BMJ Open

Decision (not) to disclose mental health conditions or substance abuse in the work environment: a multiperspective focus group study within the military

Rebecca Bogaers ,[1,2] Elbert Geuze ,[2,3] Jaap van Weeghel,[1] Fenna Leijten,[4] Nicolas Rüsch,[5] Dike van de Mheen,[1] Piia Varis,[6] Andrea Rozema,[1] Evelien Brouwers[1]

To cite: Bogaers R, Geuze E, van Weeghel J, *et al*. Decision (not) to disclose mental health conditions or substance abuse in the work environment: a multiperspective focus group study within the military. *BMJ Open* 2021;**11**:e049370. doi:10.1136/bmjopen-2021-049370

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2021-049370).

Received 25 January 2021
Accepted 13 October 2021

For numbered affiliations see end of article.

Correspondence to
MSc. Rebecca Bogaers;
r.i.bogaers@tilburguniversity.edu

ABSTRACT

Objectives Many workers in high-risk occupations, such as soldiers, are exposed to stressors at work, increasing their risk of developing mental health conditions and substance abuse (MHC/SA). Disclosure can lead to both positive (eg, support) and negative (eg, discrimination) work outcomes, and therefore, both disclosure and non-disclosure can affect health, well-being and sustainable employment, making it a complex dilemma. The objective is to study barriers to and facilitators for disclosure in the military from multiple perspectives.

Design Qualitative focus groups with soldiers with and without MHC/SA and military mental health professionals. Sessions were audiotaped and transcribed verbatim. Content analysis was done using a general inductive approach.

Setting The study took place within the Dutch military.

Participants In total, 46 people participated in 8 homogeneous focus groups, including 3 perspectives: soldiers with MHC/SA (N=20), soldiers without MHC/SA (N=10) and military mental health professionals (N=16).

Results Five barriers for disclosure were identified (fear of career consequences, fear of social rejection, lack of leadership support, lack of skills to talk about MHC/SA, masculine workplace culture) and three facilitators (anticipated positive consequences of disclosure, leadership support, work-related MHC/SA). Views of the stakeholder groups were highly congruent.

Conclusions Almost all barriers (and facilitators) were related to fear for stigma and discrimination. This was acknowledged by all three perspectives, suggesting that stigma and discrimination are considerable barriers to sustainable employment and well-being. Supervisor knowledge, attitudes and behaviour were critical for disclosure, and supervisors thus have a key role in improving health, well-being and sustainable employment for soldiers with MHC/SA. Furthermore, adjustments could be made by the military on a policy level, to take away some of the fears that soldiers have when disclosing MHC/SA.

Strengths and limitations of this study

- The current study examined the disclosure dilemma from three perspectives (soldiers with and without mental health conditions and/or substance abuse, and military mental health professionals), creating a multiperspective view on disclosure of mental health conditions and substance abuse within the military.
- The explorative qualitative method used in the current study provided in-depth insight into the complex disclosure dilemma.
- The current study had a relatively low diversity of age and rank between participants, with a majority of older and higher-ranking soldiers.
- Risk of self-selection bias cannot be ruled out, as participants could freely sign up for this study.

INTRODUCTION

Worldwide, many workers in high-risk occupations are exposed to stressors at work, increasing their risk of developing mental health conditions and substance abuse (MHC/SA) (eg, soldiers/police officers/medical doctors).[1–4] Specifically, soldiers have an increased risk of developing MHC/SA as a result of deployment.[2 5] Additionally, these occupations are often in male-dominated workplaces, where masculinity norms such as self-reliance are high, which is associated with poorer mental health.[6] This subsequently poses a threat to sustainable employment through a higher risk for sick leave and unemployment.[7–9] A crucial decision for them is whether or not to disclose MHC/SA at work.

The decision to disclose an MHC/SA is complex, with far-reaching consequences for health, well-being and ultimately sustainable employment.[7 10 11] Disclosure can lead to advantages such as improved relationships at work, being able to be one's true self, work accommodations and a more inclusive workplace culture. Alternatively, disclosure can also lead to stigmatisation and discrimination,[10–12] which often has serious negative

consequences for well-being and sustainable employment. However, non-disclosure can be helpful to avoid stigma and discrimination, but can also lead to drop-out because when MHC/SA are ignored, workers miss out on opportunities for workplace support (eg, social support and workplace adjustments) that can be crucial to stay at work.[7 13]

This disclosure dilemma is expected to be even more prominent for high-risk occupations within male-dominated workplaces, such as the military, where workers are expected to be 'strong' and to meet masculine norms.[12 14] Disclosure may yield less positive outcomes within these workplaces.[12] Previous research also found that disclosure decisions within male-dominated workplaces were entirely driven by considerations of negative aspects.[15] Additionally, masculinity is associated with poorer health literacy[16] and difficulty in talking about feelings and emotions,[17] potentially making it harder to make a well-informed disclosure decision. Generally, low mental health literacy in workplaces can lead to MHC/SA being unaddressed.[18]

As yet, there is a lack of research,[7] especially within the military, on the decision to disclose.[19] A qualitative study within the German military examined attitudes towards disclosure of MHC/SA and found that soldiers indeed feared disclosure would lead to stigmatisation, gossip, discrimination and negative career consequences.[20] A quantitative study on the disclosure dilemma showed that 25% of Dutch workers would not disclose an MHC/SA, which was influenced by the perceived relationship with the supervisor, a preference for self-management and fear of negative consequences.[21] Another study among Dutch workers found that of those who had disclosed MHC/SA, almost 50% indicated this was due to a good relationship with their manager, and the main reasons for reporting a positive or negative disclosure experience was due to whether support was received or not by the manager.[22] This indicates the importance of supervisor–worker relationships for disclosure. As research on the topic is scarce, and the decision to disclosure has major consequences for health, well-being and sustainable employment, it is important to further examine factors that influence disclosure.

