauma in childhood, a psychiatric diagnosis in adulthood: Making meaning of a double-edged phenomenon. *Psychological trauma: theory, research, practice, and policy*, *9*(2), 156.

McKeown, B., & Thomas, D. B. (2013). *Q methodology* (Vol. 66). Sage publications.

Mclean, C., Campbell, C., & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re) productive of health inequalities. *Social science & medicine*, *56*(3), 657-669.

Moncrieff, J. (2008). The Myth of the Chemical Cure. In Moncrieff, J. *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment.* (pp. 217-224). Palgrave Macmillan, London.

Neill, C., & Read, J. (2021). Adequacy of inquiry about, documentation of, and treatment of trauma and adversities: a study of mental health professionals in England. *Community mental health journal*, 1-12.

Nitzberg, M. (1980). Development of Likert scale to measure salience of need for interpersonal relationships with parents and friends. *Adolescence*, *15*(60), 871.

Pies, R. (2011). Toward a concept of instrumental validity: implications for psychiatric diagnosis. *Dialogues in Philosophy, Mental and Neuro Sciences*, *4*(1).

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science & Medicine*, *65*(3), 536-547.

Read, J. (2005). The bio-bio-bio model of madness'. *Psychologist: Leicester*, *18*(10), 596-597.

Reed, G. M., Correia, J. M., Esparza, P. et al. (2011). The WPA-WHO global survey of psychiatrists' attitudes towards mental disorders classification. *World Psychiatry*, *10*(2), 118.

Ritunnano, R. (2022). Overcoming Hermeneutical Injustice in Mental Health: A Role for Critical Phenomenology. *Journal of the British Society for Phenomenology*, 1-18. https://doi.org/10.1080/00071773.2022.2031234

Robbins, P., & Krueger, R. (2000). Beyond bias? The promise and limits of Q method in human geography. *The Professional Geographer*, *52*(4), 636-648.

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World journal of Psychiatry*, *4*(4), 133.

Sneegas, G. (2020). Making the case for critical Q methodology. *The professional geographer*, *72*(1), 78-87.

Son, D. (2019). My diagnosis, a label. *Psychosis*, *11*(4), 374-377.

Stenner, P., Watts, S., & Worrell, M. (2017). Q Methodology. In C. Willig & R. W. Stainton (Eds.) *The Sage Handbook of Qualitative Research in Psychology*. (pp. 212-37). Sage.

Storms, L. E. (2011). Milan Systemic Family Therapy. In Metcalf, L. Marriage and Family Therapy: A Practice-Orientated Approach (pp 201-227). New York: Springer Publishing Company.

Stuart, H. (2016). Reducing the stigma of mental illness. *Global Mental Health*, *3*. https://doi.org/10.1017/gmh.2016.11

Szasz, T. (2006). Defining disease: The gold standard of disease versus the fiat standard of diagnosis. *The Independent Review*, *10*(3), 325-336.

Szmukler, G. (2014). When psychiatric diagnosis becomes an overworked tool. *Journal of Medical Ethics*, *40*(8), 517-520.

ten Klooster, P. M., Visser, M., & de Jong, M. D. T. (2008). Comparing two image research instruments: The Q-sort method versus the Likert attitude questionnaire. *Food quality and preference, 19*(5), 511-518.

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology*, *14*(3), 208-215.

Van Den Tillaart, S., Kurtz, D., & Cash, P. (2009). Powerlessness, marginalized identity, and silencing of health concerns: Voiced realities of women living with a mental health diagnosis. *International journal of mental health nursing*, *18*(3), 153-163.

Van Exel, J., & De Graaf, G. (2005). *Q methodology: A sneak preview*. Retrieved February 12, 2022 from https://www.researchgate.net/profile/Gjalt_Graaf/publication/228574836_Q_Methodology_A_Sneak_Preview/links/02bfe50f946fc9978b000000.pdf

Vanheule, S., Adriaens, P., Bazan, A. et al. (2019). Belgian Governmental Superior Health Council advises against the use of the DSM categories and promotes contextualising psychiatric diagnosis. *The Lancet. Psychiatry*, *6*(9).

Warner, S. (2009). Critical Research Practices and Ethical Methodologies: Researching women and child sexual abuse. In Warner, S. *Understanding the effects of child sexual abuse: Feminist revolutions in theory, research and practice* (pp 75-90). Routledge Taylor & Francis Group: London and New York.

Watts, S., & Stenner, P. (2005). Doing Q methodology: Theory, method and interpretation. *Qualitative Research in Psychology, 2*(1), 67-91. https://doi:10.1191/1478088705qp022oa

Watts, S., & Stenner, P. (2012). *Doing Q Methodological Research: Theory, Method and Interpretation.* Sage: London.

Webler, T., Danielson, S., & Tuler, S. (2007). Guidance on the use of Q method for evaluation of public involvement programs at contaminated sites. *Greenfield, MA: Social and Environmental Research Institute*.

Whooley, O. (2010). Diagnostic ambivalence: psychiatric workarounds and the Diagnostic and Statistical Manual of Mental Disorders. *Sociology of Health & Illness*, *32*(3), 452-469.

World Health Organization (2019*). International Statistical Classification of Diseases and Related Health Problems* (11th ed.). https://icd.who.int/

Part 3: Appendices

(* indicates mandatory appendices)

Appendix A

Data Extraction Tool

Author and year
Name of study
Aim of study
Country of study
Sample size (was power considered)
Participant demographic information
Recruitment sites
How were participants allocated to conditions
Design (between/within-subjects)
Depression label applied (independent variable)
Non-mental health diagnostic label applied within control condition (independent variable)
Procedure (what methodology did they use)
Stigma outcome assessed relevant to the review (dependent variable)
Measures of dependant variable (e.g., questionnaires) and psychometric properties
Results relevant to the aims of this review
Conclusions drawn by authors
Additional information: were distress behaviours present within the vignette; were participants / labelled individuals characteristics considered.

(Created using guidance from Li et al., 2021)

References

Li, T., Higgins, J. P. T., & Deeks, J. J. (2021) Chapter 5: Collecting Data. In Higgins, J. P. T., Thomas, J., Chandler J., Cumpston, M., Li, T., Page M. J. & Welch, V. A. *Cochrane Handbook for Systematic Reviews of Interventions. Version 6.2.* Cochrane. Retrieved December 30, 2021 from https://training.cochrane.org/handbook/current/chapter-05

Appendix B

Quality Appraisal Tool

‘The Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields’ (Kmet et al., 2004)

(Prompts for each question not included)

Score yes, no, partial, or not applicable for each question. A ‘summary score’ is calculated for the total assessment, including only questions applicable to the paper which is being appraised.

Quality Assessment:

1. Question or objective sufficiently described?
2. Design evident and appropriate to answer study question?
3. Method of subject selection (and comparison group selection, if applicable) or source of information / input variables (e.g., for decision analysis) is described and appropriate.
4. Subject (and comparison group, if applicable) characteristics or input variables / information (e.g., for decision analyses) sufficiently described?
5. If random allocation to treatment group was possible, is it described?
   (Note: for within-subjects designs, counterbalancing of conditions was considered for this item)
6. If interventional and blinding of investigators to intervention was possible, is it reported?
7. If interventional and blinding of subjects to intervention was possible, is it reported?
   (Note: for within-subjects designs, this item was marked as N.A)
8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?

9. Sample size appropriate?
10. Analysis described and appropriate?
11. Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results / outcomes (i.e.., those directly addressing the study question / objective upon which the conclusions are based)?
12. Controlled for confounding?

    (Note: for within-subjects designs, this question was considered in relation to whether confounding variables (e.g., participant characteristics) had been considered generally – as opposed to comparison of group characteristics)
13. Results reported in sufficient detail?
14. Do the results support the conclusions?

    (Note: this question was marked as N.A for all papers as it was felt this was not relevant to the appraisal of the quality of the papers for inclusion within this review)

References

Kmet, L. M., Cook, L. S., & Lee, R. C. (2004). *Standard quality assessment criteria for evaluating primary research papers from a variety of fields.* Health Technology Assessment Unit Alberta Heritage Foundation for Medical Research.

Appendix C
Quality Appraisal Scores

Study Name: **Question:**	Abdullah & Brown (2019)	Cassidy & Krendl (2018) – Study 1A	Cassidy & Krendl (2018) – Study 1B	Cassidy & Krendl (2018) – Study 2	Cormack & Furnham (1998)	Cutler & Ryckman (2019)	Dixon et al. (2008)	Glozier et al. (1998)	Glozier et al. (2006)	Gonschor et al. (2020)	Hipes & Gemoets (2019)	Kroska et al. (2014)	Lawrie et al. (1998)	Lawrie (1999)	Lucas & Phelan (2019)	Mendel et al. (2015)	Reilly et al. (2005)	Rice et al. (2014) – Study 2	Selezneva & Batho (2019)	Szeto et al. (2013)	Thibodeau et al. (2015) – Study 2	Wadley & Haley (2001)
1.	Y	Y	Y	Y	Y	P	P	P	P	Y	Y	Y	P	P	Y	Y	P	P	Y	Y	Y	Y
2.	Y	Y	Y	Y	P	Y	Y	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	Y	Y	Y	Y
3.	P	P	P	P	P	P	P	P	P	P	Y	N	P	P	P	P	P	N	P	P	P	P
4.	P	P	P	P	P	Y	P	N	P	Y	Y	P	P	P	P	P	P	P	P	P	P	P
5.	Y	P	P	P	P	Y	P	N	N	P	P	Y	N	N	P	P	P	P	Y	P	N	P
6.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	P	N	N	N	Y	N	N	N
7.	N	N.A	N.A	N.A	Y	N	Y	N	N	Y	N	N	N	N	P	N	N	N.A	Y	N	N	N
8.	Y	Y	Y	Y	P	Y	Y	P	P	Y	Y	Y	Y	Y	Y	Y	P	N	N	Y	P	Y
9.	P	Y	P	P	P	Y	P	Y	Y	Y	P	P	P	P	P	P	P	P	P	P	Y	P
10.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11.	N	Y	Y	Y	N	N	Y	N	Y	Y	N	N	Y	Y	N	N	N	N	N	N	Y	Y
12.	P	P	P	P	P	Y	Y	N	P	Y	P	P	P	P	Y	Y	N	N	P	Y	P	P
13.	Y	Y	Y	Y	P	Y	P	P	P	Y	P	Y	P	P	P	P	P	P	Y	P	Y	P
14.	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A
Score	**0.62**	**0.75**	**0.71**	**0.71**	**0.54**	**0.69**	**0.69**	**0.35**	**0.54**	**0.85**	**0.62**	**0.58**	**0.54**	**0.54**	**0.65**	**0.58**	**0.42**	**0.33**	**0.69**	**0.58**	**0.62**	**0.62**
Retain	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**N**	**N**	**Y**	**Y**	**Y**	**Y**

Key: Y = yes / N = no / P = partial / N.A = not applicable

References

Abdullah, T., & Brown, T. L. (2019). Diagnostic labeling and mental illness stigma among Black Americans: An experimental vignette study. *Stigma and Health*, *5*(1), 11-21.

Cassidy, B. S., & Krendl, A. C. (2018). Believing is seeing: Arbitrary stigma labels affect the visual representation of faces. *Social Cognition*, *36* (4), 381-410.

Cormack, S., & Furnham, A. (1998). Psychiatric labelling, sex role stereotypes and beliefs about the mentally ill. *International Journal of Social Psychiatry*, *44* (4), 235-247.

Cuttler, C., & Ryckman, M. (2019). Don’t call me delusional: Stigmatizing effects of noun labels on people with mental disorders. *Stigma and Health*, *4* (2), 118-125.

Dixon, R. P., Roberts, L. M., Lawrie, S. et al. (2008). Medical students’ attitudes to psychiatric illness in primary care. *Medical education*, *42*(11), 1080-1087.

Glozier, N. (1998). Workplace effects of the stigmatization of depression. *Journal of occupational and environmental medicine*, *40*(9), 793-800.

Glozier, N., Hough, C., Henderson, M., & Holland-Elliott, K. (2006). Attitudes of nursing staff towards co-workers returning from psychiatric and physical illnesses. *International Journal of Social Psychiatry*, *52*(6), 525-534.

Gonschor, J., Eisma, M. C., Barke, A., & Doering, B. K. (2020). Public stigma towards prolonged grief disorder: Does diagnostic labeling matter? *Plos one*, *15*(9), Article e0237021.

Hipes, C., & Gemoets, D. (2019). Stigmatization of war veterans with Posttraumatic Stress Disorder (PTSD): Stereotyping and social distance findings. *Society and Mental Health*, *9*(2), 243-258.

Kroska, A., Harkness, S. K., Thomas, L. S., & Brown, R. P. (2014). Illness labels and social distance. *Society and Mental Health*, *4*(3), 215-234.

Lawrie, S. M. (1999). Attitudes of the general population to psychiatric and physical illness. *Psychiatric Bulletin*, *23*(11), 671-674.

Lawrie, S. M., Martin, K., McNeill, G. et al. (1998). General practitioners' attitudes to psychiatric and medical illness. *Psychological Medicine*, *28*(6), 1463-1467.

Lucas, J. W., & Phelan, J. C. (2019). Influence and social distance consequences across categories of race and mental illness. *Society and Mental Health*, *9*(2), 143-157.

Mendel, R., Kissling, W., Reichhart, T. et al. (2015). Managers' reactions towards employees' disclosure of psychiatric or somatic diagnoses. *Epidemiology and Psychiatric Sciences*, *24*(2), 146-149.

Reilly, N. P., Bocketti, S. P., Maser, S. A., & Wennet, C. L. (2006). Benchmarks affect perceptions of prior disability in a structured interview. *Journal of Business and Psychology*, *20*(4), 489-500.

Rice, S., Richardson, J., & Kraemer, K. (2014). Emotion mediates distrust of persons with mental illnesses. *International Journal of Mental Health*, *43*(1), 3-29.

Selezneva, E., & Batho, D. (2019). Stigma Towards Depression in the Workplace. *Psychology in Russia: State of the Art*, *12*(3), 3-12.

Szeto, A. C., Luong, D., & Dobson, K. S. (2013). Does labeling matter? An examination of attitudes and perceptions of labels for mental disorders. *Social psychiatry and psychiatric epidemiology*, *48*(4), 659-671.

*Thibodeau, P. H., Fein, M. J., Goodbody, E. S., & Flusberg, S. J. (2015). The depression schema: how labels, features, and causal explanations affect lay conceptions of depression. *Frontiers in psychology*, *6*: 1728. https://doi: 10.3389/fpsyg.2015.01728

Wadley, V. G., & Haley, W. E. (2001). Diagnostic attributions versus labeling: impact of Alzheimer's disease and major depression diagnoses on emotions, beliefs, and helping intentions of family members. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *56*(4), 244-252.

Appendix D

Information about Measures Employed by Studies

Guidance from Taber (2007) and McHugh (2001) used to interpret psychometrics.