As the work and social environment influences disclosure, it is important to not only examine the views of soldiers with MHC/SA themselves, but also to include stakeholder perspectives of soldiers without MHC/SA[20] and military mental healthcare (MMH) providers. The perspective of soldiers without MHC/SA is important, as coworkers potentially hold negative stigmatising views[23] which could influence the disclosure decisions of others around them. Additionally, they might develop MHC/SA in the future, making it relevant to examine what would influence their disclosure decision.[24] As for MMH professionals, previous research has shown that mental health professionals play a role in how stigma affects sustainable employment.[23] Moreover, MMH professionals could play a role in providing disclosure advice to patients, making it relevant to first examine how aware they are of the barriers faced by soldiers when disclosing.

In summary, the current, exploratory, study aims to identify the barriers to and facilitators for (non)-disclosure in the workplace, from multiple perspectives: soldiers with and without MHC/SA and MMH professionals.

METHOD

Design

Qualitative research was used, as it is a desirable method for exploratory research when the topic is complex.[25] Particularly, focus groups were used as interaction among participants creates a more in-depth understanding. Due to the conversational nature of focus groups, they have the advantage to clearly show what participants think and why they think this way, as participants discuss the topic with each other.[26] A qualitative descriptive design was used[27] as it provides a comprehensive summary of an event and is grounded in the general principles of naturalistic inquiry.[28] As the aim of the current study was not to develop theory, but to explore barriers and facilitators for disclosure to inform future research and interventions, this design matched the aim of the study.

Setting

The study took place within the Dutch military and data collection took place between March and June 2019. For interpretation of the results, please find policies concerning substance (ab)use in table 1.

Table 1 Policy surrounding substance (ab)use within the Dutch military

Type of substance	Rules
Alcohol	Use of alcohol is prohibited during working hours.
Soft drugs (eg, marijuana, hashish)	Use of soft drugs is prohibited, during and outside of working hours. Use of soft drugs outside of working hours results in an official warning from the military, where multiple warmings result in discharge. Use of soft drugs during working hours, results in discharge from military service and, consequently, loss of employment. However, when reported to an MMH professional, patient confidentiality is strictly adhered to and thus treatment is possible.
Hard drugs (eg, heroin, cocaine, amphetamine.)	Use of hard drugs is prohibited, during and outside of working hours. Use results in discharge from military service and, consequently, loss of employment. However, when reported to an MMH professional, patient confidentiality is strictly adhered to and thus treatment is possible.
Exception patient confidentiality	When there is immediate danger for the patient and/or others, as a result of the MHC/SA, the MMH professional is allowed to break the patient confidentiality. This will first be discussed with the patient, whereafter the patient's supervisor will be informed.

MMH, military mental healthcare.

Table 2 Sample characteristics per set of focus groups, reported in M (range) or N

Demographics	Soldiers with MHC/SA (Groups=4, N=20)	Soldiers without MHC/SA (Groups=2, N=10)	Mental health professionals (Groups=2, N=16)
Age	46.25 (27–57)	31.8 (22–55)	41.81 (26–56)
Male	18	8	11
Married/living together	19	6	11
Permanent contract	20	8	16
Ranks			
Staff officer	6	4	15
Non-commissioned officer	10	1	0
Corporals	0	1	0
Private	0	4	0
Civilian	0	0	1
Unknown	4	0	0
Branches of military			
Army	11	2	N/A
Navy	4	5	N/A
Air force	2	1	N/A
Military police	3	0	N/A
Policy and support	0	2	N/A
MHC/SA*			
Posttraumatic stress disorder	6	N/A	N/A
Depression	5	N/A	N/A
Burn-out	4	N/A	N/A
Attention deficit hyperactivity disorder	2	N/A	N/A
Addiction	2	N/A	N/A
Personality disorder	2	N/A	N/A
Autism	1	N/A	N/A
Profession			
Psychologist	N/A	N/A	7
Social worker	N/A	N/A	3
Mental health nurse	N/A	N/A	1
Chaplain	N/A	N/A	2
Occupational physician	N/A	N/A	1
Systemic family therapist	N/A	N/A	1
General practitioner	N/A	N/A	1

*Total more than 100%, caused by two participants with a dual diagnosis.
MHC/SA, mental health condition and/or substance abuse; N/A, not available.

Participants

A total of 46 people participated, distributed over eight focus groups (min. N=3, max. N=10). As the main focus was on barriers to and facilitators for disclosure, which is an individual decision of the worker with MHC/SA, four groups were recruited to represent this perspective (current and/or past MHC/SA), and two for each of the other perspectives (soldiers without MHC/SA and MMH professionals). Demographics can be found in table 2. Two people signed up for the study, but could not participate due to illness.

Procedure

The Consolidated criteria for Reporting Qualitative research checklist, a guideline for reporting qualitative research, was used in reporting this study.[29] Data collection for this study happened simultaneously with data collection of a study on treatment seeking for MHC/SA.[24]

Participants were recruited through (1) flyers at mental health departments, (2) flyers at military bases, (3) military psychologists, (4) military newsletters, (5) personal contacts and (6) word-of-mouth between participants. Once people showed interest in participating (through

email/telephone), they received the information letter and sign-up information.