Table D1

Established Measures

Outcome Measure	Description	Studies Employing	Adaptations	Psychometric Properties Reported	Interpretation of Psychometrics
Social distance scale (Link et al., 1987)	7 items assessing desire to interact / seek distance.	Abdullah & Brown (2019)	X	α=.98-.99	Acceptable
		Gonschor et al. (2020)	German translation (Angermeyer & Matschinger, 2003)	α=.89	Acceptable
		Hipes & Gemoets (2019)	4 items.	Reliability (specific psychometric property unreported) = .86	X

Attributions questionnaire-20 (Brown, 2008)	20 items. 4 subscales: fear / dangerousness; help / interact; forcing treatment; negative emotions.	Abdullah & Brown (2019)	X	Total scale: α=.97-.99 Fear / dangerousness: α=.95-.99 Help / interact: α=.91-.97 Forcing treatment: α=.88-.95 Negative emotions: α=.91-.97	Acceptable
Emotional reactions to mental illness scale (Angermeyer & Matschinger, 2003)	9 items. 3 subscales: fear; anger; pity / compassion.	Gonschor et al. (2020)	13 items, translated into German.	Fear: α=.80 Pity / compassion: .79 Anger: α=.64	Fear; pity / compassion: Acceptable Anger: Not acceptable
Requisite management traits (Schein, 1973)	Traits linked to perceptions about employability.	Hipes & Gemoets. (2019)	34 items.	Unreported	X

Empathy response scale (Campbell & Babrow, 2004)	10 items assessing empathy.	Thibodeau et al. (2015)	Added 2 items.	α=.0.843	Acceptable
Social distance scale (Bogardus, 1992)	12 items assessing social distance.	Szeto et al. (2013)	Previously adapted by Norman et al. (2008).	α=.90	Acceptable

Table D2

Bespoke Self-Report Measures

Description	**Studies Employing**	**Adaptations**	**Psychometric Properties Reported**	**Interpretation of Psychometrics**
13 items, views about a patient in primary care.	Dixon et al. (2008)	Adapted from version used by Lawrie et al. (1998) – used 12 items	Unreported	X
	Lawrie et al. (1998)	X		
12 items about a colleague.	Glozier et al. (2006)	X	α=0.76	Acceptable
5 items, attributions.	Gonschor et al. (2020)	Previously used by Eisma (2018; Eisma et al., 2019) – translated into German.	Unreported	X
6 items, social distance.	Kroska et al. (2014)	X	Unreported	X
4 items, future meeting.		X	Unreported	X

3 items, likeability.		X	α=0.86	Acceptable
10 undesirable traits.	Cuttler & Ryckman (2019)	X	Unreported	X
49 items, dangerousness, and competence.	Hipes & Gemoets (2019)	X	Unreported	X
12 items, views related to individual	Lawrie (1999)	X	Unreported	X
8 items, perceptions of job performance.	Mendel et al. (2015)	X	Unreported	X
One item, recruitment decision.	Selezneva & Batho (2019)	X	Unreported	X
One item: individual's accountability for their distress.	Thibodeau et al. (2015)	X	Unreported	X

7 items: emotions, attributions, and motivation to help the individual.	Wadley & Haley (2001)	X	Unreported	X
9 items: social distance	Cormack & Furnham (1998)	X	Unreported	X

References

Abdullah, T., & Brown, T. L. (2019). Diagnostic labeling and mental illness stigma among Black Americans: An experimental vignette study. *Stigma and Health*, *5*(1), 11-21.

Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, *108*(4), 304-309.

Bogardus, E. S. (1992). Social distance and its origins. *Journal of Applied Sociology, 9*, 216-226.

Brown, S. A. (2008). Factors and measurement of mental illness stigma: a psychometric examination of the Attribution Questionnaire. *Psychiatric rehabilitation journal*, *32*(2), 89.

Campbell, R. G., & Babrow, A. S. (2004). The role of empathy in responses to persuasive risk communication: Overcoming resistance to HIV prevention messages. *Health communication*, *16*(2), 159-182.

Cormack, S., & Furnham, A. (1998). Psychiatric labelling, sex role stereotypes and beliefs about the mentally ill. *International Journal of Social Psychiatry*, *44* (4), 235-247.

Cuttler, C., & Ryckman, M. (2019). Don't call me delusional: Stigmatizing effects of noun labels on people with mental disorders. *Stigma and Health*, *4* (2), 118-125.

Dixon, R. P., Roberts, L. M., Lawrie, S., Jones, L. A., & Humphreys, M. S. (2008). Medical students' attitudes to psychiatric illness in primary care. *Medical education*, *42* (11), 1080-1087.

Glozier, N., Hough, C., Henderson, M., & Holland-Elliott, K. (2006). Attitudes of nursing staff towards co-workers returning from psychiatric and physical illnesses. *International Journal of Social Psychiatry*, *52* (6), 525-534.

Gonschor, J., Eisma, M. C., Barke, A., & Doering, B. K. (2020). Public stigma towards prolonged grief disorder: Does diagnostic labeling matter? *Plos one*, *15*(9), Article e0237021.

Hipes, C., & Gemoets, D. (2019). Stigmatization of war veterans with Posttraumatic Stress Disorder (PTSD): Stereotyping and social distance findings. *Society and Mental Health*, *9*(2), 243-258.

Kroska, A., Harkness, S. K., Thomas, L. S., & Brown, R. P. (2014). Illness labels and social distance. *Society and Mental Health*, *4*(3), 215-234.

Lawrie, S. M. (1999). Attitudes of the general population to psychiatric and physical illness. *Psychiatric Bulletin*, *23*(11), 671-674.

Lawrie, S. M., Martin, K., McNeill, G., Drife, J., Chrystie, P., Reid, A., ... & Ball, J. (1998). General practitioners' attitudes to psychiatric and medical illness. *Psychological Medicine*, *28*(6), 1463-1467.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American journal of Sociology*, *92*(6), 1461-1500.

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia medica*, *22*(3), 276-282.

Mendel, R., Kissling, W., Reichhart, T., Bühner, M., & Hamann, J. (2015). Managers' reactions towards employees' disclosure of psychiatric or somatic diagnoses. *Epidemiology and Psychiatric Sciences*, *24*(2), 146-149.

Schein, V. E. (1973). The relationship between sex role stereotypes and requisite management characteristics. *Journal of applied psychology*, *57*(2), 95.

Selezneva, E., & Batho, D. (2019). Stigma Towards Depression in the Workplace. *Psychology in Russia: State of the Art*, *12*(3), 3-12.

Szeto, A. C., Luong, D., & Dobson, K. S. (2013). Does labeling matter? An examination of attitudes and perceptions of labels for mental disorders. *Social psychiatry and psychiatric epidemiology*, *48*(4), 659-671.

Taber, K. S. (2018). The use of Cronbach's alpha when developing and reporting research instruments in science education. Research in science education, 48(6), 1273-1296.

Thibodeau, P. H., Fein, M. J., Goodbody, E. S., & Flusberg, S. J. (2015). The depression schema: how labels, features, and causal explanations affect lay conceptions of depression. *Frontiers in psychology*, *6*: 1728. https://doi: 10.3389/fpsyg.2015.01728

Wadley, V. G., & Haley, W. E. (2001). Diagnostic attributions versus labeling: impact of Alzheimer's disease and major depression diagnoses on emotions, beliefs, and helping intentions of family members. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *56*(4), 244-252.

Appendix E

Additional Study Characteristics Information

Author	Participant Demographics	Study Design	Presentation of the labelled individual	Analysis of participant characteristics and stigma	Analysis of labelled individuals' characteristics and stigma
Abdullah & Brown (2019)	**Age:** 18-88 (x̄=42.82) **Gender:** 30 males / 76 females **Ethnicity:** 106 Black	Between-subjects	Generic context	No	No
Cassidy & Krendl (2018) – Study 1A	**Age:** 19-69 (x̄=35.83) **Gender:** 94 males / 106 females **Ethnicity:** unreported	Within-subjects	Generic context	Yes	No
Cassidy & Krendl (2018) – Study 1B	**Age:** 19-66 (x̄=36.84) **Gender:** 92 males / 93 females **Ethnicity:** unreported	Within-subjects	Generic context	Yes	No

Cassidy & Krendl (2018) – Study 2	**Age:** 18-73 ($\bar{x}=37.15$) **Gender:** 74 males / 115 females **Ethnicity:** unreported	Within-subjects	Generic context	Yes	No
Cormack and Furnham (1998)	**Age**: 16-22 ($\bar{x}=17.1$) **Gender**: 65 males / 52 females **Ethnicity**: unreported	Between-subjects	Generic context	No	Yes
Cuttler & Ryckman (2019)	**Age:** 19-78 ($\bar{x}=38.97$) **Gender:** 211 males / 239 females **Ethnicity:** 351 White, 99 unreported	Between-subjects	Generic context	No	No
Dixon et al. (2008)	**Age:** Range unreported (median = 20) **Gender:** 675 males / 406 females **Ethnicity:** 675 White, 314 Asian, 92 Other	Between-subjects	Patient	Yes	No

Glozier et al. (2006)	**Age:** Range unreported (x̄=37.5) **Gender:** 10 males / 107 females **Ethnicity:** 69 White, 48 unreported	Between-subjects	Work context	Yes	No
Gonschor et al. (2020)	**Age:** Range unreported (x̄=36.6) **Gender:** 193 males / 659 females **Ethnicity:** unreported	Between-subjects	Generic context	No	Yes
Hipes & Gemoets (2019)[1]	**Age:** 18-71 (x̄=34) **Gender:** 462 males / 368 females / 1 other **Ethnicity:** 608 White, 99 Other / Multiracial / unspecified, 73 Asian, 50 Black / African American	Between-subjects	Work context	Yes	Yes
Kroska et al. (2014)	**Age:** Unreported **Gender:** 0 males / 110 females **Ethnicity:** unreported	Between-subjects	Fellow student	Yes	No
Lawrie (1999)	**Age:** 32-70 (x̄=unreported) **Gender:** 58 males / 45 females **Ethnicity:** unreported	Between-subjects	Neighbour	Yes	No

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[1] Hipes & Gemoets (2019) classify one individual's gender as 'other' however they do not include this in their total sample.

Lawrie et al. (1998)	**Age:** 35-50 (x̄=unreported) **Gender:** 95 males / 71 females **Ethnicity:** Unreported	Between-subjects	Patient	Yes	No
Lucas & Phelan (2019)	**Age:** 30-32 (x̄=unreported) **Gender:** 78 males / 106 females **Ethnicity:** 94 European American (White), 32 Asian American, 25 African American, 20 multiple ethnicities, 7 ‘other’ 5 Hispanic, 1 Native American	Between-subjects	Fellow student	Yes	Yes
Mendel et al (2015)	**Age:** Range = unreported (x̄=45.3) **Gender:** 651 males / 95 females / 2 unreported **Ethnicity:** unreported	Between-subjects	Work context	No	No
Selezneva & Batho (2019)	**Age:** Range = unreported (x̄=20.58) **Gender:** 81 males / 81 females **Ethnicity:** unreported	Between-subjects	Work context	No	No
Szeto et al. (2013)	**Age:** Range = unreported (x̄=21.55) **Gender:** 37 males / 87 females **Ethnicity:** 54 Asian, 53 White, 17 Other	Between-subjects	Social acquaintance	No	No

Thibodeau et al. (2015) – Study 2	**Age:** 18-76 ($\bar{x}$= 33.13) **Gender:** 440 males / 407 females **Ethnicity:** unreported	Between-subjects	Generic context	Yes	Yes
Wadley & Haley (2001)	**Age:** Unreported **Gender:** 221 females **Ethnicity:** 111 White, 95 African American, 10 Asian, 4 Hispanic, 1 Native American	Between-subjects	Relative	Yes	Yes

Appendix F

Results from Literature Review

Effect sizes interpreted using Cohen (1998). Effect sizes noted for Cuttler & Ryckman (2019) are relevant to the whole MANOVA analysis (three conditions), as opposed to specific conditions (labels).

Study	**Comparator**	**Result**	**Significance**	**Effect Size**	**Effect Size Interpretation**
Abdullah & Brown (2019)	‘Stress at work’	Increased social distance from ‘depression’	$p=.02$	$\eta^2 = .05$	Small - Medium
		No impact on dangerousness, fear, enforced support, plans to engage, irritation, aggravation, anger.	Unreported	X	X
Cassidy & Krendl (2018) – 1A	‘Healthy’	‘Depression’ sadder	$p<.001$	$\eta_p^2 = .10$	Medium – Large

Cassidy & Krendl (2018) - 1B	‘Healthy’	‘Depression’ sadder	p=.01	$\eta_p^2 = .04$	Small – Medium
	‘Migraine’	No impact on sadness	p=.39	$\eta_p^2 = .004$	Small
Cassidy & Krendl (2018) - 2	‘Healthy’	‘Depression’ angrier	p<.001	$\eta_p^2 = .08$	Medium – Large
	‘Migraine’	‘Depression’ angrier	p=.006	$\eta_p^2 = .04$	Small – Medium
Cormack & Furnham (1998)	No label	No impact on social distance	Unreported	X	X
Cuttler & Ryckman (2019	No label	‘Depression’ more aggressive	p=.01	$\eta_p^2 = .02$	Small – Medium
		‘Depression’ more volatile	p<.001	$\eta_p^2 = .07$	Medium – Large
		‘Depression’ more unhappy	p<.001	$\eta_p^2 = .37$	Large
		‘Depression’ more unlikeable	p=.007	$\eta_p^2 = .02$	Small - Medium
		‘Depression’ more disorganised	p<.001	$\eta_p^2 = .04$	Small - Medium
		‘Depression’ more unreliable	p<.00	$\eta_p^2 = .08$	Medium – Large

		‘Depression’ more confused	p<.001	$\eta_p^2 = .07$	Medium – Large
		No impact on attention-seeking	p=.194	$\eta_p^2 = .01$	Small
		No impact on incompetence	p=.057	$\eta_p^2 = .01$	Small
		No impact on embarrassing	p=.153	$\eta_p^2 = .01$	Small
Dixon et al. (2008)	‘Good health’	‘Depression’ more violent	p<.001	X	X
		‘Depression’ more safeguarding concerns			
		‘Depression’ less content on caseload			
		‘Depression’ more sympathy			
		‘Depression’ more chance of referral to talking therapy			
		‘Depression’ more time consuming			

	‘Depression’ more likely to use alcohol / drugs			
	No impact of ‘depression’ on adherence to treatment, referral to specialist, liaise with GP, offer information about healthy lifestyle	Unreported	X	X
‘Diabetes’	‘Depression’ more violent	p<.001	X	X
	‘Depression’ more safeguarding concerns			
	‘Depression’ more sympathy			
	‘Depression’ more chance of referral to talking therapy			
	‘Depression’ more likely liaise with GP			

		‘Depression’ less likely to refer to specialist			
		‘Depression’ less likely to adhere to treatment			
		‘Depression’ more likely to use alcohol / drugs			
		No impact on content on caseload, offering information about healthy lifestyles, time consumption	Unreported	X	X
Glozier et al. (2006)	‘Alcohol problems’	‘Depression’ less concerns	p=.03	0.6 (specific measure of effect size unreported)	X
	‘Diabetes’	‘Depression’ more concerns	p=.01		
Gonschor et al. (2020)	‘Grief symptoms’	‘Depression’ less dependent	p<.01	$\eta_p^2 = .009$	Small

		No impact on fear	p=.48	$\eta_p^2 = .001$	Small
		No impact on social distance	p=.97	$\eta_p^2 = .001$	Small
		No impact on pity / compassion	p=.38	$\eta_p^2 = .001$	Small
		No impact on anger	p=.41	$\eta_p^2 = .001$	Small
		No impact on competence	p=.45	$\eta_p^2 = .001$	Small
		No impact on sensitivity	p=.86	$\eta_p^2 = .000$	Small
		No impact on warmth	p=.87	$\eta_p^2 = .003$	Small
		No impact on emotional stability	p=.29	$\eta_p^2 = .001$	Small
Hipes & Gemoets (2019)	No Label	‘Depression’ higher incompetence	p<.05	X	X
		‘Depression’ lower assertiveness	p<.001		
		No impact on dangerousness, social distance	Unreported		

Kroska et al. (2014)	‘No hospitalisation’	‘Depression’ higher social distance	p<.05	X	X
		‘Depression’ less chance of offering name	p<.01		
		No impact on preference to meet socially, share email address, likeability	Unreported		
Lawrie (1999)	‘Healthy’	‘Depression’ higher chance of offering hot drink	p=.01	X	X
		‘Depression’ more likely to consume alcohol	p=.004		
		No impact on safeguarding concerns for child, individual caring for child, minding individual’s child, views about	Unreported		

	visiting, discussing personal matters, going out with socially, lending sugar, joy in meeting, sympathy, ability to manage difficulties	
‘Diabetes’	‘Depression’ more likely to give sugar	p=.008
	No impact on individual caring for child, safeguarding concerns for child, minding individual’s child, views about visiting, discussing personal matters, going out with socially, offering hot drink, joy in meeting, sympathy, ability to	Unreported

		manage difficulties, alcohol use.			
Lawrie et al. (1998)	‘Healthy’	‘Depression’ more likely to prescribe antidepressants	p<.001	X	X
		No impact on violence, safeguarding children concerns, contentment on caseload, sympathy, referral to talking therapy, offering advice around healthy lifestyles, liaising with prior GP, referral to specialist, time consumption, adherence to treatment, drug / alcohol use	Unreported		

‘Diabetes’	‘Depression’ more safeguarding concerns about child	p=.0008
	‘Depression’ more likely to refer to talking therapy	p=.05
	‘Depression’ more likely to prescribe antidepressants	p<.001
	‘Depression’ less likely to refer to specialist	p<.001
	No impact on violence, contentment on caseload, sympathy, offering advice around healthy lifestyles, liaison with prior GP, time consumption, adherence to	Unreported

		treatment, alcohol / drug use.			
Lucas & Phelan (2019)	No label	‘Depression’ less likely to pick same future study slot	p=.004	X	X
		No impact on influence	p=.655	d=.12	Small
Mendel et al. (2015)	‘Burnout’	‘Depression’ more able to manage high pressure	p=.03	d=.23	Small - Medium
		No impact on agency to reduce future distress	Unreported	d=.16	Small
		No impact on experience future distress	Unreported	d=.02	Small
		No impact on beliefs about support required	Unreported	d=0.24	Small - Medium
		No impact on beliefs about absence from work	Unreported	d=0.10	Small

	No impact on beliefs about capability for leadership role	Unreported	d=0.07	Small
	No impact on perceptions to adjust criticism	Unreported	d=.10	Small
‘Private crisis’	‘Depression’ more likely to experience future distress	p=.01	d=.26	Small - Medium
	No impact on agency to reduce future distress	Unreported	d=.08	Small
	No impact on beliefs about support needed	Unreported	d=0.15	Small
	No impact on beliefs about capacity to manage high pressure	Unreported	d=0.13	Small
	No impact on beliefs about absence from work	Unreported	d=0.14	Small

	No impact on beliefs about capability for leadership role	Unreported	d=0.08	Small
	No impact on perceptions to adjust criticism	Unreported	d=0.22	Small – Medium
‘Thyroid disease’	‘Depression’ more likely to experience future distress	p<.001	d=0.36	Small - Medium
	‘Depression’ more agency to reduce future distress	p<.001	d=0.37	Small - Medium
	‘Depression’ more likely to require support	p<.001	d=0.43	Small - Medium
	‘Depression’ less able to manage high pressure	p<.001	d=0.43	Small - Medium
	‘Depression’ less capability for leadership role	p<.001	d=0.48	Small – Medium

		‘Depression’ more likely to be absent from work	p=.01	d=.25	Small - Medium
		No impact on perceptions to adjust criticism	Unreported	d=0.16	Small
Selezneva & Batho (2019)	No label	‘Depression’ lower chance of being selected for hire	p<.01	d=0.5	Medium – Large
Szeto et al. (2013)	‘Mental disease’	No impact on social distance	p=0.302	d=0.25	Small - Medium
	‘Mental disorder’			d=0.05	Small
	‘Mental health problem’			d=0.51	Medium – Large
	‘Mental illness’			d=0.37	Small – Medium
Thibodeau et al. (2012) - 2	No label	‘Depression’ lower responsibility	p=.005	d=.229	Small
		No impact on empathy	p>.20	X	X
	‘Neurological disorder’	No impact on empathy	p>.20	X	X

		No impact on responsibility	p=.667	X	X
Wadley & Haley (2001)	‘No label’	‘Depression’ more likely to agree to relative residing with them	p<.0005	X	X
		‘Depression’ higher sympathy	p<.0001	d=0.77	Medium – Large
		‘Depression’ lower anger	p<.0001	d=0.54	Medium – Large
		No impact on inclination to join family holiday	Unreported	X	X
	‘Alzheimer’s disease’	‘Depression’ less likely to join family holiday	p<.005	X	X
		‘Depression’ lower sympathy	p<.001	d=0.45	Small – Medium
		‘Depression’ higher anger	p<.001	d=0.44	Small – Medium

		‘Depression’ higher responsibility	p<.0001	X	X
		‘Depression’ higher control	ps≤.05	X	X
		No impact on likely to agree to relative residing with them	Unreported	X	X

Appendix G*

Ethical Approval Letter

UNIVERSITY OF LEICESTER

School of Psychology Research Ethics Committee

18/12/2020

Ethics Reference: 28016-efh6-ls:neuroscience,psychology&behaviour

TO:

Name of Researcher Applicant: [redacted]

Department: Psychology

Research Project Title: Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Dear [redacted],

RE: Ethics review of Research Study application

The School of Psychology Research Ethics Committee has reviewed and discussed the above application.

1. Ethical opinion

The Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

Approved

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the University Ethics Online System. With your permission, the Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

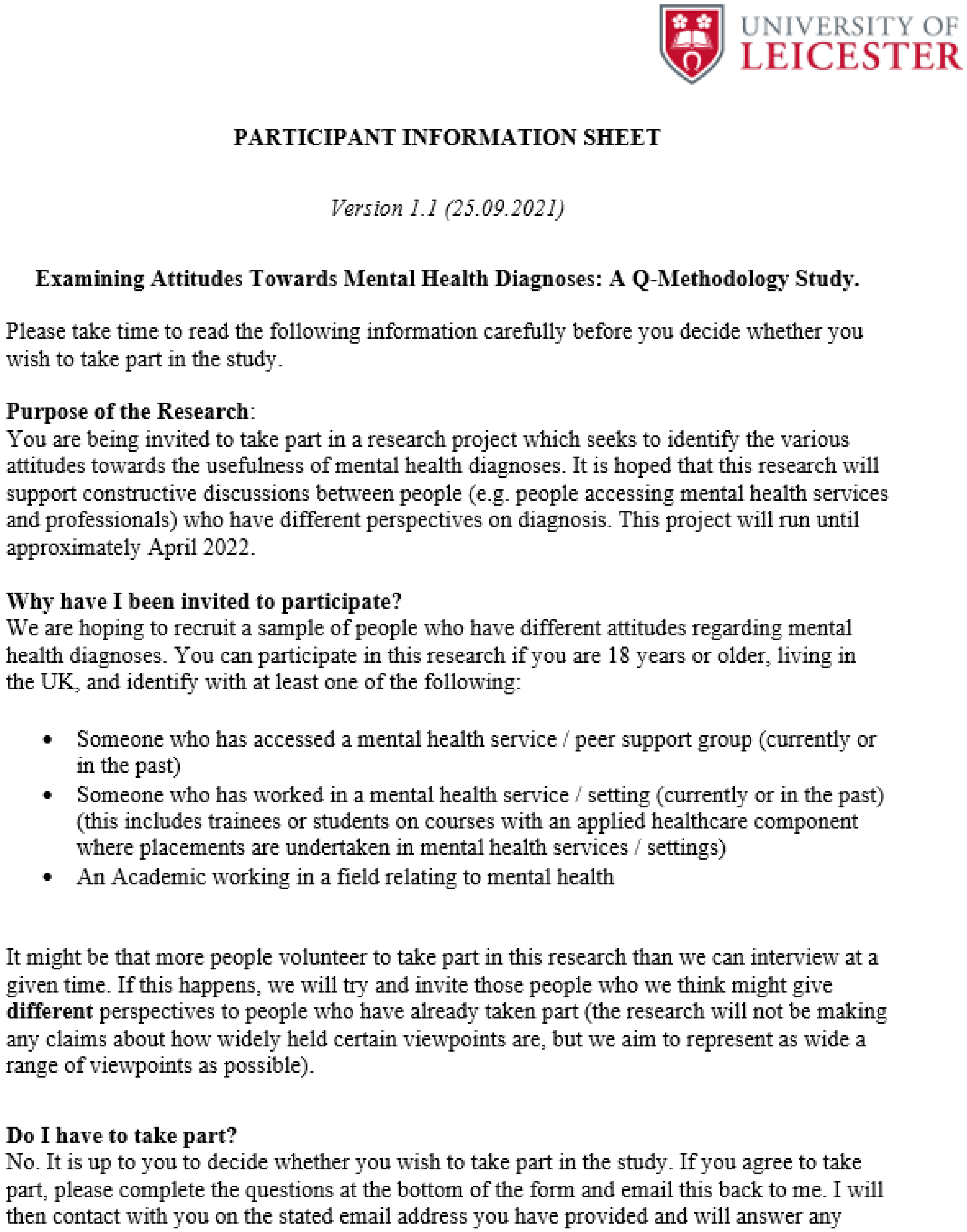
Best wishes for the success of this research project.

Yours sincerely,

[redacted]

Appendix H*

Participant Information Sheet (Main Study)



PARTICIPANT INFORMATION SHEET

Version 1.1 (25.09.2021)

Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Please take time to read the following information carefully before you decide whether you wish to take part in the study.

Purpose of the Research:
You are being invited to take part in a research project which seeks to identify the various attitudes towards the usefulness of mental health diagnoses. It is hoped that this research will support constructive discussions between people (e.g. people accessing mental health services and professionals) who have different perspectives on diagnosis. This project will run until approximately April 2022.

Why have I been invited to participate?
We are hoping to recruit a sample of people who have different attitudes regarding mental health diagnoses. You can participate in this research if you are 18 years or older, living in the UK, and identify with at least one of the following:

- Someone who has accessed a mental health service / peer support group (currently or in the past)
- Someone who has worked in a mental health service / setting (currently or in the past) (this includes trainees or students on courses with an applied healthcare component where placements are undertaken in mental health services / settings)
- An Academic working in a field relating to mental health

It might be that more people volunteer to take part in this research than we can interview at a given time. If this happens, we will try and invite those people who we think might give **different** perspectives to people who have already taken part (the research will not be making any claims about how widely held certain viewpoints are, but we aim to represent as wide a range of viewpoints as possible).

Do I have to take part?
No. It is up to you to decide whether you wish to take part in the study. If you agree to take part, please complete the questions at the bottom of the form and email this back to me. I will then contact with you on the stated email address you have provided and will answer any

questions you may have before you decide if you want to take part or not. If you change your mind, you can contact me and ask to have your data removed from the study. You can do this, without giving reason, right up until the final stages of analysis (January 2022).

What will happen if I take part?
You will be asked to complete a consent form and a demographic information sheet prior to engaging with a sorting task. The demographic information you will be asked to provide will include your age, ethnicity, gender and occupation; you will also be asked about your own experiences of mental health diagnoses and use of services. You do not have to provide answers to any of the demographic questions if you do not want to. You will then be provided with 57 cards containing statements about attitudes towards mental health diagnoses. You will be asked whether you agree, disagree or feel neutral about each statement. Then, you will be asked to sort the statements onto a grid to show which statements you agree with and disagree with most (this is called a Q-sorting task). The sorting task may take place face to face at the University of Leicester (Covid-19 restrictions permitting), or may be completed remotely using a laptop, computer or tablet with internet connection (the sorting task DOES NOT work on smartphones). After you have completed the sorting task you will answer some questions about why you sorted the statements in the way you did to get more information about your attitudes. If taking place remotely, the researcher will discuss whether they will remain present with you (virtually via a video-conferencing platform or telephone) for the duration of the sorting task, and whether the interview after the sorting task takes place via a video-call or telephone call with the researcher, or via an online survey. The sorting task and interview should take no more than 1 hour to complete in total. If you speak with the researcher for the interview (via video-call / telephone call / face to face) this may be video/audio recorded with your consent. Alternatively, the researcher will ask if they can take written notes of the things you say.

What are the potential risks of taking part?
It is unlikely that there will be any risks involved with participating within the study. However, it is recognised that discussion of attitudes to mental health diagnoses may trigger difficult emotions for some people. Please take this into consideration before agreeing to participate as the researchers will not be able to provide support following the study beyond signposting to support organisations.

What are the possible benefits of taking part?
Whilst there is no immediate benefit for participating in the study, your engagement could provide valuable contribution into investigating the attitudes which exist towards mental health diagnoses, which will in turn help explore the relationship between these attitudes and issues such as stigma. You can choose to be entered into a prize draw to win one available £25 High-Street voucher if you take part in this study.

My Data:

Information about the data you provide within this study can be found below:

- *What data will be collected?*
  To take this part in this study you will be required to provide your email address in order that I can send the link for the sorting task. If you want me to call you on the phone to complete the interview after the sorting task, you would need to supply your phone number (optional). You will be asked to provide the following information

about yourself, however you can choose not to provide an answer to these questions, and still take part in the study: age, ethnicity, gender, occupation, whether you have ever received a mental health diagnosis and whether you have ever used mental health services or a mental health peer support group. The research involves collecting information about your attitudes towards the usefulness of mental health diagnoses.

- *How will my data be collected?*
  Personal information such as your email address, age, gender, ethnicity, occupation and whether you have ever received a mental health diagnosis or accessed mental health services will be provided by you via email or through speaking to the researcher. Your attitudes to mental health diagnoses will be collected based on your sorting of statements and what you say during the interview. If you complete the sorting task online, the software *(Easy HTML-Q)* does not collect personal data about you.
- *How will my data be used?*
  The ratings you give to the different statements, and the answers you provide about how you have sorted these statements, will contribute to an analysis that will aim to identify different sets of attitudes towards mental health diagnoses. The responses that you write or say during the interview may be used as quotes in written reports, but you will not be identifiable from your quotes. The data will be used to contribute towards an academic thesis as part of a Doctorate in Clinical Psychology, academic publications and dissemination at conferences. You will have the opportunity to request a copy of the research findings.
- *Will my data be kept confidential?*
  The information you provide within this study will remain confidential within the research team unless there are any serious concerns about your safety, or the safety of others. If this is the case the researcher will, except in exceptional circumstances, firstly speak with you before making a disclosure to an authority relevant to the concern.
- *Will my data be anonymised?*
  Although information that you provide within the study will be used within written / published research reports, this will not be linked to you; therefore you will not be able to be identified from this information. Personally identifiable data will be stored separately to the answers you provide concerning attitudes towards mental health diagnoses.
- *How will my data be stored securely?*
  Data will be stored securely in line with University of Leicester guidelines. Data you provide during the online Q-Sort task through Easy HTML-Q will be stored temporarily on Google servers but will be extracted to be stored electronically in line with University of Leicester guidelines. Only your rankings of agreement/disagreement will be stored on the external servers. No personally-identifiable information will be inputted to or stored on those servers. Only members of the research team will have access to your data. Your normal rights under the Data Protection Act and the General Data Protection Regulation apply. However, we need to manage your records in specific ways for the research project to be reliable. This means that we won't always be able to let you see or change the data we hold about you.

- *How long will you keep my data for?*
  Information you provide within the study will be stored for 5 years and destroyed after this, in line with University of Leicester policies.
- *Can I remove my data from the study?*
  If you would like to remove your data from the study you can contact a member of the research team and request this. You can do this, without giving reason, right up until the final stages of data analysis (January 2022).
- *Will my data be used in other research projects in the future?*
  Non-personal data you provide within the study (your rankings of the statements within the sorting task and your answers to the interview questions) may be used to contribute to other research projects. The research team will only grant permission to other researchers to use this non-personally identifiable data if their study has gained ethical approval and the aims of their proposed research are in line with the aims of the research you have consented to.

Who is organising and funding the research project?
The research is being conducted by [redacted] (Trainee Clinical Psychologist), Department of Neuroscience Psychology and Behaviour, The University of Leicester. The research is being supervised by [redacted] (Clinical Lecturer / Clinical Psychologist), Department of Neuroscience Psychology and Behaviour, The University of Leicester. The project is not funded.