At the start of the focus groups, participants answered demographic questions, followed by introduction of the focus group leaders (names and research background). All focus groups took place at military locations, lasted approximately 2 hours and were audiorecorded and transcribed verbatim. One focus group leader led the discussion and the second took notes. Notes were reviewed after every focus group, and if needed minor adjustments were made to the topic list to ensure sufficient attention was paid to all topics in subsequent focus groups. As no major new topics came up in the last focus group, saturation was reached. All focus groups were facilitated by two (female) researchers (first author (RB, MSc) and a coauthor (EB or ADR, both PhD)), all with a background in psychology and health sciences and experienced in qualitative research. None of the researchers were actively involved in patient treatment. The first author was familiar with two participants through a friend but had no personal relationship with them.

Written informed consent was obtained from all participants prior to the start of the focus groups. Anonymity in reporting of results was guaranteed to all participants.

Patient and public involvement

Several stakeholders from the Dutch military (psychologists, psychiatrists, policy-makers and military personnel) were involved in the development of this study. The stakeholders provided advice on the recruitment of participants. For example, they ensured military appropriate language was used during recruitment. Additionally, they provided advice on the conduct of the study. For example, to ask participants to come in civilian clothing in order to not emphasise differences in ranks within each focus group. All participant groups, including patients (group soldiers with MHC/SA), were involved in recruitment by using word-of-mouth as a recruitment method.

Measurement

As this study was explorative, the aim was to see what barriers to and facilitators for disclosure participants identified themselves, using open questions. Therefore, the topic list focused on the question 'What are barriers to and facilitators for the decision to disclose MHC/SA?'. When needed, probes were used to encourage participants to elaborate on their answers, which can be found in the topic list (online supplemental materials). These probes were informed by existing research.[12 15 30] The same topic list was used for all focus groups. Prior to the focus groups, the topic list was piloted among experts within the military, by discussing what they thought was important for the disclosure decision (N=6).

Analysis

Content analysis was used by applying a general inductive approach using ATLAS.ti (V.8.4.4) software.[31] All transcripts were coded independently by the main researcher (RB) and a second member of the research team (EB/EG/JvW/ADR/FL) to ensure reliability. Differences were discussed, where-after about one fifth of all codes were modified. Coders used an open, bottom-up, inductive coding style. The research question was used as a framework. Namely, all codes were categorised into belonging to barriers to disclosure or facilitators for disclosure. During coding, the researchers aimed to stay as close to the actual data as possible, and not to interpret the data. Only after all transcripts were coded and consensus was reached between the researchers, interpretation took place. Overarching categories for the codes within the facilitators and the barriers were identified by the main researcher (RB) and checked by a second (EB). This led to the subcategories which can be found in table 3. Following, in order to increase validity, multiple members of the research team identified the final main categories. The research team was chosen in such a way that it reflected the perspective of the military (eg, FL) and of civilian researchers (RB, EB, JvW and ADR). Analysis remained on category level, in order to not lose valuable information by summarising on theme level.

RESULTS

A total of five main categories of barriers were found, and three main categories of facilitators. For a full overview, see table 3.

Barriers for disclosure

Fear of career consequences

All groups mentioned fear of career consequences as a barrier for disclosure. First, participants indicated a fear of losing their job. This was the case for all MHC/SA, but especially for substance abuse.

> Soldier without MHC/SA (male):
>
> You don't hear soldiers talk about drugs. You will get discharged for using drugs, so that must always remain a secret.

Second, participants indicated a fear of not being allowed to do what they like most about their job, for example, going on deployment.

> Soldier with MHC/SA (male):
>
> On deployment, our officer would say 'if I see that you are showing signs of MHC/SA, I will send you home'. Well, you definitely won't talk about your MHC/SA anymore.

Third, there was the fear of not being able to advance in their careers.

> MMH-professional (female):
>
> Many soldiers don't talk about MHC/SA, because they are afraid that when an opportunity for a promotion comes up, they won't be able to get it.

Table 3 Barriers to and facilitators for disclosure of MHC/SA

Categories	Subcategories	Soldiers with MHC/SA	Soldiers without MHC/SA	MHC/SA prof.
Barriers				
Fear of career consequences	Losing employment (and subsequent financial concerns).	✓	✓	✓
	Not being allowed to do what you like most about your job (eg, no deployment, no training, no flying).	✓	✓	✓
	Lack of career advancement.	✓	x	✓
Fear of social rejection	Fear of being seen as weak.	✓	✓	✓
	Fear of being rejected by the group.	✓	✓	✓
	Gossip culture of the military.	✓	✓	x
Lack of Leadership Support	Supervisor's negative attitude towards MHC/SA	✓	✓	✓
	Supervisor's lack of understanding (and taking it seriously)	✓	✓	✓
	Supervisor's lack of time for a conversation.	✓	x	✓
	Supervisor's lack of knowledge and experience.	✓	✓	✓
	No personal (trusting) relationship with supervisor.	✓	✓	✓
Lack of communication skills surrounding MHC/SA	Soldier's lack of skills to talk about own MHC/SA.	✓	✓	✓
	Coworker's lack of skills to start conversation about MHC/SA.	✓	✓	x
	Supervisor's lack of skills to start conversation about MHC/SA.	✓	✓	✓
Masculine Workplace culture	Denial of symptoms of MHC/SA.	✓	✓	x
	'We can do it' mind set.	✓	✓	✓
	Feeling shame for having MHC/SA.	✓	✓	✓
Facilitators				
Anticipated positive results	Disclosing to set an example and help others.	✓	x	✓
	Disclosing in order to heal/recover.	✓	x	x
Leadership support	Supervisor who makes time for a conversation.	✓	✓	x
	Trusting relationship with supervisor.	✓	✓	✓
	Supervisor's positive attitude towards MHC/SA.	✓	✓	✓
Work-related MHC/SA	Easier to disclose MHC/SA if they are a result of work/deployment due to perception that this is respected (especially posttraumatic stress disorder).	✓	x	✓