Who has reviewed this research project?
This research project has been approved by a University of Leicester Ethics Committee.

How to take part?
If you have read this Participant Information Sheet (*Version 1.1, 25.09.2021*) and would like to express interest in taking part, please complete the form below and email it back to the researcher at the address provided below.

Contact for Further Information
For further information about the research project please contact the researcher ([redacted]) or the research project supervisor ([redacted]). If you have any concerns or queries about the way in which this research project has been conducted, you should contact the Chair of the University Research Ethics Committee ([redacted]). If you require more GDPR data protection information then you can access this via the University's Information Assurance Services ([redacted]).

Please answer the questions below if you wish to take part in this research project.

If you are interested in taking part, please confirm the following:

☐ I confirm that I am aged 18 years or older (click to mark the box or type response here):

☐ I confirm that I live in the UK (click to mark the box or type response here):

☐ I confirm that I have read and understood the accompanying study information sheet *(Version 1.1, 25.09.2021)* (click to mark the box or type response here):

☐ I consent to be contacted via email by the researcher (click to mark the box or type response here):

Email Contact:

Please indicate the preferred email address you wish to be contacted on for participation within this study (this email address will be stored securely for your participation within the study): ____

Please indicate which of the following categories you identify with (tick all that apply):

☐Someone who has accessed a mental health service / peer support group (currently or in the past) (click to mark the box or type response here):

☐ Someone who has worked in a mental health service / setting (currently or in the past) *(this includes trainees or students on courses with an applied healthcare component where placements are undertaken in mental health services / settings)* (click to mark the box or type response here):

☐ An Academic working in a field relating to mental health (click to mark the box or type response here):

Views towards Mental Health Diagnoses:

Within this study it will be useful to include people who hold a range of views towards mental health diagnoses. It might be that more people volunteer to take part in the research than can be interviewed at a given time, if this happens we will try and invite those people who we think might be able to give **different perspectives than those who have already taken part**. To help with this, please could you answer the following question:

How strongly do you agree with the use of mental health diagnoses (e.g. personality disorder, schizophrenia, depression) in mental health services?

1	2	3	4	5
(Strongly Disagree)		(Neutral)		(Strongly Agree)

Please email your completed form to the researcher on the following email address: [redacted] ([redacted], Trainee Clinical Psychologist).

Appendix I*

Consent Form (Main Study)

UNIVERSITY OF LEICESTER

CONSENT FORM

Version 1.0 (27.11.2020)

Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

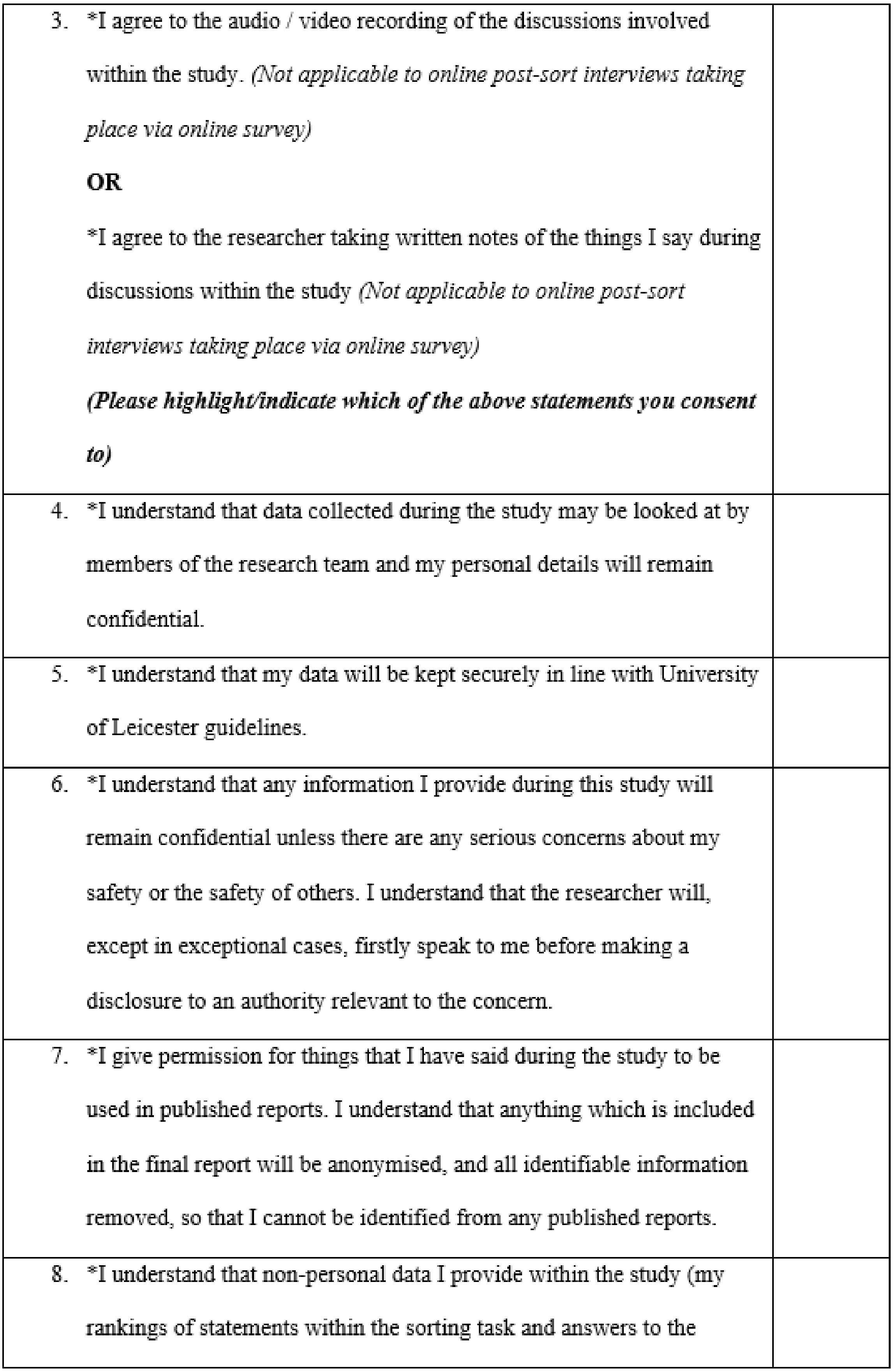
Participant ID: (to be completed by the researcher)

Questions marked with * are mandatory in order to take part.

Please indicate your agreement with each statement by typing an "X" within the corresponding box. By completing this consent form in this manner and emailing it back to the researcher you are indicating your consent to take part in the research study.

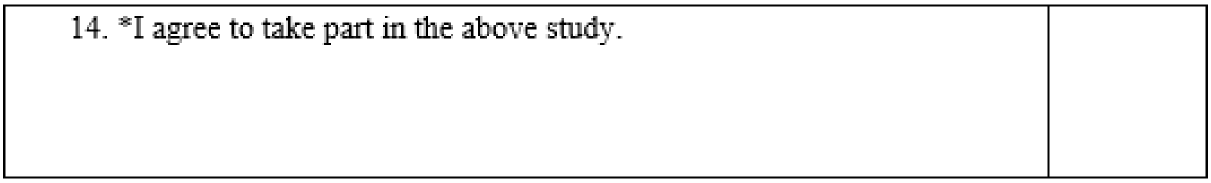
Date__/__/__

1. *I confirm that I have read and understood the participant information sheet (*Version 1.1, 25.09.2021*), for the above study, have had the opportunity to ask questions and have received satisfactory answers.	
2. *I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, up until the data analysis stage (January 2022). I can request this by emailing the researcher.	



3. *I agree to the audio / video recording of the discussions involved within the study. *(Not applicable to online post-sort interviews taking place via online survey)* **OR** *I agree to the researcher taking written notes of the things I say during discussions within the study *(Not applicable to online post-sort interviews taking place via online survey)* ***(Please highlight/indicate which of the above statements you consent to)***	
4. *I understand that data collected during the study may be looked at by members of the research team and my personal details will remain confidential.	
5. *I understand that my data will be kept securely in line with University of Leicester guidelines.	
6. *I understand that any information I provide during this study will remain confidential unless there are any serious concerns about my safety or the safety of others. I understand that the researcher will, except in exceptional cases, firstly speak to me before making a disclosure to an authority relevant to the concern.	
7. *I give permission for things that I have said during the study to be used in published reports. I understand that anything which is included in the final report will be anonymised, and all identifiable information removed, so that I cannot be identified from any published reports.	
8. *I understand that non-personal data I provide within the study (my rankings of statements within the sorting task and answers to the	

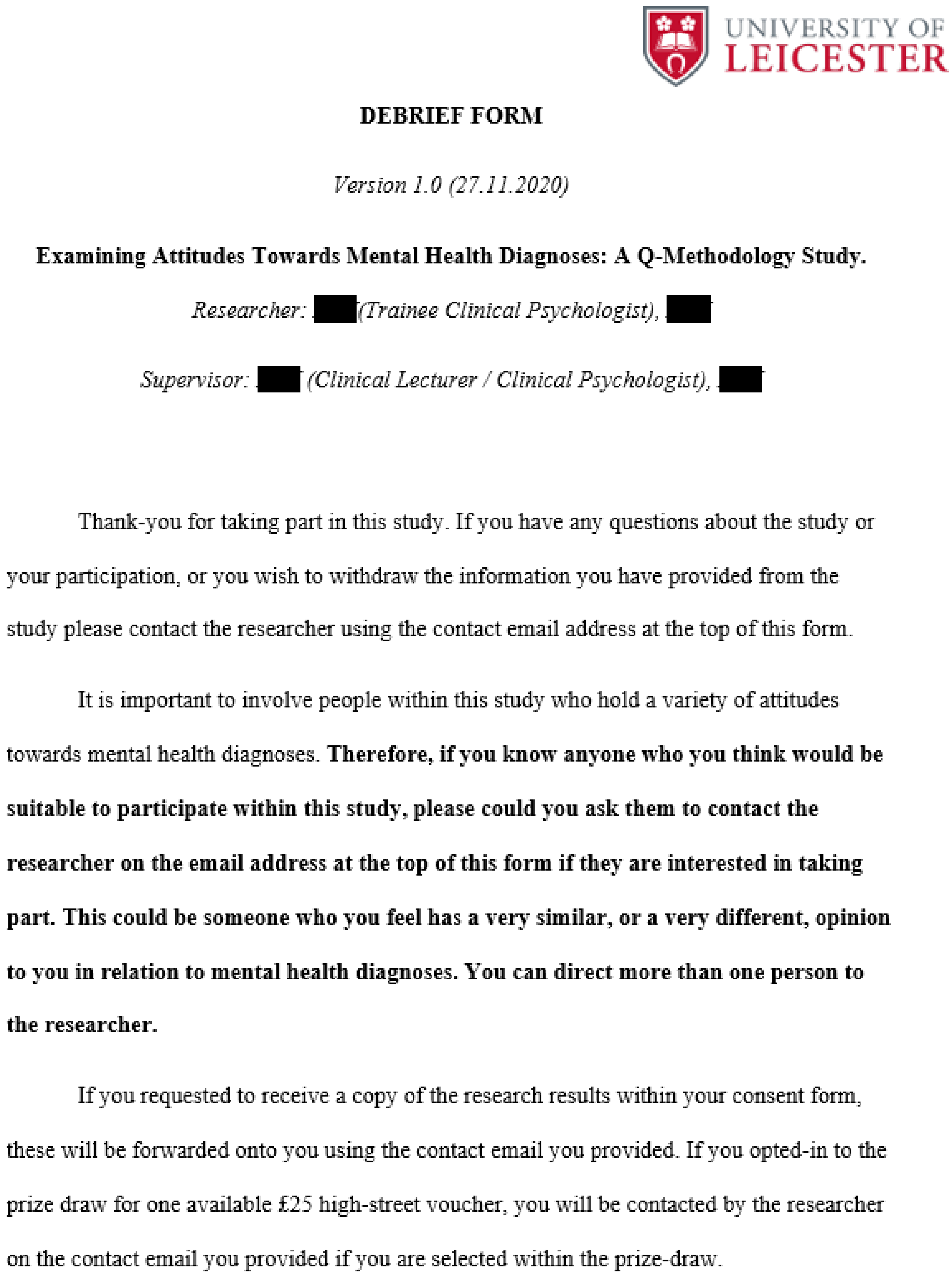
interview questions) may be used to contribute to other research projects. No personally-identifiable data will be shared, and the researchers will only share anonymised rankings with researchers if their study has gained ethical approval and the aims of their proposed research are in line with the aims of this study.	
9. *I can confirm I am aged 18 years or older.	
10. *I can confirm that I identify with one of the following: • Someone who has accessed a mental health service / peer support group (currently or in the past) • Someone who has worked in a mental health service / setting (currently or in the past) *(this includes trainees or students on courses with an applied healthcare component where placements* are undertaken in mental health services / settings) • An Academic working in a field relating to mental health	
11. *I understand that my personal data will be kept by The University of Leicester for 5 years following completion of the research, and that identifiable information will not be shared with any external organisation.	
12. I would like to receive a report of the findings, and consent to the email address I have provided being stored for this purpose.	
13. I would like to opt-in to the prize-draw to win a £25 High-Street voucher, and consent to the email address I have provided being stored for this purpose.	



14. *I agree to take part in the above study.	

Appendix J*

Debrief Form (Main Study)



DEBRIEF FORM

Version 1.0 (27.11.2020)

Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Thank-you for taking part in this study. If you have any questions about the study or your participation, or you wish to withdraw the information you have provided from the study please contact the researcher using the contact email address at the top of this form.

It is important to involve people within this study who hold a variety of attitudes towards mental health diagnoses. **Therefore, if you know anyone who you think would be suitable to participate within this study, please could you ask them to contact the researcher on the email address at the top of this form if they are interested in taking part. This could be someone who you feel has a very similar, or a very different, opinion to you in relation to mental health diagnoses. You can direct more than one person to the researcher.**

If you requested to receive a copy of the research results within your consent form, these will be forwarded onto you using the contact email you provided. If you opted-in to the prize draw for one available £25 high-street voucher, you will be contacted by the researcher on the contact email you provided if you are selected within the prize-draw.

If completing the study has brought up any difficult emotions or experiences for you, please consider seeking further support using one of the following contacts:

- The Samaritans – A confidential listening service
  -Website: https://www.samaritans.org/
  -Telephone: 116 123 (free service, operating 24 hours per day)
  -Email: jo@samaritans.org (the service aims to respond to your email within 24 hours)

- MIND – A Mental Health Charity
  -Website: https://www.mind.org.uk/
  -This website contains information on how you can seek support for your mental health

- Rethink Mental Illness – A Mental Health Charity
  -Website: https://www.rethink.org/
  -This website contains information on ways you can seek support for your mental health

- You could also contact your GP if you are concerned about your own mental health and wish to seek support from an NHS service.

Appendix K

Study Poster

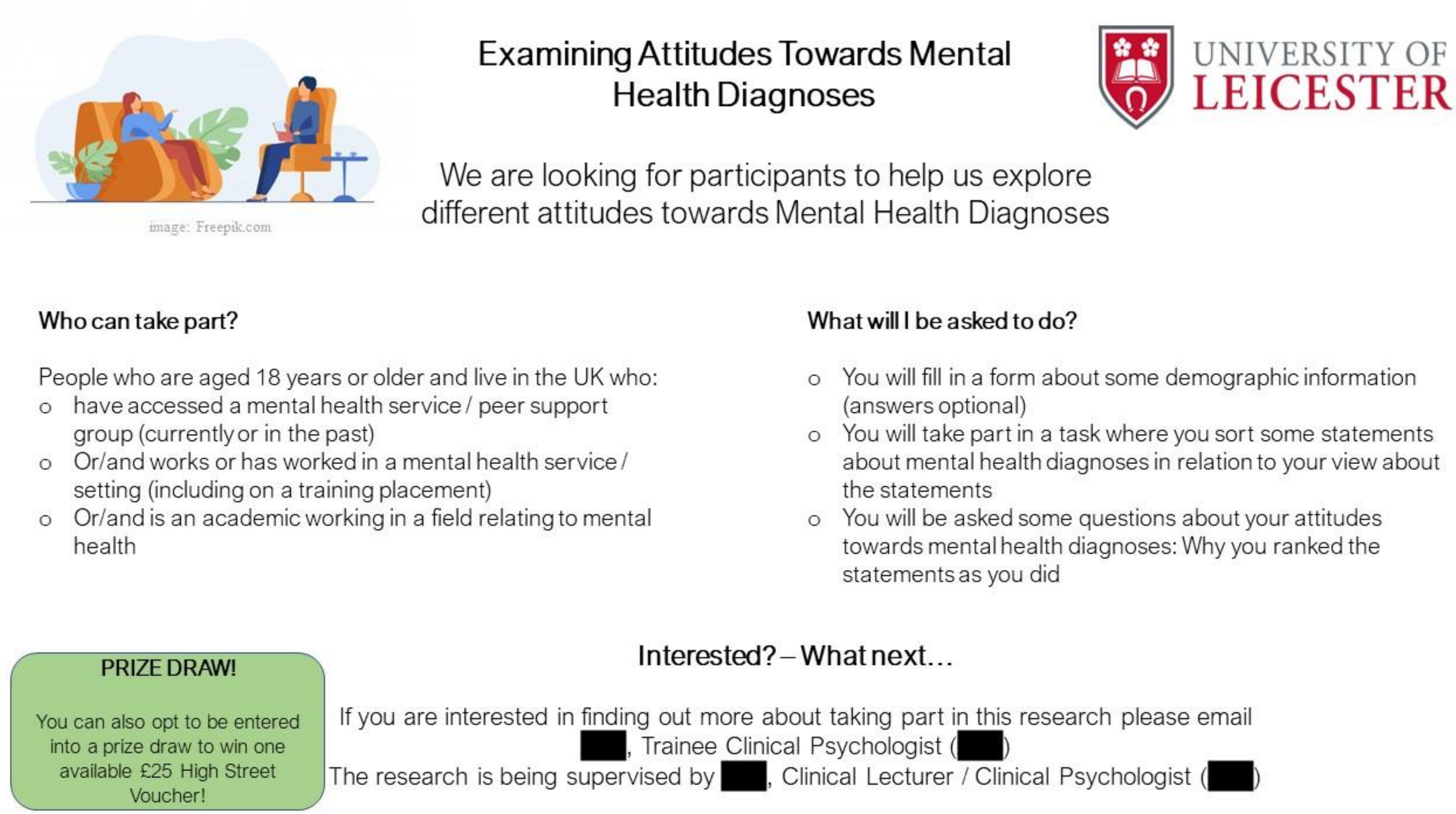


image: Freepik.com

Examining Attitudes Towards Mental Health Diagnoses

UNIVERSITY OF LEICESTER

We are looking for participants to help us explore different attitudes towards Mental Health Diagnoses

Who can take part?

People who are aged 18 years or older and live in the UK who:

- have accessed a mental health service / peer support group (currently or in the past)
- Or/and works or has worked in a mental health service / setting (including on a training placement)
- Or/and is an academic working in a field relating to mental health

What will I be asked to do?

- You will fill in a form about some demographic information (answers optional)
- You will take part in a task where you sort some statements about mental health diagnoses in relation to your view about the statements
- You will be asked some questions about your attitudes towards mental health diagnoses: Why you ranked the statements as you did

PRIZE DRAW!

You can also opt to be entered into a prize draw to win one available £25 High Street Voucher!

Interested? – What next…

If you are interested in finding out more about taking part in this research please email [redacted], Trainee Clinical Psychologist ([redacted])
The research is being supervised by [redacted], Clinical Lecturer / Clinical Psychologist ([redacted])

Appendix L*

Final Q-Set categorised into themes associated with usefulness of mental health diagnoses

BLAME (2)

- MH diagnoses suggest relatives are to blame for the diagnosed persons distress (1)
- MH diagnoses remove blame from the diagnosed person (22)

COMMUNICATIVE TOOL (2)

- MH diagnoses offer a short-hand description which is easily understood by others (34)
- MH diagnoses make others take a person's distress more seriously (12)

DIAGNOSTIC STIGMA (5)

- MH diagnoses are more problematic for people whose culture, religion, or family view MH as a taboo or stigmatising subject (33)
- MH diagnoses cause people to experience stigma, discrimination, and exclusion (51)
- Some MH diagnoses are more stigmatising than others (21)
- MH diagnoses help people to feel they have a shared experience with others (23)
- MH diagnoses make it harder for a person to see similarities between themselves and others who have different MH diagnoses (11)

SCIENTIFIC PHENOMENA (16)

The medicalisation of human experiences:

- MH diagnoses medicalise human responses to distressing circumstances (32)
- Diagnostic criteria imply there are normal and abnormal ways of thinking, feeling, and behaving (24)
- MH diagnoses highlight an individual's strengths and resources (13)

Prognosis:

- MH diagnoses tell us about the likely course and outcome of someone’s distress (35)

Reliability:

- Professionals are good at agreeing on who meets diagnostic criteria for specific MH diagnoses (2)

A Biased System:

- Men and women get different diagnoses because of gender biases within the diagnostic system (54)
- People from different racial backgrounds get different diagnoses because of cultural / racial biases within the diagnostic system (20)
- It is problematic to apply ‘western’ MH diagnostic criteria to people from ‘non-western’ cultures or faiths (10)

Validity:

- MH diagnoses are based on made up categories and diagnostic criteria (52)
- We need to be certain about the cause of MH problems for diagnostic labels to be useful (50)
- MH diagnoses are just as valid as diagnoses in the rest of medicine (46)
- MH diagnoses support the financial interests of pharmaceutical companies (41)
- MH diagnoses accurately represent the symptoms people experience (9)

Biology:

- If we reject MH diagnoses, we reject the role biology plays in a person’s distress (57)
- MH diagnoses are well supported by biological evidence (31)
- MH diagnoses are needed because some symptoms are only partly explained by a person’s experiences (3)

SERVICES & PROFESSIONALS (15)

Access:

- MH diagnoses make it harder for people to access mental health services (55)
- MH diagnoses make it harder for people to access services offering financial, social, or housing support (14)
- MH diagnoses support people to get the right talking therapy for them (36)
- MH diagnoses support people to get the right medication (19)
- MH diagnoses help people to get support and adjustments associated with work / school (4)

Standards of Care:

- Diagnostic criteria help to ensure people are discharged from services when they no longer need support (49)
- MH diagnoses help to ensure that professionals are appropriately trained for the people they work with (47)
- Giving a MH diagnosis is one of the most damaging things a professional can do to a person (42)
- MH diagnoses enable professionals to safeguard the diagnosed person from risk of abuse (25)
- MH diagnoses enable oppressive practices (e.g., sectioning and restraint etc.) (8)

Collaborative Working:

- MH diagnoses support collaboration between professionals and service users (45)
- Getting the correct diagnosis is more important than the relationship between service user and professional (30)
- MH diagnoses support professionals to empathise with service users (40)

Service Management:

- MH diagnoses are needed for the structuring, funding, and management of mental health services (37)
- MH diagnoses offer more benefits to services than to service users (18)

IDENTITY (4)

- MH diagnoses consume a person's identity (5)
- People use their MH diagnoses to account for their behaviour (26)
- Others interpret everything about a diagnosed person through the lens of their diagnosis (15)
- Diagnosing someone with a MH label increases the chance that they will receive more MH diagnoses in the future (39)

UNDERSTANDING DISTRESS (10)

- MH diagnoses help people to understand their difficulties (6)
- MH diagnoses help people to accept they need support (56)
- MH diagnoses help people to manage their distress (27)
- MH diagnoses offer descriptions rather than explanations of people's problems (43)
- Loved ones become less understanding and less supportive because of a MH diagnosis (38)
- MH diagnoses are needed for research (16)

Individual Experiences:

- MH diagnoses act as a barrier to professionals understanding how individuals make sense of their experiences (48)
- MH diagnoses support psychological understandings about a person's distress (29)

The Context for Distress:

- MH diagnoses make it difficult to see a link between adversity and distress (53)
- MH diagnoses help us to see the link between distress and discrimination (44)

HOPE VS DESPAIR (3)

- MH diagnoses give people hope for recovery / change (28)
- The initial relief that people may feel when they are given a MH diagnosis is short-lived (17)
- MH diagnoses have a positive impact on various areas of a person’s life (7)

Appendix M

Origins of the Final Q-Set statements

Statement No.	**FG1**	**FG2**	**FG3**	**FG4**	**P2 Piloting**	**Supervision discussions**	**Written Concourse**
1	x		x		x		
2	x	x	x				Doward (2013) – *newspaper article*
3					x	x	Davies (2019) - *blog*
4	x	x	x	x			
5	x		x	x			Doward (2013) – *newspaper article*
6	x	x	x	x			Pavlo et al. (2019) – *academic article*
7	x	x	x				
8	x		x				
9					x		
10	x				x		
11			x				
12	x	x	x	x			
13							Pavlo et al. (2019) – *academic article* Johnstone (2013b) – *website article*
14	x	x	x		x		
15	x	x	x	x			
16	x	x	x				
17	x		x				
18	x	x					
19	x	x	x	x			Doward (2013) – *newspaper article*

20			x			
21	x	x	x			Johnstone (2013b) – *website article*
22	x	x	x			
23	x	x	x	x		
24			x			
25					x	
26				x		
27	x		x	x		Morrill (2018) – *website article*
28	x	x	x			Dillon (2013) – *website article*
29	x	x	x	x		
30				x		
31	x	x	x			Stevens & Rodin (2011) - *Book* Aftab (2020b) – *website article* Khoury et al. (2014) – *academic article*
32	x	x	x	x		Aftab (2020a) – *website article* Doward (2013) – *newspaper article* *Blog (webpage no longer accessible)* Johnstone (2018) – *Academic Article*

33		x	x	x			
34	x	x	x	x			
35							Ruffalo (2020) – *website article* Johnstone (2013b) – *website article*
36	x	x	x	x			Doward (2013) – *newspaper article*
37	x	x	x				
38	x	x	x	x	x		
39		x	x	x	x		Johnstone (2013b) – *website article*
40			x		x		
41	x		x				Doward (2013) – *newspaper article*
42							Johnstone (2013a) – *website article* Johnstone (2013c) – *website article*
43	x	x	x	x			Shedler (2019) – *website article*
44			x	x			
45		x	x				Pavlo et al. (2019) – *academic article*
46		x				x	Pies (2011) – *academic article*
47		x	x				
48	x	x	x				Dillon (2013) – *website article*
49	x		x				

50									Hickey (2015) – *website article*
51	x	x	x	x					Pies (2015) – *website article* Dillon (2013) – *website article*
52	x	x	x	x					Reese (2013) – *website article* Hickey (2015) – *website article* Johnstone (2013b) – *website article* Simons (2019) – *website article* Caplan (2019) – *website article* Johnstone (2013c) – *website article*
53	x								
54		x							Johnstone & Cromby (2013) - *Book*
55	x	x	x	x	x				Doward (2013) – *newspaper article*
56	x		x						

57		x	Johnstone & Boyle (2018) – *Published Report*

Note. Wording of the statements was adjusted throughout to support with using understandable language. Some statements were also inverted with regards to their meaning.

FG = Focus Group (as part of pilot phase 1)

P2 = Phase 2 of Piloting (adjustments to existing statement or creation of statement at this stage)

References

Aftab, A (2020a). *Institutional Corruption and Social Justice in Psychiatry*. Psychiatric Times. Retrieved February 18, 2022 from https://www.psychiatrictimes.com/view/institutional-corruption-and-social-justice-psychiatry

Aftab, A. (2020b). *Psychiatry and the Human Condition: Joanna Moncrieff, MD.* Psychiatric Times. Retrieved February 18, 2022 from https://www.psychiatrictimes.com/view/psychiatry-and-human-condition-joanna-moncrieff-md

Caplan, P. J. (2019). *Talking about Psych Diagnoses and Drugs: A Primer for Parents & Professionals.* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2019/07/talking-about-psychiatric-diagnoses-and-drugs/

Davies, M. (2019). *Trauma is not the only cause of anxiety or depression. The EDIT lab blog.* Retrieved February 18, 2022 from https://blogs.kcl.ac.uk/editlab/2019/05/17/trauma-is-not-the-only-cause-of-anxiety-or-depression/

Dillon, J. (2013). *Hearing Voices Network Launches Debate on DSM-5 and Psychiatric Diagnoses.* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2013/05/hearing-voices-network-launches-debate-on-dsm-5-and-psychiatric-diagnoses/

Doward, J. (2013). *Medicine's big new battleground: does mental illness really exist?* The Guardian. Retrieved February 18, 2022 from https://www.theguardian.com/society/2013/may/12/medicine-dsm5-row-does-mental-illness-exist

Hickey, P. (2015). *Psychiatric Diagnoses: Labels, Not Explanations*. Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2015/04/psychiatric-diagnoses-labels-not-explanations/

Johnstone, L. (2013a). *Time to Abolish Psychiatric Diagnosis?* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2013/01/time-to-abolish-psychiatric-diagnosis/

Johnstone, L. (2013b). *Thinking about Alternatives to Psychiatric Diagnosis.* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2013/01/thinking-about-alternatives-to-psychiatric-diagnosis/

Johnstone, L. (2013c). *UK Clinical Psychologists Call for the Abandonment of Psychiatric Diagnosis and the 'Disease' Model.* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2013/05/uk-clinical-psychologists-call-for-the-abandonment-of-psychiatric-diagnosis-and-the-disease-model/

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Johnstone & Cromby (2013). Causal Influences. In Cromby, J., Harper, D., & Reavey, P. *Psychology, mental health and distress* (pp. 118-138). Bloomsbury Publishing Plc.

Khoury, B., Langer, E. J., & Pagnini, F. (2014). The DSM: Mindful science or mindless power? A critical review. *Frontiers in psychology*, 5, 602. https:// doi: 10.3389/fpsyg.2014.00602

Morrill, Z. (2018). *“Diagnostic Dissent”: Experiences of Individuals Who Disagreed With Their Diagnosis.* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2018/07/diagnostic-dissent-experiences-individuals-disagreed-diagnosis/

Pavlo, A. J., Flanagan, E. H., Leitner, L. M., & Davidson, L. (2019). Can there be a recovery-oriented diagnostic practice?. *Journal of Humanistic Psychology*, 59(3), 319-338.

Pies, R. W. (2011). Toward a concept of instrumental validity: implications for psychiatric diagnosis. *Dialogues in Philosophy, Mental and Neuro Sciences*, *4*(1).

Pies ,R. W. (2015). *The War on Psychiatric Diagnosis.* Psychiatric Times. Retrieved February 18, 2022 from https://www.psychiatrictimes.com/view/war-psychiatric-diagnosis

Reese, H. (2013). *The Real Problems with Psychiatry.* The Atlantic. Retrieved February 18, 2022 from https://www.theatlantic.com/health/archive/2013/05/the-real-problems-with-psychiatry/275371/

Ruffalo, M. L. (2020). *Psychiatric Diagnosis 2.0: The Myth of the Symptom Checklist.* Psychology Today. Retrieved February 18, 2022 from https://www.psychologytoday.com/us/blog/freud-fluoxetine/202006/psychiatric-diagnosis-20-the-myth-the-symptom-checklist

Shedler, J. (2019). *A Psychiatric Diagnosis is Not a Disease*. Psychology Today. Retrieved February 18, 2022 from https://www.psychologytoday.com/us/blog/psychologically-minded/201907/psychiatric-diagnosis-is-not-disease?fbclid=IwAR3u-KSnLisi99ovkMgJVMCa4n7Gm3-d5MDWnluDCNEeiH_pes1UQVwzvsU

Simons, P. (2019). *The DSM: "Scientifically Meaningless" Diagnoses.* Mad in America. Retrieved February 18, 2022 from https://www.madinamerica.com/2019/07/dsm-scientifically-meaningless-diagnoses/

Stevens, L. & Rodin, I. (2011). Introduction: Classification in Psychiatry. In Stevens, L. & Rodin, I. (2nd Eds.) *Psychiatry* (pp. 6-7). Elsevier Health Sciences.