✓Indicates that subcategory was brought up and discussed by participants within a specific group of participants.
XIndicates that subcategory was not mentioned within specific group of participants.
MHC/SA, mental health condition and/or substance abuse.

Fear of social rejection

All groups indicated fear of social rejection as a barrier for disclosure. Participants indicated a fear of being seen as weak and of being rejected by the group.

> MMH-professional (female):
>
> They are afraid to be seen as weak, to get a label.

Participants also indicated that social rejection was an especially important barrier, because of high social cohesion within the military.

> Soldier with MHC/SA (male):
>
> It is hard. The culture within the military is that if you can keep up, it is really fun, a very tight group. But once you can't keep up anymore, you are the outsider.

Furthermore, participants indicated a fear of gossip.

> Soldier with MHC/SA (male):
>
> People gossip a lot within the military, and people quickly know what is going on with someone. So that made me reluctant to talk about my MHC/SA.

Lack of leadership support

All participants indicated lack of leadership support formed a barrier for disclosure. This showed in several ways. First, participants indicated that supervisors often hold negative attitudes towards MHC/SA and that many have little understanding and knowledge of, and experience with MHC/SA.

> Soldier with MHC/SA (male):
>
> Officers who just started their job, just finished training, no life experience, they won't see it when a soldier has MHC/SA.

Additionally, supervisors often do not make time for a conversation. There was also a lack of a trusting personal relationship with supervisors. Participants indicated that this often happens because of high turnover within the military (obligated job rotation every 3 years).

Soldier with MHC/SA (male):

I don't talk to my supervisor often; I don't know him well. I would tell him less.

This lack of trust in the supervisor, was also caused by how soldiers saw supervisors treat others with MHC/SA.

Soldier without MHC/SA (male):

I had a sergeant, and one of my colleagues talked to him about MHC/SA once, and during a debrief this sergeant discussed what my colleague told him. Suddenly everyone knew, while my colleague told him in confidence.

Lack of communication skills surrounding MHC/SA

All participants discussed that soldiers themselves often lack the skills to talk about their own MHC/SA.

MMH-professional (female):

I noticed that a lot of soldiers are not able to put their feelings into words. When they come to us, they are still in the phase of recognising their symptoms. They need to learn a lot before they can put everything into words.

In addition, it was also mentioned that colleagues and supervisors often lacked skills to start a conversation about MHC/SA.

Soldier with MHC/SA (male):

My supervisor kept talking about other things than my MHC/SA. He did not want to touch upon the topic. Because that was scary, what if I started crying?

Masculine workplace culture

All participants described the military as a place where soldiers are expected to be strong (ie, having a 'can-do' attitude), rather than showing weakness. This 'can-do' attitude is also associated with the denial of symptoms of MHC/SA.

MMH-professional (male):

Focus is to always keep on going, take your own responsibility, you are trained in that way.

This 'can-do' attitude can also lead to a feeling of shame associated with MHC/SA.

Soldier without MHC/SA (male):

There is also the feeling associated with MHC/SA, that it means you are not worthy of being a soldier, because MHC/SA mean you are weak, and that you cannot be a soldier.

Facilitators for disclosure

Anticipated positive results

Soldiers who had experienced MHC/SA themselves, indicated that a facilitator for disclosure was the expectation that it would lead to positive results. They indicated disclosing their own MHC/SA was necessary both for receiving treatment themselves and for helping others who might have similar problems.

Soldier with MHC/SA (female):

I couldn't do it alone; I had to do something [to recover]—so I told my supervisor'.

Leadership support

Whereas lack of leadership support was mentioned as a barrier, positive leadership support was mentioned by all groups as a facilitator for disclosure. Participants mentioned that it is important to have a supervisor who makes time for a conversation, that the supervisor has a positive attitude towards MHC/SA and that there is a relationship of trust.

MMH-professional (female):

'It is very important that officers endorse the importance of mental health.'

Soldier with MHC/SA (male):

[I told my supervisor because] I just knew him so well, had worked with him for a long time. That creates a different bond than when you have only worked with someone for two years.

Work-related MHC/SA

Participants mentioned that it was easier to disclose MHC/SA that were work-related injuries (eg, posttraumatic stress disorder as a result of deployment), than non-work-related MHC/SA. Work-related MHC/SA yielded more respect from others in the work environment.

MMH-professional (male):

'When something that happened in public (eg, deployment) [causing MHC/SA], it has some sort of status, it is easier to discuss that.'