Appendix N

Full details of the Piloting Process

Phase one of piloting consisted of four focus-groups where a semi-structured interview schedule supported participants to consider their own and other people’s views in response to specific questions relating to mental health diagnoses. This aimed to generate material related to the concourse, defined as all available commentaries related to a topic (e.g., Van Exel & De Graaf, 2005). Phase two included individual interviews where participants considered their agreement / disagreement / neutral views about statements and shared their feedback on the statements via a semi-structured interview. Phase two specifically attempted to ensure that the statements encompassed views relevant to racialised groups and ‘non-western’ cultures.

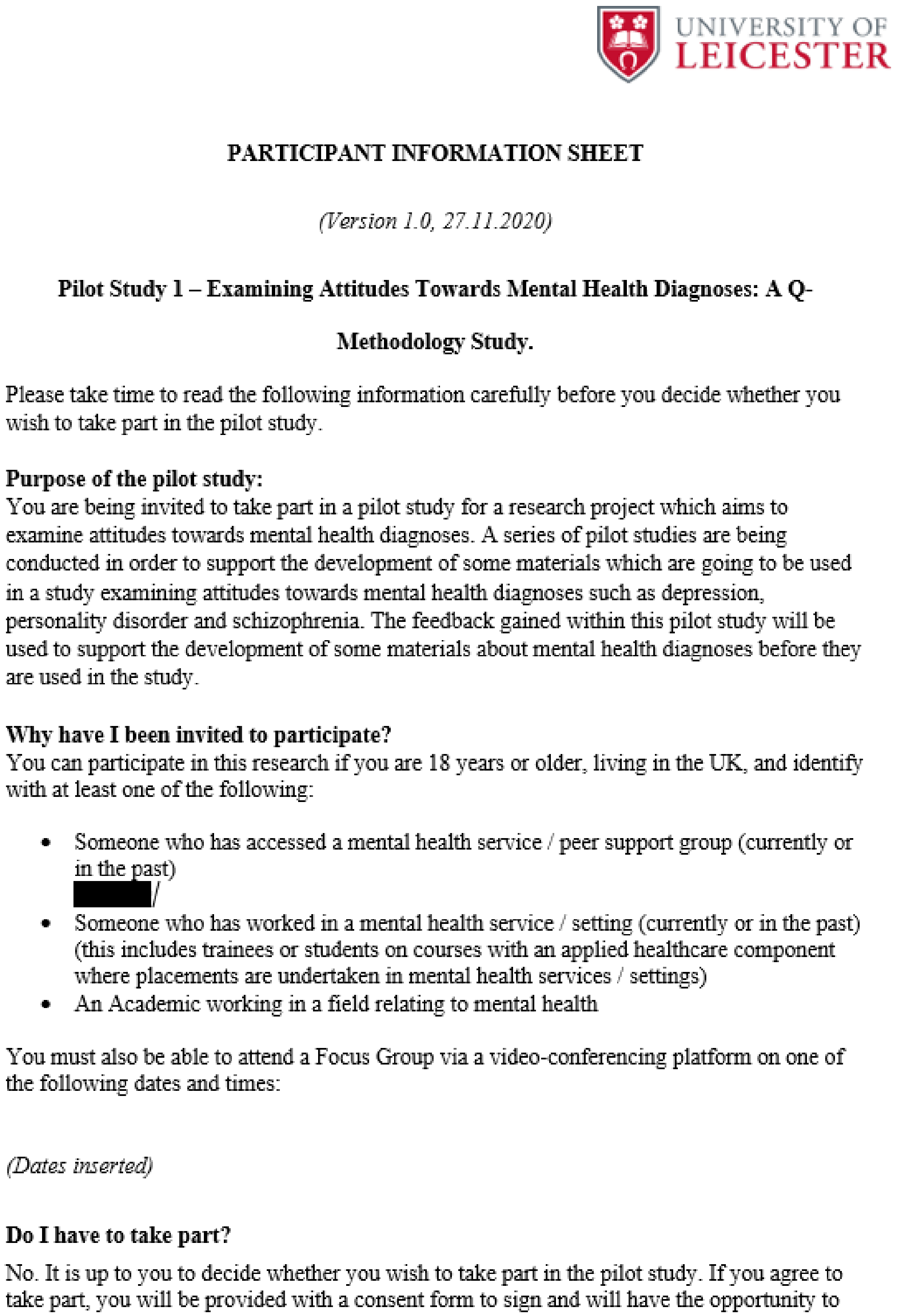
References

Van Exel, J., & De Graaf, G. (2005). *Q methodology: A sneak preview*. Retrieved February 12, 2022 from https://www.researchgate.net/profile/Gjalt_Graaf/publication/228574836_Q_Methodology_A_Sneak_Preview/links/02bfe50f946fc9978b000000.pdf

Appendix O*

Participant Forms and Questionnaires for Pilot Phases

Pilot Study 1: Information Sheet



UNIVERSITY OF LEICESTER

PARTICIPANT INFORMATION SHEET

(Version 1.0, 27.11.2020)

Pilot Study 1 – Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Please take time to read the following information carefully before you decide whether you wish to take part in the pilot study.

Purpose of the pilot study:
You are being invited to take part in a pilot study for a research project which aims to examine attitudes towards mental health diagnoses. A series of pilot studies are being conducted in order to support the development of some materials which are going to be used in a study examining attitudes towards mental health diagnoses such as depression, personality disorder and schizophrenia. The feedback gained within this pilot study will be used to support the development of some materials about mental health diagnoses before they are used in the study.

Why have I been invited to participate?
You can participate in this research if you are 18 years or older, living in the UK, and identify with at least one of the following:

- Someone who has accessed a mental health service / peer support group (currently or in the past)
[redacted]/
- Someone who has worked in a mental health service / setting (currently or in the past) (this includes trainees or students on courses with an applied healthcare component where placements are undertaken in mental health services / settings)
- An Academic working in a field relating to mental health

You must also be able to attend a Focus Group via a video-conferencing platform on one of the following dates and times:

(Dates inserted)

Do I have to take part?

No. It is up to you to decide whether you wish to take part in the pilot study. If you agree to take part, you will be provided with a consent form to sign and will have the opportunity to ask the researcher any questions you may have. You can change your mind and withdraw up until the end of the Focus Group.

What will happen if I take part?

Ahead of the focus group, you will be asked some optional questions to gather demographic information. The focus group will be an online meeting with you and up to five other participants in which you will be asked to note down your views towards the use and usefulness, or otherwise, of mental health diagnoses, and how valid and reliable you believe the diagnoses to be. There are no right or wrong answers as the research is interested in the variety of attitudes which exist, even if these are not your own attitudes but viewpoints you have come across. You will then be asked to share and discuss your responses with the group to support the generation of more viewpoints.

It is estimated that the focus group should last no longer than 60 minutes and will be video or audio recorded. Please note that it is possible that your email address may be visible to other participants within the focus group via the online platform. The researchers will aim to group participants within focus groups who have some familiarity with each other. Due to the limitations on the number of individuals who can take part in a focus group, and attempts to group participants within focus groups based on their familiarity with one another, it may be that you are unable to take part in this stage of the piloting. There will however be further opportunities to take part in later stages of piloting. Please speak to the researcher if you are interested in the later phase of piloting.

What are the potential risks of taking part?

It is unlikely that there will be any risks involved with participating within the pilot study. However, it is recognised that discussion of attitudes to mental health diagnoses may trigger difficult emotions for some people. Please take this into consideration before agreeing to participate within the pilot study as researchers will not be able to provide support following the pilot study beyond signposting to support organisations.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for taking part in the pilot study, your engagement could provide valuable contribution to the creation of materials which will be used within the main research project.

My Data:

Information about the data you provide within the pilot study can be found below:

- *What data will be collected?*
  To take part in this pilot study you will be required to provide your email address and your views towards statements relating to mental health diagnoses. You will also be asked to provide the following information about yourself, however you can choose not to provide an answer to these questions and still take part: age, ethnicity, gender, occupation, whether you have ever received a mental health diagnosis and whether you have ever used mental health services or a peer support group.
- *How will my data be collected?*
  Personal information such as your email address, age, ethnicity, gender, occupation and your experiences with mental health diagnoses/ services will be provided by you

via email or through speaking to the researcher. Your responses to statements relating to mental health diagnoses will be provided by you during the Focus Group, either through things you say or type in the chat function of the video conferencing platform.

- *How will my data be used?*

  Your responses to the statements about mental health diagnoses will be used in the next stage of the research project which will be focussed on exploring how attitudes to mental health diagnoses group together.

- *Will my data be kept confidential?*
  The information you provide within the pilot study will remain confidential within the research team unless there are any serious concerns about your safety, or the safety of others. If this is the case the researcher will, except in exceptional circumstances, firstly speak with you before making a disclosure to an authority relevant to the concern.

- *Will my data be anonymised?*
  Although things you say within the Focus Group may be used to support the creation of materials for the main research project, these will not be linked to you; therefore you will not be able to be identified from this information. This is with the exception of those who were present within your Focus Group, who may be able to link you to these statements. Personally-identifiable data you provide for the pilot study will be stored separately to things you say within the Focus Group.

- *How will my data be stored securely?*
  Data will be stored securely in line with University of Leicester guidelines. Only members of the research team will have access to your data. Your normal rights under the Data Protection Act and General Data Protection Regulation apply. However, we need to manage your records in specific ways for the research to be reliable. This means that we won't always be able to let you see or change the data we hold about you.

- *How long will you keep my data for?*
  Information you provide within the pilot study will be stored for 5 years and destroyed after this, in line with University of Leicester guidelines.

- *Can I remove my data from the pilot study?*
  You can withdraw your data up until the end of the Focus Group.

- *Will my data be used in other research projects in the future?*
  The materials which are created for the main research project as a result of the pilot studies, could be used in other research projects in the future. No one outside of the research team and the Focus Group will be able to link you to any of the things you say within the pilot study which may contribute to these materials.

Who is organising and funding the research project and associated pilot studies?
The research is being conducted by [redacted] (Trainee Clinical Psychologist), Department of Neuroscience Psychology and Behaviour, The University of Leicester. The research is being supervised by [redacted] (Clinical Lecturer / Clinical Psychologist), Department of Neuroscience

Psychology and Behaviour, The University of Leicester. The project is not funded.

Who has reviewed this research project?
This research project has been approved by a University of Leicester Ethics Committee.

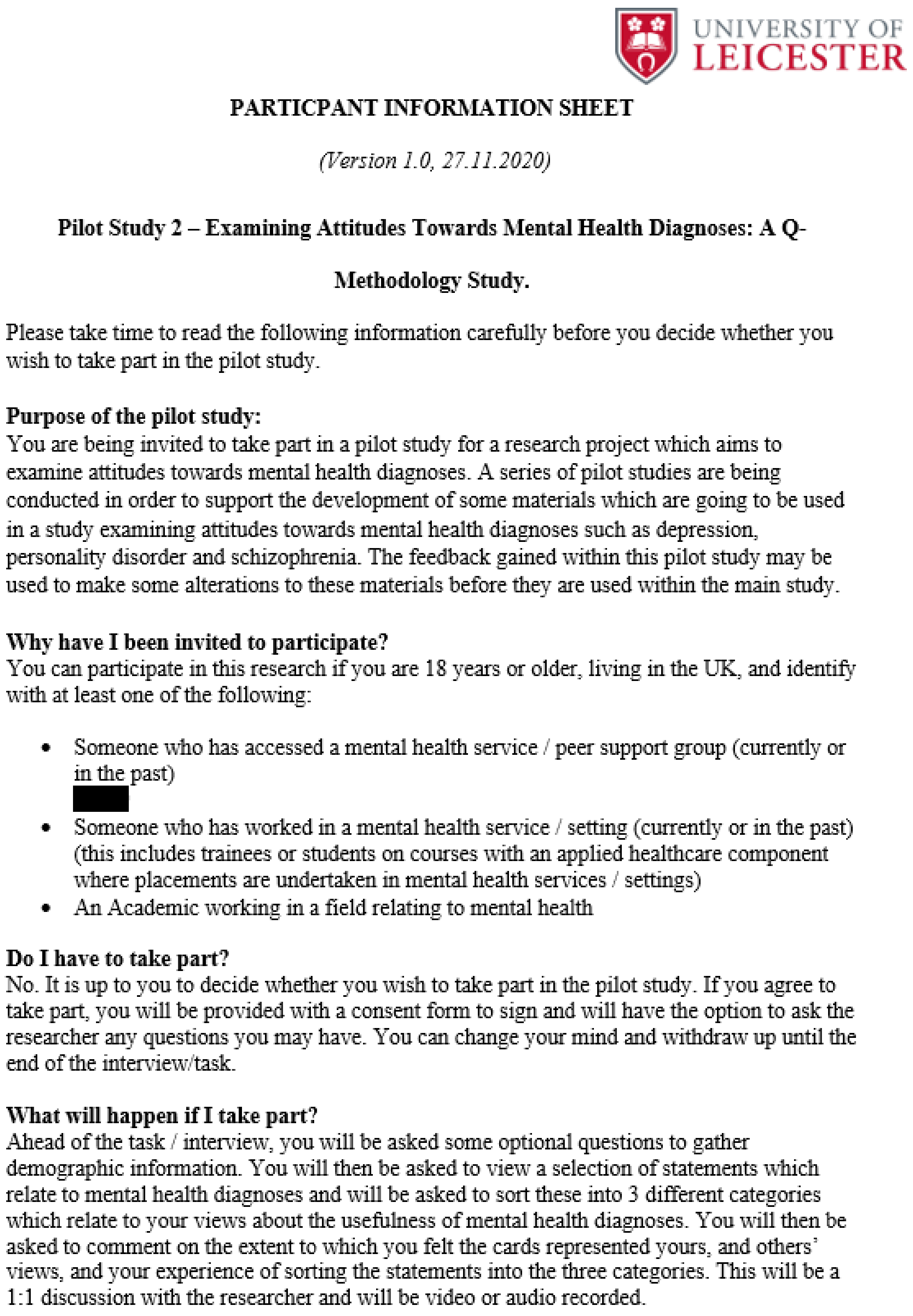
How to take part?
If you have read this Pilot Study Participant Information Sheet *(Version 1.0, 27.11.2020)* and would like to take part in a Focus Group, please email the researcher on the email address below, and inform them of the dates and times you would be able to attend a Focus Groups (listed within the "why have I been invited to participate" section of this form). Please indicate all dates you would be available. The email address you use to contact the researcher will be the email address stored for your participation within the pilot study.

Contact for Further Information
For further information about the pilot studies or research project please contact the researcher ([redacted]) or the research project supervisor ([redacted]). If you have any concerns or queries about the way in which this pilot study has been conducted, you should contact the Chair of the University Research Ethics Committee ([redacted]). If you require more GDPR data protection information then you can access this via the University's Information Assurance Services ([redacted]).

Thank-you for taking the time to read this participant information sheet.

Pilot Study 2: Information Sheet

Note: The information sheet was adjusted to include variations related to payment for participation.



UNIVERSITY OF LEICESTER

PARTICPANT INFORMATION SHEET

(Version 1.0, 27.11.2020)

Pilot Study 2 – Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Please take time to read the following information carefully before you decide whether you wish to take part in the pilot study.

Purpose of the pilot study:
You are being invited to take part in a pilot study for a research project which aims to examine attitudes towards mental health diagnoses. A series of pilot studies are being conducted in order to support the development of some materials which are going to be used in a study examining attitudes towards mental health diagnoses such as depression, personality disorder and schizophrenia. The feedback gained within this pilot study may be used to make some alterations to these materials before they are used within the main study.

Why have I been invited to participate?
You can participate in this research if you are 18 years or older, living in the UK, and identify with at least one of the following:

- Someone who has accessed a mental health service / peer support group (currently or in the past)
  [redacted]
- Someone who has worked in a mental health service / setting (currently or in the past) (this includes trainees or students on courses with an applied healthcare component where placements are undertaken in mental health services / settings)
- An Academic working in a field relating to mental health

Do I have to take part?
No. It is up to you to decide whether you wish to take part in the pilot study. If you agree to take part, you will be provided with a consent form to sign and will have the option to ask the researcher any questions you may have. You can change your mind and withdraw up until the end of the interview/task.

What will happen if I take part?
Ahead of the task / interview, you will be asked some optional questions to gather demographic information. You will then be asked to view a selection of statements which relate to mental health diagnoses and will be asked to sort these into 3 different categories which relate to your views about the usefulness of mental health diagnoses. You will then be asked to comment on the extent to which you felt the cards represented yours, and others' views, and your experience of sorting the statements into the three categories. This will be a 1:1 discussion with the researcher and will be video or audio recorded.

It is estimated that the whole process of sorting the statements and the discussion with the researcher should last no longer than 60 minutes. You will be sent the statements via email and the following discussion will take place via an online video platform.

What are the potential risks of taking part?
It is unlikely that there will be any risks involved with participating within the pilot study. However, it is recognised that discussion of attitudes to mental health diagnosis may trigger difficult emotions for some people. Please take this into consideration before agreeing to participate within the pilot study as researchers will not be able to provide support following the pilot study beyond signposting to support organisations.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for taking part in the pilot study, your engagement could provide valuable contribution to the creation/refinement of the materials and procedure which will be used within the main research project.

My Data:

Information about the data you provide within the pilot study can be found below:

- *What data will be collected?*
  To take part in this pilot study you will be required to provide your email address, your views on some statements about mental health diagnosis and your opinion on engaging in sorting these statements into categories. You will also be asked to provide the following information about yourself, however you can choose not to provide an answer to these questions, and still take part: age, ethnicity, gender, occupation, whether you have ever received a mental health diagnosis and whether you have ever used mental health services or a peer support group.
- *How will my data be collected?*
  Personal information such as your email address, age, ethnicity, gender, occupation and your experiences with mental health diagnoses/ services will be provided by you via email or through speaking to the researcher. Your views on the statements about mental health diagnoses and your opinion on sorting these statements into categories will be provided through a discussion with the researcher.
- *How will my data be used?*
  Information collected within the pilot study will be used to inform the expansion or refinement of a set of statements concerning mental health diagnoses, which will be used within the main research project.
- *Will my data be kept confidential?*
  The information you provide within the pilot study will remain confidential within the research team unless there are any serious concerns about your safety, or the safety of others. If this is the case the researcher will, except in exceptional circumstances, firstly speak with you before making a disclosure to an authority relevant to the concern.
- *Will my data be anonymised?*
  Although things you say within the pilot study may be used to support the creation/ refinement of materials for the main research project, these will not be linked to you; therefore you will not be able to be identified from this information. Personally-

identifiable data you provide for the pilot study will be stored separately to things you say within the interview.

- *How will my data be stored securely?*
  Data will be stored securely in line with University of Leicester guidelines. Only members of the research team will have access to your data. Your normal rights under the Data Protection Act and General Data Protection Regulation apply. However, we need to manage your records in specific ways for the research to be reliable. This means that we won't always be able to let you see or change the data we hold about you.
- *How long will you keep my data for?*
  Information you provide within the Pilot Study will be stored for 5 years and destroyed after this, in line with University of Leicester guidelines.
- *Can I remove my data from the Pilot Study?*
  You can withdraw your data up until the end of the interview/sorting task.
- *Will my data be used in other research projects in the future?*
  The materials which are created for the main research project as a result of the pilot studies could be used in other research projects in the future. No one outside of the research team will be able to link you to any of the things you say within the pilot study which may contribute to these materials.

Who is organising and funding the research project and associated Pilot Studies?
The research is being conducted by [redacted] (Trainee Clinical Psychologist), Department of Neuroscience Psychology and Behaviour, The University of Leicester. The research is being supervised by [redacted] (Clinical Lecturer / Clinical Psychologist), Department of Neuroscience Psychology and Behaviour, The University of Leicester. The project is not funded.

Who has reviewed this research project?
This research project has been approved by a University of Leicester Ethics Committee.

How to take part?
If you have read this Pilot Study Participant Information Sheet (*Version 1.0, 27.11.2020)* and would like to take part in the sorting task and interview, please email the researcher on the email address below. The email address you use to contact the researcher will be the email address stored for your participation within the pilot study. A time slot will then be booked for the pilot study to take place.

Contact for Further Information
For further information about the pilot studies or research project please contact the researcher ([redacted]) or the research project supervisor ([redacted]). If you have any concerns or queries about the way in which this pilot study has been conducted, you should contact the Chair of the University Research Ethics Committee ([redacted]). If you require more GDPR data protection information then you can access this via the University's Information Assurance Services ([redacted]).

Thank-you for taking the time to read this participant information sheet.

Pilot Study 1: Consent Form

Note: The consent form was adjusted to include variations specific to certain groups targeted for this phase of the piloting.

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CONSENT FORM

(Version 1.0, 27.11.2020)

Pilot Study 1– Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Participant ID: ______________(to be completed by the researcher)

Questions marked with * are mandatory in order to take part.

Please indicate your agreement with each statement by typing an "x" within the corresponding box. By completing this consent form in this manner and emailing it back to the researcher you are indicating your consent to take part within the pilot study.

Date: __/__/__

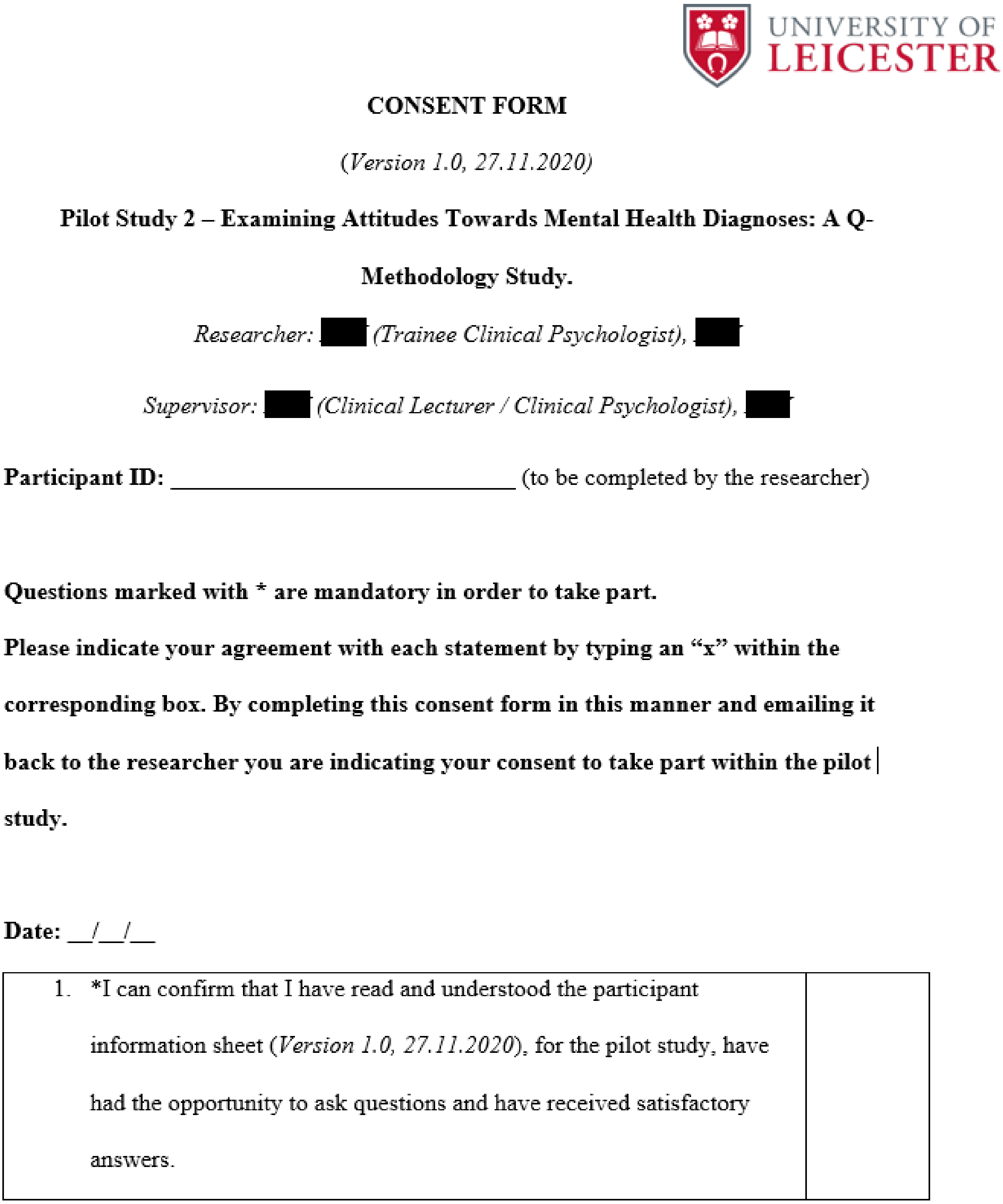
1. *I can confirm that I have read and understood the participant information sheet (*Version 1.0, 27.11.2020*), for the pilot study, have had the opportunity to ask questions and have received satisfactory answers.	

2. * I understand that my participation is voluntary and that I am free to withdraw at any time up until the end of the focus group, without giving reason.	
3. *I agree to the audio / video recording of the discussions involved within the pilot study.	
4. *I understand that data collected during the pilot study may be looked at by members of the research team. I understand that my personal details will be kept confidential.	
5. *I understand that my data will be kept securely in line with University of Leicester guidelines.	
6. *I understand that any information I provide during this pilot study will remain confidential unless there are any serious concerns about my safety or the safety of others. I understand that the researcher will, except in exceptional cases, firstly speak to me before making a disclosure to an authority relevant to the concern	
7. *I give permission for things that I have said/written during discussions within the pilot study to be used within the materials for the study and in published reports. I understand that other people will not be able to link me to statements I have made (apart from the research team and participants within the same focus group). Anything which is included in the final report will be anonymised, and all identifiable information removed, so that I cannot be identified from any published reports.	
8. *I understand that the materials which are created for the main research project as a result of the pilot studies, could be used in other research projects in the future. No one outside of the research team and the	

focus group will be able to link me to any of the things I say within the Pilot Study which may contribute to these materials.	
9. *I can confirm I am aged 18 years or older.	
10. *I can confirm that I identify with one of the following **(please highlight/indicate which one(s) apply to you)**: • Someone who has accessed a mental health service / peer support group *(currently or in the past)* • Someone who has worked in a mental health service / setting (currently or in the past) *(this includes trainees or students on courses with an applied healthcare component where placements are undertaken in mental health services / settings)* • An Academic working in a field relating to mental health	
11. *(*Applicable only to remote Focus Groups*) I am aware that other participants may be able to see my email address through the video-conferencing platform. I am aware that other participants within the group [redacted].	
12. *I agree to take part in the above pilot study.	

Pilot Study 2: Consent Form

Note: The consent form was adjusted to include variations related to payment for participation.



UNIVERSITY OF LEICESTER

CONSENT FORM

(Version 1.0, 27.11.2020)

Pilot Study 2 – Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Participant ID: ________________________________ (to be completed by the researcher)

Questions marked with * are mandatory in order to take part.

Please indicate your agreement with each statement by typing an "x" within the corresponding box. By completing this consent form in this manner and emailing it back to the researcher you are indicating your consent to take part within the pilot study.

Date: __/__/__

1. *I can confirm that I have read and understood the participant information sheet (*Version 1.0, 27.11.2020*), for the pilot study, have had the opportunity to ask questions and have received satisfactory answers.	

2. *I understand that my participation is voluntary and that I am free to withdraw at any time up until the end of the interview/task, without giving reason.	
3. *I agree to the audio / video recording of the discussions involved within the pilot study.	
4. *I understand that data collected during the pilot study may be looked at by members of the research team. I understand that my personal details will be kept confidential.	
5. *I understand that my data will be kept securely in line with University of Leicester guidelines.	
6. *I understand that any information I provide during this pilot study will remain confidential unless there are serious concerns about my safety or the safety of others. I understand that the researcher will, except in exceptional cases, firstly speak to me before making a disclosure to an authority relevant to the concern.	
7. *I give permission for things that I have said/written during discussions within the pilot study to be used within the materials for the study and in published reports. I understand that other people will not be able to link me to statements I have made (apart from the research team). Anything which is included in the final report will be anonymised, and all identifiable information removed, so that I cannot be identified from any published reports.	
8. *I understand that the materials which are created for the main research project as a result of the pilot studies, could be used in other research projects in the future. No one outside of the research team will be able	

to link me to any of the things I say within the pilot study which may contribute to these materials.	
9. *I can confirm I am aged 18 years or older.	
10. *I can confirm that I identify with one of the following **(please highlight/indicate which one(s) apply to you)**: • Someone who has accessed a mental health service / peer support group *(currently or in the past)* • Someone who has worked in a mental health service / setting (currently or in the past) *(this includes trainees or students on courses with an applied healthcare component where placements* are undertaken in mental health services / settings) • An Academic working in a field relating to mental health	
11. *I agree to take part in the above pilot study.	

Pilot Study 1: Interview Questions

PILOT 1 STUDY QUESTIONS

Version 1.0 (27.11.2020)

Pilot Study 1 - Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Pilot Phase 1 Questions for Focus Groups.

Participants will be made aware that the researcher is interested in their views towards mental health diagnoses (such as schizophrenia, personality disorder, depression). Participants will be informed that there are no right or wrong answers to the questions.

Participants will be asked to note down up to 3 of their initial responses to the following questions. Participants will be made aware their responses could include their own, or others views towards the questions being asked.

1. In what ways are mental health diagnoses useful for mental health services?
2. In what ways are they problematic for mental health services?
3. In what ways can a mental health diagnosis be useful for someone accessing services?
4. In what ways might a mental health diagnosis cause problems for a diagnosed person?
5. Are there groups of people whom you think mental health diagnoses are more or less problematic for? Please state why in your response.

6. What are the effects of mental health diagnoses in terms of how friends or family may react?
7. What effects does diagnosis have on other aspects of a person’s life, such as work, education, access to services and benefits?
8. How useful or otherwise are diagnoses for mental health professionals or people researching mental health?
9. What are your beliefs regarding whether the mental health diagnoses reflect real discrete disorders?
10. What do mental health disorders mean to you?
11. Are there any mental health disorders that you regard as more valid or more problematic? Please state why in your response.

Participants will then be asked to share these responses with the group via the chat function and will be asked to discuss their own and each other’s responses.

The researcher will prompt for further exploration of participants’ responses.

Pilot Study 2: Interview Questions

PILOT 2 STUDY QUESTIONS

Version 1.0 (27.11.2020)

Pilot Study 2 – Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Pilot Phase 2 Questions for Interview

Participants will be asked to sort the statements they are provided with into 3 categories (those they agree with, those they disagree with, and those they feel impartial about). They will be asked to sort these in relation to their views around the usefulness of mental health diagnoses.