Differences and similarities in views between groups

Across the three different perspectives, barriers and facilitators mentioned were highly similar, with almost all main categories mentioned by all perspectives. There were only minor differences in the subcategories. MMH professionals did not mention the gossip culture, the lack of skills of coworkers to talk about MHC/SA, the denial of symptoms, and the importance of disclosing to get better and supervisors who make time for a conversation. Soldiers without MHC/SA did not mention the fear of a lack of career advancement, supervisors lack of time for a conversation, the anticipated positive results as a reason for disclosure, and that it might be easier to disclosure work-related MHC/SA.

DISCUSSION

Soldiers feared that disclosure would lead to career consequences (losing employment, not being allowed to do what you like most about your job, lack of career advancement) and social rejection (being seen as weak, being rejected, gossip). Additionally, the masculine military culture was found to be a barrier to disclosure as people were expected to be strong, and soldiers with MHC/SA, colleagues and supervisors were found to lack skills to talk about MHC/SA. Supervisor behaviour, attitudes, skills and knowledge of MHC/SA played an important role, as it was both a barrier to and facilitator for disclosure. While the workplace can form a barrier for disclosure, results also showed that when soldiers experience support from supervisors and when their MHC/SA are work related, this can facilitate disclosure. Finally, motivation to disclose was due to hopefulness of recovery and helping others with MHC/SA.

Many barriers for disclosure were related to stigma. In line with research within the German military,[20] the current study found fear of career consequences and social rejection. Fear of career consequences relates to structural discrimination (rules and regulations which disadvantage individuals with MHC/SA[32]) and fear of social rejection relates to public stigma (prejudice held by member of the general population[33]). These fears are not specific for the military; a study among Dutch employees also found fear of career damage and social rejection as important barriers for disclosure.[21] Another form of stigma, self-stigma (*internalised* prejudices held by individuals with MHC/SA[34]) was not found to play a role in the current study, opposed to the study within the German military. Further quantitative research is needed to examine whether self-stigma influences disclosure within the Dutch military.

Comparing the sample of the study within the German military,[20] where a fear of career consequences was also found, to the sample of the current study, it should be noted that the current sample included more people with permanent contracts. Still fear of career consequences remained of such strong influence on disclosure. The study within the German military found that soldiers with MHC/SA on a fixed-term contract did not want to disclose due to their goal of getting a permanent contract, and that soldiers with MHC/SA on a permanent contract found it easier to disclose.[20] Another qualitative study in a civilian setting also found that perceived job security was of influence on the disclosure decision.[30] Since the current study as well as the study within the German military and among civilians are all qualitative, future quantitative research should further examine the relationship between contract type and disclosure decision.

Furthermore, the military culture formed a barrier for disclosure. While existing research into disclosure within the military is scarce, masculine workplace culture has been found as a barrier in similar occupations. Research showed that working in a male-dominated workplace makes it hard to disclose.[4 15] Increasing mental health literacy in these male-dominated workplaces, specifically the military, could potentially facilitate disclosure decisions.[35] This also relates to the lack of communication skills surrounding MHC/SA found in the current study. A study among firefighters also found managers' unease to discuss mental health as a barrier for disclosure.[36] In order to increase communication skills, interventions proven to be effective in other settings should be transformed to be applicable within the Dutch military. For example, a mental health training for managers in an Australian fire and rescue service improved confidence in communicating with their employees and could be adapted for use within the military.[37]

Majority of facilitators were also related to workplace culture. When a soldier experienced support from their supervisor this made it easier to disclose. Importance of supervisors for the disclosure decision has been found both in a military population,[20] other male-dominated workplaces,[15] and in regular civilian workplaces.[21 38] Therefore, it is important to provide training to supervisors to improve their knowledge, attitudes and communication skills surrounding MHC/SA, as mentioned before, and to improve employee-manager relationships through team building and lower turnover. Additionally, the current study showed that it was easier to disclose work-related MHC/SA, that is, a result of a work-related incident. There are two explanations for this finding. First, the current study showed that there was more respect for MHC/SA related to deployment than if those health issues were not seen as the result of work. Second, a study within the German military showed that officers thought that PTSD could be dealt with better compared with other MHC/SA, because there was more knowledge and awareness about PTSD.[20] If disclosure is easier when there is more knowledge and awareness, this highlights the importance of increasing knowledge and awareness of other MHC/SA within the military.

As for the comparison of views between perspectives, all three perspectives mentioned the same main barriers and facilitators. This high agreement implies that disclosure actually does pose a risk for career consequences and social rejection, and the supervisor behaviour plays a crucial role, rather than this only being the perceptions of soldiers with MHC/SA themselves. Second, high similarity in views stresses the importance of the barriers and facilitators found, and if dealt with adequately in practice, barriers can be converted to facilitators that ultimately will improve health, well-being and sustainable employment.

Interestingly, however, MMH professionals did not mention several barriers faced by soldiers related to the workplace, while it would be helpful for professionals to address these barriers during treatment. They appear less aware that coworkers do not have skills to start a conversation about MHC/SA. Additionally, professionals did not mention gossip culture as a barrier for disclosure. Presumably, professionals could help soldiers in making wise decisions about who to disclose to, with what information, in order to avoid gossip. Previous research in non-military

settings has shown that thorough preparation of mental health disclosure in the work environment, such as being selective in information you share, and with whom, can help avoid adverse occupational outcomes.[12 39 40] As there seems to be a disconnect between the MMH professionals and the soldiers, MMH professionals could benefit from more awareness about the barriers faced by soldiers. They could likely benefit from training about how the workplace culture forms a barrier for disclosure. It is also interesting to note that soldiers without MHC/SA did not mention fear for lack of career advancement as a barrier for disclosure. It is possible that this fear is related to self-stigma of soldiers with MHC/SA, and not recognised by soldiers without MHC/SA. However, a study within the Dutch military into the decision to seek treatment for MHC/SA did find that soldiers without MHC/SA reported lack of career advancement as a barrier for treatment seeking.[24]

Strengths and limitations

The first strength was the explorative qualitative method used to gain insight into a complex subject matter, which will be used to inform further quantitative research. Second, the current study included multiple perspectives (soldiers with and without MHC/SA and MMH professionals) on disclosure within the military.[41 42] Third, as research on disclosure of MHC/SA, especially within the military, is scarce, and completely lacking within the Dutch military, this study provides insights for development of interventions specific for the Dutch military. Fourth, several measures were taken during data collection to ensure that soldiers could speak freely (eg, participants did not know each other, use of civilian clothes to not emphasise difference in ranks and focus group leaders were independent researchers and therefor had no influence on participants' careers).

The first limitation relates to the generalisability of this study. Even though a stratified sample was approached, the sample contained a relatively low diversity of age and rank, with a majority of older and higher-ranking soldiers. Additionally, there was an over-representation of the army within the soldiers with MHC/SA group and the navy within the soldiers without MHC/SA group. Results might differ for different layers and branches of the military organisation, and younger, lower-ranking soldiers, may face different barriers than older, higher-ranking ones. For example, a study among Dutch employees showed that compared with people who had disclosed their MHC/SA, those who had not were significantly younger.[22] However, generalisability was not the purpose of the study. As with other qualitative studies, the aim was to provide insight into a complex challenge of which more knowledge is urgently needed. Future quantitative research should further examine disclosure using a representative sample, which will also provide opportunity to examine actual disclosure rates within the military and whether disclosure depends on certain demographics, but also whether it depends for example on type of MHC/SA, beyond whether MHC/SA are work related or not.

Second, the current study did not include the perspective of supervisors, while supervisor support was found to be important for the decision to disclose. A previous study within the German military did include the supervisor perspective and found similar results. Supervisors indicated more knowledge and awareness surrounding PTSD compared with other MHC/SA and recognised that stigma was a barrier for disclosure. However, to gain more insight into supervisor support, and how to increase it, future research should further examine the perspective of supervisors.

Third, risk of self-selection bias cannot be ruled out, as participants could freely sign up for this study, meaning that views on the topic could be different for other soldiers and MMH professionals. Additionally, there is a risk of researcher bias, as the researchers coded the transcripts. However, to limit this bias and prevent the subjective interpretation of one researcher, multiple researchers coded the data.

Fourth, a limitation of using a focus group study is that participants are not anonymous to each other. This poses the risk that participants only provide socially desirable answers, especially when the topic studied is sensitive topic such as in this study. However, focus groups were chosen because compared with individual interviews, focus groups have the advantage that participants can respond to each other's answers, providing additional insight into the topic.[25] Furthermore, the first author was familiar with two participants, also forming a risk for socially desirable answers. However, as there was no personal relationship and only familiarity, it is expected that effects of socially desirable answers are negligible. Additionally, several measures were taken to allow participants to speak freely, as discussed in the strengths section.

CONCLUSIONS

The results showed that the disclosure process is complex, and suggest that discrimination and stigma are considerable barriers to disclosure and subsequent well-being and sustainable employment. To enhance health, well-being and sustainable employability, it is of crucial importance that stigma is eliminated. Focus should be on interventions that create a more supportive workplace environment for soldiers with MHC/SA. For example, by improving supervisor–worker relationships and by creating more knowledge and awareness about MHC/SA in general (not just PTSD), to increase mental health literacy, as this makes disclosure easier. This is especially important at the level of the supervisor, as they play such a crucial role in the disclosure decision.

Furthermore, soldiers showed fear of career consequences and social rejection. High agreement across different perspectives implies that disclosure actually does pose a risk for career and social relations. Future research should focus on interventions that assist soldiers in disclosure decisions, in order to stop these adverse outcomes from occurring.[39 43] MMH professionals could

play an important role by discussing disclosure as part of treatment, but they should first be made more aware through training about certain workplace cultures influencing disclosure. Additionally, military policy could be revised concerning the negative career consequences of MHC/SA.

Together, these findings can be used to create a safer environment for soldiers, and other high-risk occupations, to disclose MHC/SA, providing supervisors with opportunity to support their employees, leading to improved health, well-being and sustainable employment.

Author affiliations
[1]Tranzo Scientific Center for Care and Wellbeing, Tilburg School of Social and Behavioral Sciences Tilburg University, Tilburg, The Netherlands
[2]Brain Research and Innovation Centre, Netherlands Ministry of Defence, Utrecht, The Netherlands
[3]Brain Center Rudolf Magnus, University Medical Centre Utrecht Psychiatry, Utrecht, The Netherlands
[4]Strategic Military Healthcare Department, Netherlands Ministry of Defence, Utrecht, The Netherlands
[5]Department of Psychiatry II, University of Ulm, Ulm, Germany
[6]Department of Culture Studies, Tilburg School of Humanities and Digital Sciences Tilburg University, Tilburg, The Netherlands

Twitter Evelien Brouwers @EvelienBrouwers

Acknowledgements We thank the people who participated in this study and shared their personal experiences with us, giving us insight into this important topic. We also thank the providers of the funding for this research, the IMPACT PhD Program 2018 of Tilburg University and a grant from the Dutch Ministry of Defence.