Questions:

1. Please can you tell me how many cards you have in each of the three categories (agree / disagree / impartial)?
2. To what extent did you feel the statements represented your own views in relation to mental health diagnoses?
3. To what extent do you feel the statements may represent others' views surrounding mental health diagnoses?
4. Do you feel there are any views towards mental health diagnoses which were not captured within the statements? *If yes, prompt for further information / examples.*

5. Do you feel there are any statements missing? *If yes, prompt for further information.*
6. Were there any statements which you felt were unclear with regards to their meaning? *If yes, prompt for further information.*
7. Please comment on your experience of completing the sorting task. *Prompt for ease of task, understanding of task, anything additional information which could be provided to support the task.*

Pilot Study 1 and 2: Debrief Form

DEBRIEF FORM

(Version 1.0, 27.11.2020)

Pilot Study 1 / 2– Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Thank-you for taking part in this pilot study, your involvement will provide a valuable contribution to the adaptation of the materials for the main research project. If you have any questions about the pilot study or your participation, please contact the researcher using the email address at the top of this sheet.

If completing the pilot study has brought up any difficult emotions or experiences for you, please consider seeking further support using one of the following contacts:

- The Samaritans – A confidential listening service

  -Website: https://www.samaritans.org/

  -Telephone: 116 123 (free service, operating 24 hours per day)

  -Email: jo@samaritans.org (the service aims to respond to your email within 24 hours)

- MIND – A Mental Health Charity

  -Website: https://www.mind.org.uk/

  -This website contains information on how you can seek support for your mental health

- Rethink Mental Illness – A Mental Health Charity

  -Website: https://www.rethink.org/

  -This website contains information on ways you can seek support for your mental health

- You could also contact your GP if you are concerned about your own mental health and wish to seek further support from an NHS service.

Appendix P*

Demographic Form – used for Pilot 1, 2 and Main Study

DEMOGRAPHIC FORM

Version 1.0 (27.11.2020)

Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

Please complete the following information about yourself, you can indicate that you would prefer not to answer a certain question by highlighting the option, “prefer not to say”.

1. Age: ________________________________ (Prefer not to say)
2. Ethnicity: ____________________________ (Prefer not to say)
3. Gender: _______________________________ (Prefer not to say)
4. Occupation: ____________________________ (Prefer not to say)

   (if student, please indicate which course you are enrolled on)
5. Have you ever received a mental health diagnosis?

   (Yes / No / Prefer not to Say)
6. Have you ever used mental health services or a mental health peer support group?

   (Yes / No / Prefer not to Say)

Appendix Q*

Interview Schedule – Main Study

POST-SORT INTERVIEW SCHEDULE

Version 1.2 (19.09.2021)

Examining Attitudes Towards Mental Health Diagnoses: A Q-Methodology Study.

Researcher: [redacted] *(Trainee Clinical Psychologist),* [redacted]

Supervisor: [redacted] *(Clinical Lecturer / Clinical Psychologist),* [redacted]

(May be discussed via an interview or using an online survey)

I am going to ask you some questions about the task you have just completed.

1. I can see that you most strongly agreed with the statement that says *(insert statement from card),* please can you tell me why? *(repeat for all cards ranked as "strongly agree") – most like my point of view*
2. I can see that you most strongly disagreed with the statement that says *(insert statement from card),* please can you tell me why? *(repeat for all cards ranked as "strongly disagree") – least like my point of view*
3. Were there any statements you found hardest to sort? Can you explain why this was?
4. Can you explain if you approached the sorting task in a particular way? (For example, were there diagnoses you were thinking about in particular?)
5. Do you feel there were any cards missing, for example, are there certain views that you feel were not captured well by the statements?

6. One statement reads: “Some MH diagnoses are more stigmatising than others” – do you have any comments about this statement? (E.g., if you agree with this card, which diagnoses are more stigmatising than others?)
7. One statement reads “MH diagnoses give people hope for recovery / change” – do you have any comments about this statement? (E.g., in what ways do / don’t diagnoses give people hope for recovery / change?)
8. Is there anything else you would like to say in relation to your sorting of the cards?

Appendix R

Additional Information about Analysis

Factor Extraction

Following the correlational analysis, seven factors were originally selected for extraction as recommended by Brown (1980). Considerations including the Kaiser-Guttman Criteria, Humphrey's Rule and significant q-sort loadings supported the decision to determine the quantity of factors to subject to rotation (Watts & Stenner, 2012).

Kaiser-Guttman Criteria

The Kaiser-Guttman Criteria (Kaiser, 1960; Watts & Stenner, 2012) proposes that a factor should possess an eigenvalue above one to be retained for further analysis; this ensures that a factor accounts for a larger proportion of the study variance than one q-sort would (Watts & Stenner, 2005). Based on this criterion four factors would remain, see Table S1.

Table S1

Eigenvalues from seven initial extracted factors.

Factor	Eigenvalue
1	9.5753
2	9.1337
3	1.5405
4	1.0952
5	0.8673
6	0.7181
7	0.8547

Significant Loadings

Brown (1980) suggests that factors which possess two significantly loading q-sorts may also be worth considering for further analysis. Using guidance from Watts and Stenner

(2012), q-sorts were considered as significantly loading onto a factor at a value of +/- 0.34 ($p<.01$). Among the factors which contained eigenvalues greater than one, factors 1, 2, and 3 met this criterion, with factor 4 containing only one significant loading.

Humphrey's Rule

Factor significance according to Humphrey's Rule (Fruchter, 1954, as cited in Brown, 1980), is determined by the cross-product of the two q-sorts which load most strongly onto that factor; the cross-product should be greater than double the standard error. Watts and Stenner (2012) also suggest a more lenient criterion whereby the cross-product is merely greater than the standard error. Using guidance from Watts and Stenner (2012) the standard error was calculated as 0.13. Factors 1 and 2 met the stricter criterion of Humphrey's Rule, and Factor 3 met the more lenient criterion. Factor 4 approached the value of the studies standard error.

Considering the results of the multiple criteria, plus guidance which suggests that it is acceptable to extract a greater number of factors initially to ensure that important attitudes are not prematurely rejected (Watts & Stenner, 2012), four factors were extracted for rotation.

References

Brown, S. R. (1980). *Political Subjectivity: Applications of Q Methodology in Political Science.* New Haven, CT: Yale University Press.

Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and psychological measurement, 20*(1), 141-151.

Watts, S., & Stenner, P. (2005). Doing Q methodology: Theory, method and interpretation. *Qualitative Research in Psychology, 2*(1), 67-91. doi:10.1191/1478088705qp022oa

Watts, S,. & Stenner, P. (2012). *Doing Q Methodological Research: Theory, Method and Interpretation.* Sage: London.

Appendix S*

Statement of Epistemological Position

The systematic literature review and the empirical research project were both undertaken from a position of critical realism. Critical realism assumes that phenomena within our environment manifest outside of the realm of our own understandings or awareness of them (Frauley & Pearce, 2007; Pilgrim, 2020). With regards to the thesis this meant that I considered both public stigma and attitudes towards mental health diagnoses to be ‘real’ phenomenon.

Critical realism also supposes that visible events, such as behaviours, are governed by potentially unseen mechanisms (Frauley & Pearce, 2007) and it is the part of the researcher’s job to investigate the mechanisms underpinning the phenomena which can be explicitly detected (Willig, 2013). This is relevant to the systematic literature review whereby the notion of public stigma is not a tangible phenomenon which can be explicitly seen, but aspects explicitly assessed by prior research, such as the behaviours, emotional experiences, and beliefs of participants were considered to reflect the underlying component of public stigma. Similarly, in relation to the empirical research project, the attitudes which exist towards the utility of mental health diagnoses required delineating from the information that participants offered through their q-sorts and qualitative interviews. Furthermore, critical realism has been suggested to be an appropriate epistemological position for researchers engaging with methodology encompassing both quantitative and qualitative components (Hurrell, 2014), which is relevant to the Q-methodological design I employed for the empirical research project.

References

Frauley, J., & Pearce, F. (2007). Critical Realism and the Social Sciences: Methodological and Epistemological Preliminaries. In Frauley, J., & Pearce, F. *Critical Realism and* *the Social Sciences: Heterodex Elaborations* (pp3-29). Toronto: University of Toronto Press.

Hurrell, S. A. (2014). Critical Realism and Mixed Methods Research: Combining the Extensive and Intensive at Multiple Levels. In Edwards, P. K., O'Mahoney, J., & Vincent, S. *Studying Organizations using Critical Realism: A Practical Guide* (pp241-263). Oxford University Press.

Pilgrim, D. (2020). The Utility of Critical Realism. In Pilgrim, D., *Critical Realism for Psychologists* (pp.1-33). Routledge.

Willig, C. (2013). Chapter 2: Epistemological bases for qualitative research. In Willig, C., *Introducing qualitative research in psychology* (pp14-22). UK: McGraw-Hill education.

Appendix T*

Guidelines for Target Journal

The target journal for the systematic literature review and the empirical research project is the *Journal of Mental Health.* This journal was deemed appropriate as it accepts papers which present alternative understandings or considerations to conventional practice. The journal is also open to research from different professionals and fields, which would support the reach of both the systematic literature review and the empirical project to different types of practitioners working within mental health systems and services.

Information about the Journal:

https://www.tandfonline.com/action/journalInformation?show=aimsScope&journalCode=ijmh20

Guidelines for Authors:

https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=ijmh20

Appendix U*

Chronology of the Research Process

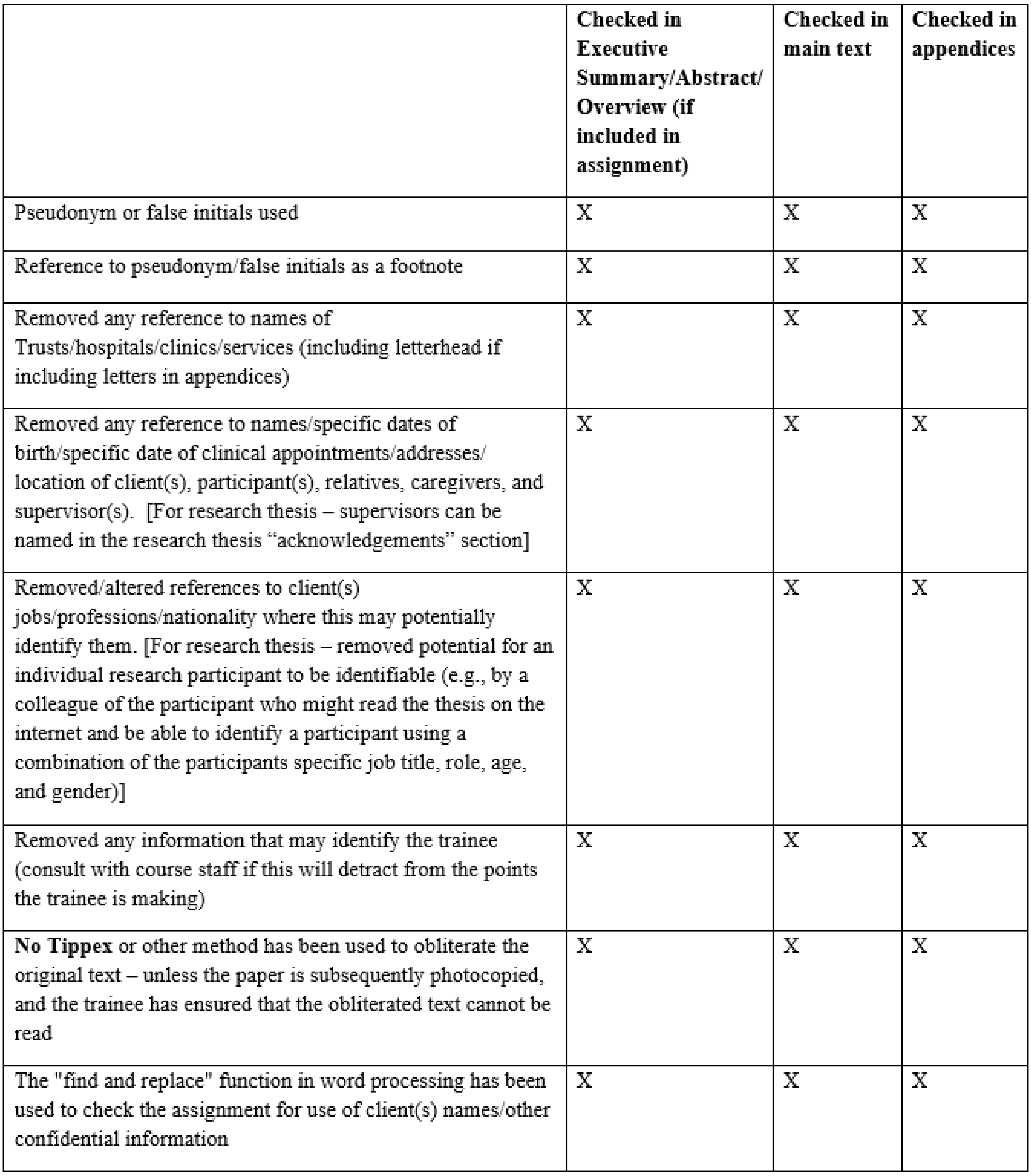
Date	Task
December 2019	Research supervisor allocation
January 2020	Initial meetings with supervisor to discuss project ideas
April 2020	Research proposal development
May 2020	Research proposal submitted as part of University of Leicester peer review process
June 2020	-Meeting with internal / external peer reviewers to discuss research proposal -Beginning to review written concourse for Q-set
June / July 2020	Minor amendments made to research proposal from review process
August 2020	Re-submission of research proposal for peer review
September 2020	Service User Reference Group peer review summary submitted and approved
October 2020	Peer review feedback for research proposal
November 2020	Initial ethics application submitted to The University of Leicester School of Psychology Research Ethics Committee
December 2020	Initial ethics application approved by The University of Leicester School of Psychology Research Ethics Committee
February 2021 to March 2021	Pilot Phase 1 (4x Focus Groups) to support with creation of the Q-Set
July 2021	Beginning to consider scope for literature review
August 2021 to September 2021	Pilot Phase 2 (Individual Interviews) to support with refinement of the Q-Set
September 2021	-Q-Set finalised -Initial search for literature review conducted -Data collection commenced
October 2021	Submission of draft literature review
November 2021	Revised search for literature review conducted

January 2022	Submission of draft literature review
March 2022	-End of data collection -Analysis
February 2022 to May 2022	Write up
May 2022	Submission of doctoral thesis
Planned for Summer 2022	Dissemination of findings to participants who requested this
Planned for Summer-Autumn 2022	Poster presentation and publication within journal

Note: ongoing development and amendments to the q-set occurred from June 2020 to September 2021

Appendix V*

Anonymity Checklist



	Checked in Executive Summary/Abstract/ Overview (if included in assignment)	Checked in main text	Checked in appendices
Pseudonym or false initials used	X	X	X
Reference to pseudonym/false initials as a footnote	X	X	X
Removed any reference to names of Trusts/hospitals/clinics/services (including letterhead if including letters in appendices)	X	X	X
Removed any reference to names/specific dates of birth/specific date of clinical appointments/addresses/ location of client(s), participant(s), relatives, caregivers, and supervisor(s). [For research thesis – supervisors can be named in the research thesis "acknowledgements" section]	X	X	X
Removed/altered references to client(s) jobs/professions/nationality where this may potentially identify them. [For research thesis – removed potential for an individual research participant to be identifiable (e.g., by a colleague of the participant who might read the thesis on the internet and be able to identify a participant using a combination of the participants specific job title, role, age, and gender)]	X	X	X
Removed any information that may identify the trainee (consult with course staff if this will detract from the points the trainee is making)	X	X	X
No Tippex or other method has been used to obliterate the original text – unless the paper is subsequently photocopied, and the trainee has ensured that the obliterated text cannot be read	X	X	X
The "find and replace" function in word processing has been used to check the assignment for use of client(s) names/other confidential information	X	X	X