Contributors RB: As the PhD student on the project, RB was involved in all aspects of the study. RB is also the guarantor for this study. EG: Was involved by advising RB during the formulating of research question(s) and designing the study. Was second coder for two of the focus group manuscripts and provided multiple rounds of feedback on the manuscript of the paper. JvW: was involved by advising RB during the formulating of research question(s) and designing the study. Was second coder for two of the focus group manuscripts and provided multiple rounds of feedback on the manuscript of the paper. FL: was involved by advising RB during the formulating of research question(s) and designing the study. Was second coder for two of the focus group manuscripts and provided one critical round of feedback on the manuscript of the paper. NR: was involved by advising RB during designing the study and provided one critical round of feedback on the manuscript of the paper. DvdM: was involved by advising RB during the formulating of research question(s) and designing the study and provided one critical round of feedback on the manuscript of the paper. PV: was involved by advising RB during the formulating of research question(s) and designing the study and provided one critical round of feedback on the manuscript of the paper. ADR: was involved by advising RB during the formulating of research question(s) and designing the study. Was one of the focus group leaders for two of the focus groups. Was second coder for one of the focus group manuscripts and provided one round of critical feedback on the manuscript of the paper. EB: is project leader who wrote the research proposal. Was involved by advising RB during the formulating of research question(s) and designing the study. Was one of the focus group leaders for four of the focus groups. Was second coder for one of the focus group manuscripts and provided multiple rounds of critical feedback on the manuscript of the paper.

Funding This work was mainly supported by the IMPACT PhD Programme 2018 of Tilburg University (no grant number). Additionally, the work was partially supported by a grant from the Dutch Ministry of Defence (no grant number), but this grant did not influence the interpretation of the data; the writing of the paper; or the decision to submit the paper for publication.

Competing interests RB reports grants from The Dutch Ministry of Defence, during the conduct of the study. EG has nothing to disclose. JvW reports grants from The Ministry of Defence, during the conduct of the study. FL has nothing to disclose. NR has nothing to disclose. DvdM reports grants from Dutch Ministry of Defence, during the conduct of the study. PV reports grants from The Dutch Ministry of Defence, during the conduct of the study. ADR reports grants from The Dutch Ministry of Defence, during the conduct of the study. EB reports grants from The Dutch Ministry of Defence, during the conduct of the study; other from the Netherlands School of Public and Occupational Health, the Occupational Psychologists' organisation Ascender, the occupational Healthcare provider Humantotalcare and the Employer network Transvorm, outside the submitted work.

Patient consent for publication Not applicable.

Ethics approval All procedures were approved by the Tilburg School of Social and Behavioural Sciences Ethics Review Board (approval number EC-2018.107) and the Military Ethics Review Board (no approval number provided).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request. The data that support the findings of this study are available on reasonable request from the corresponding author, R.B. The data are not publicly available due to containing information that could compromise the privacy of research participants.

ORCID iDs
Rebecca Bogaers http://orcid.org/0000-0002-3908-9861
Elbert Geuze http://orcid.org/0000-0003-3479-2379

REFERENCES

1 McFarlane AC, Williamson P, Barton CA. The impact of traumatic stressors in civilian occupational settings. *J Public Health Policy* 2009;30:311–27.
2 Reijnen A, Rademaker AR, Vermetten E, *et al*. Prevalence of mental health symptoms in Dutch military personnel returning from deployment to Afghanistan: a 2-year longitudinal analysis. *Eur Psychiatry* 2015;30:341–6.
3 Sundin J, Fear NT, Greenberg N, *et al*. Differences in the reporting of mental health outcomes between US and UK military personnel. *Occup Environ Med* 2011;68:A49.
4 Kyron MJ, Podlogar MC, Joiner TE, *et al*. Allowing nondisclosure in surveys with suicide content: characteristics of nondisclosure in a national survey of emergency services personnel. *Psychol Assess* 2020;32:1106–17.
5 Stevelink SAM, Malcolm EM, Mason C, *et al*. The prevalence of mental health disorders in (ex-)military personnel with a physical impairment: a systematic review. *Occup Environ Med* 2015;72:243–51.
6 Milner A, Kavanagh A, King T, *et al*. The influence of masculine norms and occupational factors on mental health: evidence from the baseline of the Australian longitudinal study on male health. *Am J Mens Health* 2018;12:696–705.
7 Brouwers EPM. Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: position paper and future directions. *BMC Psychol* 2020;8:1–7.
8 Leijten FRM, de Wind A, van den Heuvel SG, *et al*. The influence of chronic health problems and work-related factors on loss of paid employment among older workers. *J Epidemiol Community Health* 2015;69:1058–65.
9 Leijten FRM, van den Heuvel SG, Ybema JF, *et al*. Do work factors modify the association between chronic health problems and sickness absence among older employees? *Scand J Work Environ Health* 2013;39:477–85.
10 Jones AM. Disclosure of mental illness in the workplace: a literature review. *Am J Psychiatr Rehabil* 2011;14:212–29.
11 Brohan E, Henderson C, Wheat K, *et al*. Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry* 2012;12:11.

12 Brouwers E, Joosen M, van Zelst C, *et al*. To disclose or not to disclose: a multi-stakeholder focus group study on mental health issues in the work environment. *J Occup Rehabil* 2019:1–9.
13 Coleman SJ, Stevelink SAM, Hatch SL, *et al*. Stigma-related barriers and facilitators to help seeking for mental health issues in the armed forces: a systematic review and thematic synthesis of qualitative literature. *Psychol Med* 2017;47:1880–92.
14 Stergiou-Kita M, Mansfield E, Bezo R, *et al*. Danger zone: men, masculinity and occupational health and safety in high risk occupations. *Saf Sci* 2015;80:213–20.
15 Stratton E, Einboden R, Ryan R, *et al*. Deciding to disclose a mental health condition in male dominated workplaces; a Focus-Group study. *Front Psychiatry* 2018;9:684.
16 Milner A, Shields M, King T. The influence of masculine norms and mental health on health literacy among men: evidence from the ten to men study. *Am J Mens Health* 2019;13:1557988319873532.
17 Chandler A. Masculinities and suicide: unsettling 'talk' as a response to suicide in men. *Crit Public Health* 2021;39:1–10.
18 Moll S, Zanhour M, Patten SB, *et al*. Evaluating mental health literacy in the workplace: development and psychometric properties of a vignette-based tool. *J Occup Rehabil* 2017;27:601–11.
19 Hom MA, Stanley IH, Schneider ME, *et al*. A systematic review of help-seeking and mental health service utilization among military service members. *Clin Psychol Rev* 2017;53:59–78.
20 Rüsch N, Rose C, Holzhausen F, *et al*. Attitudes towards disclosing a mental illness among German soldiers and their comrades. *Psychiatry Res* 2017;258:200–6.
21 Dewa CS, Weeghel JV, Joosen MC, *et al*. What could influence workers' decisions to disclose a mental illness at work? *Int J Occup Environ Med* 2020;11:119–27.
22 Dewa CS, van Weeghel J, Joosen MCW, *et al*. Workers' decisions to disclose a mental health issue to managers and the consequences. *Front Psychiatry* 2021;12:631032.
23 Beukering van I, Smits S, Janssens K, *et al*. In what ways does health related stigma affect sustainable employment and well-being at work? A systematic review. *Journal of Occupational Rehabilitation* 2021:1–15.
24 Bogaers R, Geuze E, van Weeghel J, *et al*. Barriers and facilitators for treatment-seeking for mental health conditions and substance misuse: multi-perspective focus group study within the military. *BJPsych Open* 2020;6:e146.
25 Ritchie J, Lewis J, Nicholls CM, *et al*. *Qualitative research practice: a guide for social science students and researchers*. sage, 2013.
26 Cyr J. The pitfalls and promise of focus groups as a data collection method. *Sociol Methods Res* 2016;45:231–59.
27 Lambert VA, Lambert CE. Qualitative descriptive research: an acceptable design. *Pacific Rim International Journal of Nursing Research* 2012;16:255–6.
28 Colorafi KJ, Evans B. Qualitative descriptive methods in health science research. *HERD* 2016;9:16–25.
29 Booth A, Hannes K, Harden A, *et al*. *COREQ (consolidated criteria for reporting qualitative studies). Guidelines for reporting health research: a user's manual*, 2014: 214–26.
30 Toth KE, Dewa CS. Employee decision-making about disclosure of a mental disorder at work. *J Occup Rehabil* 2014;24:732–46.
31 Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval* 2006;27:237–46.
32 Rüsch N, Thornicroft G. Does stigma impair prevention of mental disorders? *Br J Psychiatry* 2014;204:249–51.
33 Wright KM, Cabrera OA, Bliese PD, *et al*. Stigma and barriers to care in soldiers postcombat. *Psychol Serv* 2009;6:108–16.
34 Vogt D. Mental health-related beliefs as a barrier to service use for military personnel and veterans: a review. *Psychiatr Serv* 2011;62:135–42.
35 Rüsch N, Evans-Lacko S, Thornicroft G. What is a mental illness? public views and their effects on attitudes and disclosure. *Aust N Z J Psychiatry* 2012;46:641–50.
36 Bryan BT, Gayed A, Milligan-Saville JS, *et al*. Managers' response to mental health issues among their staff. *Occup Med* 2018;68:464–8.
37 Milligan-Saville JS, Tan L, Gayed A, *et al*. Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial. *Lancet Psychiatry* 2017;4:850–8.
38 Donaldson-Feilder E, Yarker J, Lewis R. Line management competence: the key to preventing and reducing stress at work. strategic HR review 2008.
39 Scior K, Rüsch N, White C, *et al*. Supporting mental health disclosure decisions: the honest, open, PROUD programme. *Br J Psychiatry* 2020;216:243–5.
40 Henderson C, Brohan E, Clement S, *et al*. Decision aid on disclosure of mental health status to an employer: feasibility and outcomes of a randomised controlled trial. *Br J Psychiatry* 2013;203:350–7.
41 Sheehan LL, Corrigan PW, Al-Khouja MA, *et al*. Stakeholder perspectives on the stigma of suicide attempt survivors. *Crisis* 2017;38:73–81.
42 Corrigan PW, Shah BB, Lara JL, *et al*. Stakeholder perspectives on the stigma of fetal alcohol spectrum disorder. *Addict Res Theory* 2019;27:170–7.
43 Stratton E, Choi I, Calvo R, Hickie I, *et al*. Web-based decision aid tool for disclosure of a mental health condition in the workplace: a randomised controlled trial. *Occup Environ Med* 2019;76:595–602.